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

April 2004

Acknowledgements

The Inquiry Panel wish to express their gratitude to the Panel Co-ordinator, Mrs Catherine Weightman, for all her hard work and assistance in the administration of the Inquiry.

The Panel also wish to thank Mrs Diane Budding for preparing transcripts of all the oral evidence received in the course of the Inquiry.

Finally, the Panel wish to acknowledge their appreciation for the clerical support provided by Mrs Ann Hammond in the preparation of the report of the Inquiry.

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Terms of reference

The Inquiry Panel was appointed by the Northumberland and Tyne & Wear Health Authority (succeeded by the Northumberland, Tyne and Wear Strategic Health Authority) on 20th August 2002 to enquire into the health care and treatment of Mark Towell and to prepare a report and make recommendations to the Authority. The members of the Inquiry Panel were:

- Mr Kester Armstrong - Barrister (Chairman)
- Dr Adrian Berry - Consultant Forensic Psychiatrist
- Mr Robert Craig - Head of Nursing Development
- Mr Roger Statham - Former Chief Probation Officer
- Mrs Kay Whittle - Former Director of Social Services

The Inquiry was established under the terms of the Health Service Guidance HSG (94) 27, following the conviction and sentence to life imprisonment of Mark Towell on 18th July 2002 for the murder of Arthur Leonard Leak, on 22nd September 2001.

The Inquiry Panel's terms of reference were as follows:

Mark Towell - d.o.b. 29.5.1975

To consider the Internal Inquiry into the care and treatment of Mark Towell initiated by Gateshead Health NHS Trust and Gateshead Local Authority's Community Based Services (Social Services Department) within the joint working arrangements for Adult Mental Health and Addictions and:

To examine the circumstances surrounding his health care and treatment, in particular:

- the quality and scope of the assessment and management of risk
- the appropriateness of professional and in service training of those involved in the care of Mark Towell
- the suitability of his care and the extent to which it complied with statutory obligations and relevant guidelines from the Department of Health

To examine the adequacy of collaboration and communication between the agencies involved in the care of Mark Towell.

To prepare a report and make recommendations to Northumberland and Tyne & Wear Health Authority.

The Inquiry Panel met on: 26th November 2002, 13th, 22nd, 23rd January, 28th, 29th, 30th April, 1st, 14th, 15th May, 4th, 5th June, 2nd, 3rd, 8th, 9th July, 9th, 10th October, 10th, 11th November and 8th December 2003.

The Panel heard evidence from 26 individuals, read substantial documentation from the relevant agencies involved and considered the Report of the Internal Inquiry into the care and treatment of Mark Towell by Gateshead Health NHS Trust and also Gateshead Local Authority's Community Based Services (Social Services Department) within the joint working arrangements for Adult Mental Health and Addictions. The Panel further considered the Report of the Gateshead Inter-Agency Review of Services provided to Mark Towell.

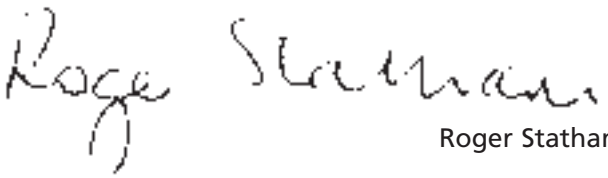
All of those witnesses who gave formal evidence have had the opportunity to amend and approve the transcripts of their evidence.

Having been invited to disclose all relevant documentation and information to the Inquiry Panel, the respective agencies responded punctually to the requests made of them for records and documentation.

The object of this Inquiry was to endeavour to throw light on the events which led to the death of Arthur Leonard Leak and to identify areas in which practice could be improved. It is not the purpose of this Report to attribute blame to individuals. For this reason and in order to encourage uninhibited contributions to the Inquiry, the professionals who came into contact with Mark Towell are not identified by name. Furthermore, insofar as it is practicable, the names of individuals who had personal relationships with Mark Towell are not identified.

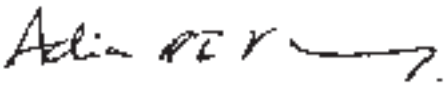
The report has been prepared with the expectation that all witnesses have provided full and frank disclosure to the Inquiry Panel.

Kester Armstrong

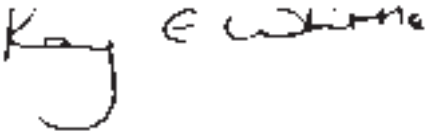


Roger Statham

Robert Craig



Adrian Berry



Kay Whittle

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Introduction

On 22nd September 2001 Mark Towell killed Arthur Leonard Leak by pouring petrol over him which he then ignited. At his criminal trial, whilst not giving evidence to the Court, Mark Towell maintained that Mr Leak's death had been caused accidentally in the course of an argument between the two men. The jury by their verdict rejected this explanation and determined that the killing had been the result of a deliberate act on the part of Mark Towell. Mark Towell was convicted of murdering Mr Leak and was sentenced to life imprisonment.

At the time of Mr Leak's death he and Mark Towell were known to each other. They had been drinking heavily together in a public house on the day the offence was committed. Mr Leak was 49 years old at the time of his death. He was the long-term partner of AY, a lady whose daughter had intermittently been involved in a relationship with Mark Towell. In the days immediately before the offence, Mark Towell had moved into the home shared by AY and Arthur Leak.

The precise motivation precipitating Mark Towell's attack on Mr Leak remains unclear notwithstanding the account given by Mark Towell to the Panel in the course of an interview in Durham Prison. It is clear, however, that, at the time of the offence, Mark Towell was heavily preoccupied by the difficulties in his relationship with AY's daughter and that he had identified Mr Leak, in his own mind, as being in some way implicated in these problems. Mark Towell's personal history, as documented in this report, was marked by significant difficulties on his part in coping with rejection in the course of his close relationships with others.

At the commencement of the Inquiry the Panel met with AY, Arthur Leak's partner at the time of his death, and MP, Mr Leak's daughter. From these interviews it was apparent that Mr Leak's whole family has been deeply traumatised by his death and are anxious to know whether any lessons could be learned from the circumstances giving rise to his murder. The Panel would wish to express its condolence and appreciation to the family members for the assistance they gave through their respective contributions to the Inquiry.

The Panel was also assisted by Mr Towell, Mark Towell's father, who attended a meeting with the Panel and provided valuable information relating to the background to the case. The Panel would wish to acknowledge its appreciation for his involvement in the Inquiry.

In order to obtain an understanding of the various problems presented by Mark Towell and the care and treatment afforded to him, it is necessary to consider in some detail the key dates and events in his life, beginning with his early years.

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Narrative of key dates and events

29.5.1975 – 5.7.1994

Mark Towell was born on 29th May 1975 and was placed immediately with pre-adoptive foster parents. At the age of 8 weeks he was placed with his adoptive parents, Mr and Mrs Towell. The legal adoption of Mark Towell took place very soon thereafter. Mr and Mrs Towell described him as a bright, attractive baby in whom they took great pleasure.

In 1979, when Mark Towell was 4 years old, twin baby boys were placed with Mr and Mrs Towell and were subsequently adopted by them. From an early stage there were indications that Mark Towell viewed the introduction of siblings into the family with considerable jealousy. Mr and Mrs Towell were sensitive to his initial antipathy and endeavoured to provide individual attention for him, taking him out on his own and enjoying activities with him on his own. An extension was added to the family home so the three boys could each have their own room.

In the course of the Inquiry Mr and Mrs Towell were spoken to by the Panel co-ordinator and Mr Towell attended in person and spoke with the members of the Panel. It is clear that Mark Towell was a much loved and wanted child. Whilst he was a boisterous toddler, there was nothing in his early childhood which indicated anything untoward.

Mark Towell was informed by his parents that he was adopted as soon as they believed he was old enough to understand. They received no expert advice or support in providing this explanation but used their common sense, explaining to him that he had been chosen by them as he was special. As he grew older and occasionally expressed interest in identifying his birth parents, Mr and Mrs Towell supported him to the best of their ability and offered to help him with this. Increasingly, however, expressions of such interest on Mark Towell's part were made in the course of angry and intoxicated outbursts against his parents and were not subsequently pursued by him.

In later years, Mark Towell stated to the Probation Service that he had lived with Mrs Towell's parents between the ages of 4 and 9 years. Mr and Mrs Towell denied this suggestion and stated that he had only spent the occasional night at his grandparents' home. This was one of a number of examples where Mark Towell proved to be an unreliable historian in the course of his contacts with various health and other professionals.

By the time Mark Towell was of school age, Mr and Mrs Towell were aware of his destructive behaviour. He would deliberately break items that were purchased for him, for example a ruler and a calculator. When Mark Towell was 5 years old, Mr Towell recalled being shocked to learn, when upon attending the first parents' meeting at school, that Mark Towell was a disruptive influence on the other children in the class.

On 5th July 1983 when Mark Towell was 8 years old, an entry in his GP notes recorded that Mrs Towell was stating that he had been "horrible and fractious all week, despite her anxiety to reassure him that he was still loved".

When Mark Towell attended secondary school in Newcastle upon Tyne, he was assessed as being in the second of eight grades, with potential to achieve the first grade. Mr and Mrs Towell sought to encourage his academic studies. Mr Towell enrolled at Gateshead College to learn German so that he could assist Mark Towell with his own study of that language. Mark Towell subsequently dropped German as a subject without informing Mr and Mrs Towell. Mr and Mrs Towell believed that he was frightened of not succeeding and would rather not attempt something than run the risk of failure.

At secondary school Mark Towell found himself in trouble on a regular basis, with threats being made by the school of suspension and expulsion. Mr Towell described how he visited the Head Teacher at the school on a number of occasions to make representations on behalf of him in respect of various incidents. He was involved in incidents of smoking on school premises and of truanting. He would invariably deny allegations made against him. Eventually, at the age of 15, Mark Towell was expelled after swearing at a French teacher and thereafter did not return to school.

When Mark Towell was approximately 13 years of age, he was involved in an incident where he pushed another youth onto the Metro railway line. The incident was passed off by him both at the time and thereafter as a joke, although it was treated as being sufficiently serious by his GP so as to justify a referral of him to the Young People's Unit at Newcastle upon Tyne where he was seen by a mental health professional. Two sessions of role play and anger management were subsequently arranged. It has proved impossible to obtain the records relating to this referral. Mr Towell, however, informed the Panel that Mark Towell perceived the therapy as being a "waste of time" and refused to attend any further sessions. Mark Towell's father told the

Panel that even at this early age he was extremely headstrong and could not be prevailed upon to attend against his wishes. He further indicated that throughout Mark Towell's childhood, professional help which he and his wife attempted to obtain for him through his GP was in each instance frustrated by Mark Towell's own lack of motivation to access such assistance.

Mark Towell informed the Panel that by the age of 13 years he had started drinking alcohol, which he would steal from his parents' sideboard. As he grew older his parents noticed that his behaviour would markedly deteriorate after he had been drinking and he would be particularly aggressive.

Mr Towell informed the Panel that when Mark Towell reached the age of 16, he was initially disinterested in obtaining work but that he soon became disenchanted by existing on Social Security Benefits and started to look for employment. He found employment as a labourer through an agency and worked on various construction sites in the area. Mr Towell believed that Mark Towell was motivated to work and that he found periods of unemployment difficult. Mr Towell explained that when in employment Mark Towell was receiving sufficient earnings, but that he couldn't manage his money, spending significant sums on alcohol and drugs and that he would then subject his parents to emotional pressure in order to obtain money from them.

Mr Towell informed the Panel that he did not believe that Mark Towell had ever been mentally ill but that his difficulties were brought about by his drug and alcohol use.

Mr Towell indicated to the Panel that as Mark Towell grew older, his behaviour at home became increasingly difficult. He described how Mark Towell would flare up in a temper for no apparent reason and would cause damage to the family home by putting his fist through a door or window if thwarted or challenged by a family member. His behaviour in the home was, at times, threatening. On occasions he would return home under the influence of alcohol and threaten both Mr and Mrs Towell, on at least one occasion using a baseball bat. Mr Towell described how the life of the family came to revolve around Mark Towell's various moods. He gave an account of an incident when Mark Towell telephoned late at night requesting that he be collected by car. During the journey home, and in the course of an argument, Mark Towell attempted to make his father crash the car and upon arrival at the family home he kicked his father.

On 3rd June 1992, when Mark Towell was 17 years of age, he consulted his GP stating that his life was "going nowhere" and that "no-one listens". He appeared angry in his presentation and mentioned his adoptive status. A referral was made by his GP to the community psychiatric nurse (CPN). Mark Towell's father told the Panel that Mark Towell was not particularly

motivated to seek this help himself but did so as a result of parental pressure.

On 17th June 1992 Mark Towell was seen for the first time by CPN(1) as a consequence of the GP referral. During his consultation, Mark Towell complained of:

- aggressive thoughts and feelings which were acted upon occasionally
- feeling that people were against him
- having low stress tolerance.

He reported drug use by him at this stage as including "magic mushrooms, ecstasy, cocaine, acid, cannabis and opium". He stated that he was unemployed, having left an employment training scheme because he didn't like it. He described how he had been jealous of his twin adoptive brothers and had rebelled. He felt that his parents no longer cared for or had an interest in him. A course of six weekly counselling appointments with CPN(1) was arranged to assist Mark Towell in gaining insight into his thoughts and feelings and to develop constructive alternative ways in which he could address his behaviour including relaxation and anxiety management techniques.

On 24th June 1992 Mark Towell attended his second appointment with CPN(1) together with Mr Towell. Mr Towell expressed his concern as to Mark Towell's aggressive behaviour in the family home which he said had deteriorated over recent months. He was afraid that Mark Towell would use a weapon when he became aggressive and hurt a member of the family. Mark Towell acknowledged that there were times when he was out of control and he described these times as a "yellow phase".

On 2nd July 1992 CPN(1) met with Mark Towell again. He reported suicidal feelings and mood changes. He discussed his feelings of jealousy in relation to his brothers and how he would have temper tantrums when he was unable to get what he wanted. At the conclusion of the consultation CPN(1) spoke with GP(1) and suggested that Mark Towell would benefit from a full psychiatric assessment. GP(1) agreed with this proposal.

On 14th July 1992, Mark Towell attended a further appointment with the CPN(1). He described an extreme range of moods during the preceding week, from being suicidal to happy. He admitted to smoking cannabis to excess but did not see this as a problem. He had commenced a Youth Training Scheme which he was happy with and his aggressive behaviour had diminished a little. He indicated, however, that there were some youths in Birtley who were "after him for fighting" and he was now afraid for himself because these people had a reputation for aggression.

On 21st July 1992 CPN(1) wrote to GP(1) summarising her involvement with Mark Towell and formally requesting a referral for a full psychiatric assessment.

On 28th July 1992, CPN(1) had a further consultation with Mark Towell. He spoke positively about his employment. He believed that he was cutting down his consumption of drugs. He acknowledged that this had affected the way he had been feeling. He did, however, describe aggression in his relationships and fighting with his friends.

On 11th August 1992, CPN(1) visited Mark Towell after receiving a telephone call from him. He was off work at the time due to a throat infection. He reported that he was enjoying his job and that it was distracting him from his negative thoughts. He was finding life at home with his family more tolerable. In the light of the improved presentation, the CPN(1) made no further appointments to see him.

On 18th September 1992, CPN(1) wrote to GP(1), describing the work undertaken by her with Mark Towell. She indicated that throughout the sessions they had addressed his reluctance to take responsibility for his behaviour and had considered ways in which he could channel his aggressive thoughts and behave more productively. She indicated that she had concluded the planned programme of appointments and would make no further visits unless otherwise directed.

On 14th January 1993 Mark Towell visited GP(2), requesting further counselling. He described how life at home was getting worse and that he had "had enough of fighting". GP(2) made a further referral for an appointment to be arranged with the same CPN who had seen Mark Towell previously.

On 2nd February 1993 Mark Towell attended the first appointment with CPN(1). He described similar problems to those previously identified including: difficulty in his relationship with his parents; aggressive feelings; difficulty in concentrating at college, causing him to be disruptive within the classroom. He described his use of steroid drugs and was encouraged to discontinue his use of these because of their potential effect upon his feelings and behaviour. He indicated that he had been seen by a psychologist at his college. A further appointment with CPN(1) was arranged. At the conclusion of the appointment, CPN(1) spoke with GP(2) indicating that she believed that Mark Towell would benefit from a full psychiatric assessment.

On 15th February 1993, CPN(1) wrote to GP(2) requesting a full psychiatric assessment by a named consultant psychiatrist. She recorded that Mark Towell had stated that he had not abused drugs since June 1992. She highlighted a number of difficulties in his life including relationship problems with his parents, when it appeared that he constantly tested their

love for him; low stress tolerance and responding in an aggressive manner and a dislike of people generally.

On 16th February 1993, Mark Towell attended a further appointment with CPN(1) He described his hostility towards peers at college and wanting to harm them for no obvious reason. There were tensions in the family home between himself and his brothers. CPN(1) was of the view that Mark Towell "is unable to accept his behaviour as being inappropriate and usually blames other people". Mark Towell reported to CPN(1) that he was continuing to take steroids. Advice was given to him in relation to techniques for managing his thoughts and feelings.

On 23rd February 1993 Mark Towell attended what was to be his final appointment with CPN(1). CPN(1) formed the opinion that Mark Towell was using the session for other people's benefit and that he was rejecting any therapeutic intervention. She challenged him with her view and he agreed, stating that he was only attending for his parents' benefit. CPN(1) believed that it would be inappropriate in the circumstances to arrange any further sessions and the situation was left on the basis that Mark Towell would contact CPN(1) if and when he felt the need to do so.

On 10th March 1993 Mark Towell was involved in an incident of violence in the community when he assaulted a deputy head teacher. Mark Towell and a male friend were walking a Bull Mastiff dog in the grounds of Portobello Primary School in Vigo, Birtley. When told to vacate the premises Mark Towell and his friend refused to do so. The deputy head teacher was approached by the dog and tried to ward it off. Mark Towell accused the man of kicking his dog and punched the man in his face approximately three times and then kicked him about the body and face. The other youth took no part in the assault. The injured party sustained cuts and bruises to the face and body as a result of the assault. When interviewed by police officers in the presence of his father Mark Towell stated "I only hit him because he was kicking my dog."

On 18th March 1993 GP(2), made a referral in respect of Mark Towell to a consultant psychiatrist at the Child and Adolescence Unit at the Newcastle General Hospital. The referral highlighted that Mark Towell quite openly spoke of his "attacks" of violence. GP(2) described how, according to Mark Towell's parents, Mark Towell would demonstrate a total loss of control when he was thwarted. Mark Towell himself had reported voices within his head that commanded him to become rough. He had indicated that he coped with life until he sensed people were not listening to him and then he noticed he couldn't get his words out, things went yellow and he blacked out. When he came round he would notice that "people and things have been hurt".

On 8th April 1993 Mark Towell failed to attend an appointment which had been arranged for him with the Consultant in Adolescent Psychiatry, at the Child and Adolescence Unit at Newcastle General Hospital. He was unable to attend as he was suffering from tonsillitis.

On 13th April 1993 Mark Towell was arrested at Washington Services and found to be in possession of a quantity of cannabis.

On 23rd April 1993, Mark Towell was seen by a consultant adolescent psychiatrist at the Child and Adolescence Unit. Consultant psychiatrist(1) wrote to GP(2) on the same date describing his consultation with Mark Towell. He described how Mark Towell had "been involved in a number of fights with friends and assaulted people in the past". Consultant psychiatrist(1) also recorded the significant problems experienced by Mark Towell at school. He had been withdrawn from one school to prevent a suspension. He had attended another school and had stayed on in the Lower 6th to re-sit GCSEs but had shown only modest motivation. At the time of the appointment, he was attending Gateshead College, taking GCSEs but was experiencing difficulties with the teaching staff. Consultant psychiatrist(1) stated "Though he has taken alcohol in the past and this has made his loss of temper worse and also abused drugs, substance misuse does not appear to be a causative feature."

Consultant psychiatrist(1) noted that Mark Towell was complaining of being troubled by "voices" namely second person commands telling him to "do things". These voices were particularly bad at night when he was alone. Mark Towell also described yellow vision. He did not accept, however, that there had not been a good reason for him losing his temper and assaulting people in the past. Although Mark Towell told consultant psychiatrist(1) that he felt his life was going nowhere, consultant psychiatrist(1) could not elicit any formal signs of depression. On balance, consultant psychiatrist(1) concluded that Mark Towell did not have an organic basis for his loss of control. Consultant psychiatrist(1) indicated that he would arrange for an EEG and would thereafter see Mark Towell again with a view to addressing ways in which he might increase his level of control and divert himself from situations where he was likely to lose his temper.

In the notes made by consultant psychiatrist(1) in the course of his consultation with Mark Towell it is recorded that Mark Towell spoke of the assault of the deputy head teacher on 10th March 1993 stating that "He hit me. I could not stop." It is also recorded that Mark Towell had stated he was "snapping" the whole time and that the "voices" had instructed him to "kill people".

On 5th May 1993, Mark Towell's solicitor, instructed in the criminal assault proceedings, wrote to consultant psychiatrist(1) requesting an opportunity to speak on the telephone about Mark Towell in connection with the

forthcoming court case. A telephone conversation subsequently took place where Mark Towell's solicitor appraised consultant psychiatrist(1) of the circumstances of the offence and Mark Towell's proposed defence, namely self-defence.

On 17th May 1993, Mark Towell failed to attend a follow-up appointment with consultant psychiatrist(1) at the Child and Adolescence Unit.

On 25th June 1993, Mark Towell was seen by the consultant psychiatrist(1) at the Child and Adolescence Unit for the purposes of a psychiatric report being prepared at the request of Mark Towell's solicitor, in relation to the criminal proceedings arising from the assault of the deputy head teacher.

On 7th July 1993, consultant psychiatrist(1) provided a psychiatric report for the Magistrates' Court in the criminal proceedings. The report highlighted Mark Towell's propensity for loss of temper after very little provocation. Mark Towell was credited, however, with having made efforts to get appropriate help from the agencies to address his difficulties. Consultant psychiatrist(1) recommended that a Probation Order would underline the seriousness of the assault and offer Mark Towell help in controlling his behaviour.

On 13th July 1993 Mark Towell was convicted of the offence of Assault Occasioning Actual Bodily Harm and was placed on probation for 12 months.

In July 1993 the initial assessment of Mark Towell carried out by the Probation Service noted the problems being caused by his aggression and poor temper control. Contact with Mark Towell's parents indicated that they were experiencing a considerable degree of stress. Mark Towell's contact with his probation officer had been "very good" but he stated that he did not feel very positive about any help he could receive from the Probation Service or the Child and Adolescence Unit. The probation officer decided that it was not beneficial to replicate the work she believed would be undertaken at the Child and Adolescence Unit although she indicated her intention to attempt to explore with Mark Towell why he was experiencing so much anger. She identified Mark Towell's adoptive status as a possible cause of some of his difficulties.

On 19th July 1993 and 26th July 1993, Mark Towell kept his appointments with his probation officer. Mark Towell appeared to be apathetic and was difficult to engage. He was resistant to accepting responsibility for his aggressive outbursts, blaming others instead. He expressed the view that nothing could be achieved by either his visits to see consultant psychiatrist(1) or by being placed on probation.

On 4th August 1993, Mark Towell's probation officer telephoned consultant psychiatrist(1) and ascertained that Mark Towell had a further appointment to see him the following day. Consultant psychiatrist(1) expressed doubt as to

whether Mark Towell would keep his appointment. Consultant psychiatrist(1) clarified the nature of the work being undertaken with Mark Towell. Consultant psychiatrist(1) agreed to telephone the probation officer if Mark Towell didn't keep his appointment.

On 5th August 1993, Mark Towell did not attend his appointment with consultant psychiatrist(1) at the Child and Adolescence Unit. Mark Towell was written to by the Unit and offered a further appointment on 16th September 1993.

On 23rd August 1993, Mark Towell did not attend an appointment at the Department of Neurophysiology at Newcastle General Hospital for an EEG.

On 25th August 1993, Mark Towell kept his appointment with his probation officer. He reported that life at home continued to be strained and that he was continuing to get into fights.

By September 1993, Mark Towell's probation officer recorded that Mark Towell was maintaining that neither probation nor consultant psychiatrist(1) were of any use to him. She believed that Mark Towell was "playing games" and that "maybe a firm line needs to be taken to him in order that he begins to address seriously his aggression and offending behaviour".

On 14th September 1993, Mark Towell kept his appointment with his probation officer. He claimed that he wanted to change but people kept "picking fights" with him. He stated that he had cut down drastically in his drinking as he had started weight training. He admitted that he had been injecting steroids in association with his weight lifting.

On 16th September 1993 Mark Towell did not attend an appointment with consultant psychiatrist(1) at the Child and Adolescence Unit.

On 11th October 1993, in a meeting with his probation officer, Mark Towell indicated that he thought he would re-offend at some point in the future as he quite liked fighting. The probation officer recorded that she doubted whether she had made much impression on Mark Towell at this stage.

On 8th November 1993, Mark Towell told his probation officer that he had assaulted a friend of his, although no charges had been pressed. He claimed that his friend had started the incident and he saw no reason why he shouldn't have retaliated. He indicated that he had no desire to continue at college. The probation officer advised him to reconsider this decision.

On 13th December 1993, Mark Towell admitted to his probation officer occasional use of cannabis and that he was taking steroids regularly.

In January and February 1994, Mark Towell described to his probation officer how his plans in relation to returning to college and finding employment were in a state of flux.

On 7th March 1994, during a meeting with his probation officer, Mark Towell described how he was spending his days doing nothing and didn't know what he wanted to do. He was uncommunicative and admitted taking "quite substantial" amounts of drugs at the weekend.

On 11th April 1994, Mark Towell attended an appointment with his probation officer and appeared to be under the influence of drugs. He stated that he had been using heroin. He presented as being depressed and indicated that he didn't care if he died and that he had nothing to live for. He gave an account of associating with a group of armed drug dealers. Mark Towell's probation officer passed this information on to a senior probation officer.

On 3rd May 1994 Mark Towell informed his probation officer that he had commenced a two year Leisure NVQ Course. The probation officer had a lengthy discussion with him about his drug abuse. He stated that he took overdoses of drugs as a means of escape. The probation officer encouraged him to contact his GP but he refused to do so.

On 23rd May 1994 Mark Towell's probation officer recorded that he still seemed to enjoy violence. He showed no desire to change. He actually enjoyed the adrenalin surge. She noted "I am concerned because if Mark does not address this he could actually commit a very serious offence, some time in the future."

On 6th June 1994, Mark Towell informed his probation officer that he was trying to reduce his drugs intake and that this was going "fine". The probation officer was sceptical about what she was told.

After a break of one month between contacts with Mark Towell and his probation officer due to the probation officer's absence on holiday, Mark Towell met with her for the final time on 5th July 1994. He stated that he had attended a job interview but had an alternative plan to attend college. He said that he had stopped taking drugs as a result of a recent incident when, after consuming drink with Temazepam, he had become very aggressive with his father and had attacked him with a knife. The probation officer thought that the incident appeared to have scared Mark Towell.

On 13th July 1994, the Probation Order expired. The Final Summary of his probation officer concluded: " Mark's potential to stay out of trouble will depend upon his motivation to stay away from the drugs scene. If he does not, it is my opinion that he will re-offend. However, judging by his response to this Probation Order, I would assess him as a good candidate for future supervision."

On 17th July 1994 at 4 a.m. Mark Towell was walking home from a party together with an older couple when allegedly without warning he punched

the male repeatedly until he lost consciousness. When the female tried to intervene she was also punched. Neither person wished to make a complaint against Mark Towell and no criminal proceedings were commenced.

Commentary upon Mark Towell's health care and treatment up to 5th May 1994

(i) During the first 18 years of Mark Towell's life a pattern of disturbed behaviour emerged which was to become well established in later years. These difficulties became apparent at a relatively tender age but escalated during his adolescence and included:

- A preoccupation by him with his adoptive status and jealousy of his adopted siblings.
- A profound difficulty on his part in accepting responsibility for his own actions and a propensity for projecting blame onto others.
- Violent and aggressive behaviour by him particularly when thwarted.
- Drug and alcohol abuse.
- A reluctance to engage with health professionals, attending for appointments only at the instigation of others and failing to attend a number of other consultations.

(ii) The problems being generated by Mark Towell in his early years were largely contained within his family. There has been increasing recognition in more recent years as to the importance of post adoption professional support for families. At the time in question, however, there was a marked absence of such assistance for the Towell family.

(iii) The two series of appointments with CPN(1), in July 1992 and February 1993 respectively, were the most sustained contact Mark Towell was ever to have with a mental health professional. The sessions identified many of the issues highlighted at paragraph (i) above. Notwithstanding Mark Towell's attendance for the appointments, it became apparent that he was only attending as a result of parental pressure.

(iv) Although the issue of drugs and alcohol had emerged during the course of CPN(1)'s involvement, no referral was made for any specialist drug or alcohol treatment. CPN(1) told the Panel that she believed that Mark Towell's reluctance to acknowledge that he had any problem with drug and/or alcohol misuse, represented a

fundamental obstacle to such a referral being warranted. In any event, at this particular time, such a referral could not have been made by her and would have been instigated by the GP. At the request of CPN(1), GP(2) did make a referral to a Child and Adolescent Psychiatrist, which was clearly appropriate.

(v) Mark Towell's assault of the Deputy Head Teacher in March 1993 was similar to a number of subsequent incidents. It involved him being violent when confronted: lacking in self-control after the assault began and denying responsibility in the aftermath, blaming the injured party.

(vi) The psychiatric assessment of consultant psychiatrist(1) at the Child and Adolescent Unit did not identify any particularly significant problems. No formal signs of depression and no organic basis for Mark Towell's loss of control were identified.

(vii) The psychiatric involvement of consultant psychiatrist(1) became enmeshed with the criminal proceedings in respect of the assault on the Deputy Head Teacher. The Court adopted consultant psychiatrist's(1) recommendation of a Probation Order, but did not stipulate that there should be any further psychiatric input. The consent of Mark Towell would have had to have been forthcoming for any such condition to be attached to the Probation Order. In the course of the Probation Order it is apparent that the Probation Service consciously sought to avoid duplicating the work it was believed was being undertaken by consultant psychiatrist(1). It is not clear to what extent the pending Court appearance galvanised Mark Towell into keeping his initial appointments with consultant psychiatrist(1) but, upon the proceedings being concluded and the making of a Probation Order, he did not attend any further appointments.

(viii) The probation officer allocated to Mark Towell during the operation of the Order found him difficult to engage and by the end doubted that she had made much impression on him. She believed that Mark Towell was "playing games" and that a firm line needed to be taken with him in order that he began to seriously address his aggression and offending behaviour. There is no evidence that any material progress was made during the Probation Order. At the final meeting with his probation officer, Mark Towell disclosed that he had recently attacked his father with a knife under the influence of drink and Temazepam.

(ix) It is difficult to quantify with any accuracy the extent of Mark Towell's violent conduct towards others during these early years. His criminal record viewed in isolation suggests only one material

offence. There are clear indications, however, from information which has emerged from the family, his work with CPN(1) and his contacts with the Probation Service that Mark Towell was involved in a number of violent incidents which appear to have attracted neither police intervention nor action.

(x) Employment appeared to offer Mark Towell a degree of stability and constructive diversion, but also arguably served to mask some of his more problematical behaviour.

6.7.1994 – 5.11.1998

Between November 1994 and July 1995 Mark Towell attended the Accident and Emergency Department at Queen Elizabeth Hospital on a number of occasions in relation to two successive fractures to his wrist, as a result of falling and a knee injury occasioned whilst playing football. There were at least four occasions when he failed to attend follow-up appointments at the Fracture Clinic. On 2nd February 1995 he informed staff at the hospital that he had removed the plaster cast from his wrist himself on 29th December 1994, with a saw.

On 16th July 1995 Mark Towell was involved in a violent incident after a party at a public house in Birtley. A number of other youths were involved. In the course of the incident Mark Towell and others threw stones at the male and female injured parties and threatened to kill them. Mark Towell assaulted the male person causing injury to his hand and face. He was charged with Affray.

On 2nd August 1995 Mark Towell was seen by his GP. He complained of headaches which he attributed to being hit on the head a few weeks previously.

On 16th October 1995 Mark Towell attended Sunderland District General Hospital following a referral by his GP complaining that the right knee was now giving way. The knee was x-rayed but no abnormality was identified.

On 14th March 1996 a Pre-Sentence Report was prepared in respect of the offence of Affray on 16th July 1995. Mark Towell had admitted to probation officer(1) that he was the principal player in the incident. He accepted that he had previous difficulties for which he accepted "full responsibility". At the time that the report was prepared Mark Towell stated that he was no longer body building and had been working for the past five weeks for a local butcher. In relation to the risk to the public of re-offending it was stated that "Mr Towell is a young man for whom temper control has been recognised as an area of concern throughout his adolescence, though it has only once

previously resulted in his appearance before the Courts. In the past he has responded to help offered by both the medical services and probation and appears to be adopting a more mature attitude to life of late. Whilst he accepts only limited responsibility for his part in this offence, the fact that he was involved at all would suggest that there are still grounds for concern and he would do well to remain vigilant with regard to this particular area of his life. If he is able to do so then the risk of re-offending is likely to be reduced."

The Pre-Sentence Report concluded that a prison sentence would place Mark Towell in an environment where physical strength and aggression would be valued as survival techniques. A recommendation to the Court was made for a Combination Order to be imposed, placing him on probation and requiring him to undertake community service at weekends.

On 15th March 1996 Mark Towell appeared at Newcastle Crown Court and was made subject to a Community Service Order for 80 hours. No Probation Order was made.

On 14th May 1996 Mark Towell attended the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead complaining that he had been assaulted three days ago. He was noted to have sustained abrasions to the dorsum of the finger and a small laceration of the palm of the right hand.

On 23rd August 1996 Mark Towell attended the Accident and Emergency Department at the Queen Elizabeth Hospital Gateshead with an injury to his right hand. He left without seeing a doctor. On the same day he attended his GP's surgery stating that he had punched his right hand through a double glazed window. He was observed to have a laceration of the right middle and ring fingers.

On 24th November 1996, Mark Towell attended the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead. He stated that he had been assaulted the previous night and hit about the head with fists. He had scratches to his face, and swelling and bruising to his back. He was advised and referred back to his GP.

On 26th November 1996 Mark Towell attended the Accident and Emergency Department. He complained of having coughed up blood. He had also been experiencing headaches since being struck on 24th November 1996. He was diagnosed with concussion and given advice in relation to rest and monitoring.

On 19th February 1997 Mark Towell attended the Accident and Emergency Department again stating that he had hit his finger with a hammer causing a laceration. The wound was cleaned and dressed.

On 10th October 1997 Mark Towell was arrested outside a nightclub in Newcastle upon Tyne City centre. He had been refused admission and was shouting, swearing, swinging out with his arms and was threatening to kill the door staff and to burn down the premises.

On 12th May 1998 Mark Towell attended the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead complaining of recent bleeding from his mouth. He left hospital before seeing a doctor. He later telephoned the department and was directed to see his GP.

On 29th May 1998 Mark Towell was convicted of an offence of Threatening Words and Behaviour at Newcastle Magistrates' Court in relation to the disturbance outside the nightclub on 10th October 1997. He had pleaded not guilty to the charge but had been convicted. He was fined £75 and ordered by the Court to pay £25 costs.

On 14th June 1998 police were called to the family home after a disturbance when Mark Towell had returned from training with the Marine Reserves in an "agitated state". He was arrested for being Drunk and Disorderly.

In September 1998 Mark Towell commenced employment with a firm engaged in constructing metal cladded roofs.

On 26th October 1998 and 5th November 1998 Mark Towell did not attend appointments he had made for consultations with his GP.

Commentary upon Mark Towell's health care and treatment from 6th November 1994 up to 5th November 1998

(i) This period was marked by the second and third convictions of Mark Towell for offences of violence. For a young man in his early twenties there was nothing remarkable in such a criminal record. The nature and frequency of Mark Towell's attendances at the Accident and Emergency Department of Queen Elizabeth Hospital in Gateshead, however, suggests a more extensive level of violence in the community but, apart from the offences of Affray and Threatening Words and Behaviour, there is no police record relating to these incidents. Mr Towell informed the Panel, however, that Mark Towell continued to cause difficulties for the family at this time, resulting in significant stress.

(ii) The attendances by Mark Towell at the Accident and Emergency Department demonstrate the difficulty experienced by health professionals in engaging with him. His attendances for follow-up appointments were extremely erratic. His action in removing his plaster cast with a saw was indicative of a reckless disregard for his own well-being and the medical advice he was receiving.

(iii) The fragmented nature of Mark Towell's attendances at the Accident and Emergency Department prevented the formulation of a coherent overview of the situation at this time, which would have been more likely to have occurred had Mark Towell chosen to involve his GP more frequently in relation to these difficulties.

(iv) The Magistrates' Court, when making a Community Service Order on 15th March 1996, rejected the recommendation made in the Probation Report for a Combination Order, which would combine probation supervision with community work. Having regard to the fact that Mark Towell's problem in relation to controlling his temper had been clearly identified in the Probation Report, the Panel note that the Court's decision not to involve the Probation Service in supervision again at this stage was contrary to the recommendation in the Pre-Sentence Report.

(v) With the exception of the Accident and Emergency Department, there is no significant record of any health or other professional involvement with Mark Towell during this period. There is no evidence that Mark Towell was interested in obtaining any further assistance at this time or that anyone was requesting such intervention on his behalf.

(vi) For substantial parts of this period Mark Towell was in regular employment which, as has been indicated earlier, appeared to have an ameliorating effect upon his behaviour.

6.11.1998 – 6.8.2000

On 23rd November 1998 police officers were called to an incident where Mark Towell had been allegedly fighting with a male and female in the street. Neither of the complainants wished to press charges.

On 5th December 1998 at 1.26 a.m. police officers were called to the family home after Mark Towell had arrived home intoxicated and threatened his parents with violence. When police officers arrived, he was observed to be on the roof of the house. He then climbed down and ran away from the area. No further action was taken by the police in relation to this incident.

On 10th December 1998 Mark Towell attended at his GP who noted "impulsive aggressive behaviour" and "paranoid thoughts". Mark Towell stated that he was a "nutter". His GP made the observation that he appeared "obsessional". Anti-depressive medication was prescribed and Mark Towell was provided with a two week sick note.

On 21st December 1998, Mark Towell attended the Accident and Emergency Department with an injured hand which he stated had been caused by punching someone three days earlier. He had sustained a laceration to his knuckle caused by a human tooth. The wound had become infected.

On 7th January 1999, Mark Towell did not attend an appointment made for him with his GP relating to his depressed presentation on 10th December 1998.

On 12th January 1999, Mark Towell was involved in an incident which resulted in a conviction for offences of Affray and Criminal Damage. He had become involved in a long-standing feud with two female friends. On the day of the offences he had been drinking heavily. Towards the conclusion of the evening in question he received a telephone call from the woman, who he maintained was abusive and threatening. He resolved to call at their property to confront them. During the course of the incident he used a knife to stab the wall of the premises and to puncture four tyres belonging to one of the women.

On 21st January 1999 police officers were called to the family home after Mark Towell had been very disruptive. By the time the police had arrived, the situation had been brought under control.

On 26th January 1999, Mark Towell attended his GP's surgery. He presented as being angry and explained that he was in trouble with the police for Criminal Damage. He stated that he had no control over his temper. He gave a history of alcohol and cannabis abuse. He said his anger was related to the fact that he didn't know his parents, having been adopted. He was advised that the GP would make a referral for counselling from the Gateshead Alcohol and Drug Problem Service (GADPS).

On 29th January 1999 police officers were again called to the family home after Mark Towell's parents alleged that he had been breaking up furniture in the house. He had damaged a wardrobe and a chest of drawers. Mark Towell was arrested on suspicion of having committed Criminal Damage.

On 2nd February 1999 Mark Towell's GP(3) made a formal referral to GADPS. The referral described a background of impulsive aggressive outbursts of behaviour which seemed to be related to excessive alcohol consumption. Mark Towell was also smoking cannabis. GP(3) described how Mark Towell had stated that he found it very difficult to control his temper and lashed out. He felt that people were watching him and often took out his aggression on them. GP(3) could not find any evidence of true psychosis and suggested that Mark Towell's adoptive background had made him feel very bitter and angry.

On 8th February 1999 Mark Towell was written to by the Clinical Leader at GADPS indicating that he would be offered an appointment within the next

four weeks, but that because of the high demand placed on the service it "may take a little longer".

On 18th February 1999 police officers attended Mark Towell's family home. Mark Towell's family reported that he had been going "berserk". No formal complaint was made and he was escorted away from the premises.

On 21st February 1999 Mark Towell attended the Homelessness Service at Gateshead Council and registered as being homeless.

On 23rd February 1999 a local councillor, who was also a longstanding friend of Mark Towell and his family, contacted the Emergency Duty Team at Gateshead Social Services Department. She explained that Mark Towell had been requested to leave his family home during the previous week and was sleeping at the homes of various friends. (Mark Towell's father explained to the Panel that Mark Towell had been excluded from the family home permanently after attempting to assault Mrs Towell, resulting in Mark Towell being forcibly restrained by his brothers.) The local councillor reported that Mark Towell was threatening to self-harm and that, in her opinion, he needed to be in hospital. She described how there was a background of violence and threatening behaviour by Mark Towell within the family home culminating in an attack on his younger brother during the previous week. He had recently threatened his parents with a baseball bat and a few months ago had run around on the roof of his parents' home. According to the local councillor, Mark Towell was unemployed but not obtaining his Job Seeker's Allowance. She believed he was a "time bomb waiting to go off" and she was fearful that unless he was picked up and treated he could cause a "tragedy". The Emergency Duty Team advised that Mark Towell be seen by a GP, and established that there was a likelihood of accommodation at Byker Bridge project the following day. The local councillor indicated that she would fund Mark Towell's stay at bed and breakfast accommodation until then. Mark Towell was seen by GP(4) that day and Mark Towell told the GP that "I feel like a time bomb" and stated that his mood fluctuated rapidly. The GP did not think that the threat of self-harm was serious and concluded that Mark Towell's problems were social not medical. Mark Towell was later seen by a duty social worker from Gateshead Social Services.

On 24th February 1999 the referral to the Emergency Duty Team was picked up by Gateshead Social Services Department. On the same day Mark Towell visited the premises of the Social Services Department at Gateshead Civic Centre. He presented as being surly, stating that he was sick of being pushed around. He wanted a flat of his own and thought that he should be taken to a clinic. There were significant but unsuccessful efforts made on his behalf by staff to find accommodation for Mark Towell but, having absented himself to attend an appointment with his solicitor, he did not return to the Civic

Centre. He later attended the home of the local councillor who indicated to the Social Services Department her unwillingness to allow him to remain there having regard to the presence of other children at the home. The Social Services Department advised that as a last resort the local councillor could inform the police of the situation and have him arrested as part of his bail conditions in respect of the offences of Affray and Criminal Damage, to avoid him sleeping rough.

On the same day Mark Towell attended GP(4)'s surgery and indicated that he was up and down having been "quite depressed yesterday".

On 25th February 1999 Mark Towell was arrested at 9.40 a.m. for breach of his bail conditions and despite giving his address as being of "no fixed abode" was again granted bail. He sought a crisis loan from the Department of Social Security but was refused on the grounds that he was of no fixed abode. He was refused accommodation by the bail hostel due to his history of violence. The duty worker at the Social Services Department made strenuous attempts to obtain accommodation for Mark Towell, during which time he was threatening to shoplift for food, assault someone or jump off the Tyne Bridge. Later on the same day at 17.25 he presented himself to the Accident and Emergency Department at Queen Elizabeth Hospital in Gateshead with abdominal pains. He gave a history of having been recently discharged from the Tranwell Unit having suffered from "depression/mania" and was discharged later the same day. There is no corroboration for Mark Towell's contention that he had been admitted previously to the Tranwell Unit nor that he had attracted such a diagnosis.

At some stage on 25th February 1999, police officers were called to the family home having allegedly smashed two windows. Mark Towell's parents expressed concerns that he might return to the house and force entry.

On 1st March 1999 a duty social worker with the CMHT spoke with GP(4) and obtained information as to Mark Towell's current treatment.

On 10th March 1999, Mark Towell was written to and offered an appointment with GADPS in approximately eight weeks' time. The delay was explained by reference to a long waiting list.

On 25th March 1999 Mark Towell failed to attend an appointment at the Department of Plastic and Reconstructive Surgery at the Royal Victoria Infirmary in respect of his hand.

On 26th March 1999 the local councillor made a referral to the CMHT. She stated that Mark Towell had obtained the tenancy of and had moved in to a property in Gateshead but she was still helping him with his social and mental health difficulties. She believed he needed to be involved in work with anger management and requested information as to how such a service

could be obtained. The local councillor was advised that anger management was the domain of the GP and it was suggested that an appointment with Mark Towell's GP would be the appropriate course of action. The local councillor agreed to pursue this option. Accordingly, the CMHT decided to take no further action.

On 9th April 1999 Mark Towell was written to by GADPS and was offered an appointment on 21st April 1999.

On 19th April 1999 Mark Towell was convicted of the offences of Affray and Criminal Damage in respect of the incident on 12th January 1999. The Court adjourned sentence.

On 21st April 1999 Mark Towell was seen by a drug and alcohol counsellor at GADPS. A number of problems were identified including excessive consumption of alcohol and aggressive behaviour. Mark Towell stated that he had no control once he consumed in excess of five pints and became aggressive when intoxicated. The counsellor carried out a risk assessment by means of a tick box form which concluded that there were no issues relating to self-harm, self-neglect, exploitation or abuse apart from fleeting suicidal intention. The past history of violence was identified but no significant current risk of violence was identified. Mark Towell was noted to be unemployed at the time of the appointment and living by himself although spending a lot of time with his girlfriend (GF1) who he believed to be pregnant. He believed he had the ability to stop drinking but required positive occupation during the day to achieve this. No history of drug abuse was volunteered by him during the consultation.

On 28th April 1999 the Counsellor at GADPS discussed Mark Towell's case at a team referral meeting and it was agreed that he should be offered a follow-up appointment.

On 10th May 1999 Mark Towell's probation officer carried out an assessment of Mark Towell. He was assessed as being a medium risk to the public but a low risk to the probation staff. He was assessed as being a medium risk of self-harm and suicide.

On 12th May 1999 Mark Towell did not attend an appointment with his GP.

On 12th May 1999 a Probation Report was presented to the Court for the purposes of sentence in respect of the offences of Affray and Criminal Damage prepared by probation officer(1). The report indicated that after his recent homelessness Mark Towell had been allocated a tenancy in Gateshead and had formed a relationship with a woman, who was pregnant with his child. The report describes the fact that Mark Towell had experienced the breakdown of an earlier relationship and had also recently suffered a family bereavement. At the time that the report was prepared Mark Towell was

unemployed. The report concluded, "At one level, given Mr Towell's account, one could be inclined to regard these offences simply as the response of a drunken man to provocation. At the same time his reaction appears to have been quite extreme and one is conscious that, whilst not heavily convicted, he does have previous convictions for violence and that anger control has been recognised as being an issue in his life for some time now. The risk of re-offending therefore cannot be discounted and I would suggest that he should be regarded as at least a medium risk in this regard, particularly given his somewhat vulnerable state of mind at the present time. As with all violence one cannot discount the possibility that it could result in serious harm being inflicted." The report recommended that a Probation Order would assist monitoring and examining Mark Towell's future behaviour and attitudes. The report made no reference to the history of drugs and alcohol problems.

On 13th May 1999 Mark Towell did not attend a follow-up appointment with GADPS. On the following day, he was written to and his failure to attend was pointed out. GADPS indicated that in the event that a further appointment was considered necessary he should contact GADPS within two weeks of 13th May 1999.

On 28th May 1999, Mark Towell did not attend an appointment with his GP.

On 11th June 1999 a specialist nurse involved in drug and alcohol counselling wrote to GP(3) indicating that as Mark Towell had not attended appointments and had not subsequently made contact with the service, he had been discharged from GADPS' caseload.

On 21st June 1999 Mark Towell was placed on probation for 12 months in respect of the offences of Affray and Criminal Damage.

On 22nd June 1999 during a meeting with a probation officer, Mark Towell reported that he had begun work since the Pre-Sentence Report had been written and was undertaking contract work out of the area connected with the construction of superstores and retail parks. He could be placed anywhere in the country. His girlfriend (GF1) had recently miscarried and he was upset about this.

Between July and September 1999 the probation records indicate that Mark Towell was working in Edinburgh and Southampton and returning home to Gateshead at weekends. Despite being in employment, Mark Towell regularly found himself in financial difficulties and requesting assistance from his parents. Because of Mark Towell's work commitments there was little direct contact between him and his probation officer. He was working eleven hour shifts which made reporting difficult. The probation officer considered that his employment was "a means of significantly reducing the risk of re-offending".

On 9th August 1999 Mark Towell's GP in Birtley, who believed that Mark Towell was still living in Birtley, offered Mark Towell an appointment which he did not attend.

In October 1999 the Probation Service became concerned about Mark Towell's limited history of reporting but upon being advised that he was working in London, deemed the situation acceptable. Mark Towell indicated that he had moved to a nearby property in Gateshead, the address of his girlfriend (GF1). Mark Towell had vacated his own property leaving £1,320.36 of rent arrears behind. In the early stages of the relationship Mark Towell's parents formed a very positive view of the relationship and the apparently beneficial and stabilising effects upon Mark Towell. His girlfriend (GF1), however, later informed the police after Mr Leak's murder, that shortly after Mark Towell moved into her property, he began being violent to her. He would assault her on many occasions, punching her about the stomach, back and arms. On one occasion he grabbed her around her throat. She stated that these assaults occurred when Mark Towell was drunk. She believed that he had a drink problem, drinking both at home and in local pubs and clubs. She indicated that all of his wages appeared to be spent on drink and that he had told her that he was in debt to his employer.

On 17th December 1999 the probation records note that Mark Towell was off work for Christmas and that there were "no problems".

In January 2000 Mark Towell's probation officer recorded that Mark Towell was working in Luton and was "in good spirits".

On 25th January 2000 the probation records state that Mark Towell was still working in Luton but wanted a move of home due to a neighbourhood disturbance. He was perceived by his probation officer to be "still low risk due to stable employment". It was believed that he was not taking drugs and had a low consumption of alcohol.

On 5th March 2000 Mark Towell was recorded by Gateshead Council's Housing Service as being of no fixed abode.

On 24th March 2000 Mark Towell advised his probation officer that he was still working away in Luton, but coming home every two weeks. He gave his address as being his girlfriend's (GF1) address in Gateshead.

On 15th April 2000 Mark Towell's parents requested police intervention at the family home alleging that Mark Towell had attended in a drunken condition, repeatedly kicking the doors. No further action was taken by the police.

On 16th June 2000 Mark Towell attended his final meeting with his probation officer. It was recorded that his work was "going well" and that he had paid for his father's window which had been broken following an

argument and that the charge of Criminal Damage had been withdrawn. The Probation Order ended on 20th June 2000.

Commentary upon Mark Towell's health care and treatment from 6th November 1998 up to 6th August 2000

(i) This period marked the end of Mark Towell's residence at the family home, which came about when he was excluded, after his behaviour had become intolerable for the other family members. Mark Towell's relationship with his parents, in particular his mother, deteriorated thereafter, although contact was maintained and his parents continued to provide financial and other support to him.

(ii) After his exclusion from home, Mark Towell experienced a period of homelessness before obtaining his own accommodation where he began to live independently in the community. He formed a relationship with a woman who lived in the close vicinity of his flat, which was to be his first long-term relationship. This former girlfriend (GF1) subsequently alleged that she was subjected to serious domestic violence during the relationship. Little, if any, of this violence came to the attention of the police however, until the relationship ended and Mark Towell continued to cause problems for her through his behaviour. In the course of a police statement made after Mr Leak's murder, this former girlfriend (GF1) also alleged that Mark Towell was drinking to excess and taking illicit drugs during the relationship.

(iii) The referral of Mark Towell to Gateshead Drug and Alcohol Service followed a consultation with his GP on 26th January 1999. The referral and subsequent attendance by Mark Towell at GADPS coincides with his appearance before the Magistrates' Court for further criminal offences. It may be of significance that once he had been sentenced, his further attendance at GADPS ceased altogether.

(iv) The evidence received by the Panel from professionals involved in the provision of services at GADPS indicates that at this time the organisation was under considerable pressure and was undergoing structural changes. There was a significant waiting list for clients. There were staff shortages and staff morale was low. It was accepted by a number of staff that, in these circumstances, clients who did not attend were discharged without any vigorous attempt being made to establish the cause of the non-attendance. Non-attendance was dealt with by one follow-up letter only.

(v) The Probation Order which was imposed by the Court on 21st June 1999, operated largely at arm's length owing to the fact that Mark Towell was working out of the area for the majority of its duration.

The opportunity afforded to the probation officer to address any of Mark Towell's problems was accordingly extremely limited.
The Probation Service appears to have been unaware of both the nature or extent of the allegations of domestic violence made by Mark Towell's girlfriend (GF1) during this period or his significant drug and alcohol problems. The fact that Mark Towell was in employment was viewed by the Probation Service as such a positive factor that it outweighed any other concerns which there might have been at this time. In reality, the Probation Order appears to have had little, if any, opportunity to impact upon Mark Towell or his behaviour.

(vi) There is an absence of information as to how Mark Towell was functioning in the various locations where he was based throughout the country as a consequence of his employment.

7.8.2000 – 5.1.2001

At 11.35 a.m. on 7th August 2000 Mark Towell was admitted to the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead. At the time of the admission he was not registered with a GP. He stated that he had taken 50 co-proximal tablets at 12.30 a.m. after drinking vodka, beer and Weedol. He was transferred to the Medical Admissions Unit at the hospital and the SHO arranged for a referral to the Deliberate Self-Harm Team.

On 8th August 2000 Mark Towell was assessed on the Medical Admissions Unit by a nurse from the Deliberate Self-harm Team, at the Tranwell Unit in Gateshead. He described how he had impulsively taken an overdose after a row with his girlfriend (GF1) and that he now regretted his actions.
He admitted having been violent to his girlfriend (GF1) and others in the recent past. He described how he had smashed up his own flat and moved in with his girlfriend (GF1). He had taken medication which he had found in a drawer. He said that he was employed working away during the week but was returning at weekends. The nurse was unable to identify any previous incidents of self-harm. The nurse established that Mark Towell's history suggested long-standing drug and alcohol abuse. Mark Towell indicated that he didn't require follow-up treatment. He subsequently absconded from the ward.

On 9th August 2000 Mark Towell was brought to the South & East area Community Mental Health Team (CMHT) by a male friend having changed his mind about seeing the nurse from the Deliberate Self-harm Team again but having been unsuccessful in an attempt to obtain a further appointment with him that day. He indicated that he was not registered with a GP but

intended to register with a GP in Felling. He described the incident when he had overdosed on 8th August 2000 and gave a history of depression and drug/alcohol abuse. He confirmed his earlier account of the self-harm incident stating that he had had problems in his relationship with his girlfriend (GF1) and he was homeless, sleeping at friends' houses. Mark Towell was encouraged to identify a GP and referred to the Homelessness Section at Gateshead Council.

On 10th August 2000 Mark Towell attended the South & East CMHT again and indicated that he had arranged an appointment with the Homelessness Section at Gateshead Council. He had arranged to register with GP(5) and had an appointment fixed for 14th August 2000.

On 12th August 2000 Mark Towell presented himself to the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead. He stated that he had fallen on some glass and had cut his right forearm. He stated that he was not registered with a GP and gave his parents' address. It was noted that he smelt of alcohol. The wound was cleaned and dressed.

On 14th August 2000 Mark Towell was seen by GP(5) and registered at a new practice. Mark Towell provided information to GP(5) of having no history of drug abuse, information which was clearly untrue. He described how he was depressed and had recently been hospitalised following an overdose. He was prescribed Fluoxetine, an anti-depressant.

There is evidence to suggest that in or about September 2000, Mark Towell commenced a relationship with a new girlfriend (GF2), a daughter of AY, Mr Leak's partner, although it appears that his previous relationship continued concurrently.

On 19th October 2000 Mark Towell attended his GP's practice and complained of continuing to feel depressed and of not sleeping. His anti-depressant medication was varied to Dothiepin.

On 20th October 2000 Mark Towell attended the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead having been brought there by police officers. He was observed to have abrasions to his face and gave an account of having been assaulted by three other people. He was abusive and aggressive to the hospital staff and discharged himself abruptly.

On 6th December 2000 a letter of discharge was sent by the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead to GP(5) in respect of the admission on 7th August 2000.

On 29th December 2000 Mark Towell was seen at the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead. He complained of back pain after falling from a roof at work and landing on

a beam. He was prescribed pain-killers and discharged into the care of his GP. The injuries sustained by Mark Towell were to result in a significant period of unemployment for him.

Commentary upon Mark Towell's health care and treatment from 7th August 2000 – 5th January 2001

(i) This relatively brief period provides an illustration of the difficulties faced by health and other professionals involved with Mark Towell, in engaging with him.

(ii) By this time there was a chaotic quality to Mark Towell's personal relationships and his lifestyle. Problems in his relationships reflected themselves in emotional instability and homelessness difficulties.

(iii) The overdose/self-harm incident in August 2000, which brought him into contact with the Deliberate Self-Harm Team and then the CMHT, was attributed by him to the problems in his relationship and was explained by him as an impulsive act, which he regretted.

(iv) This was the first recorded episode of self-harm involving Mark Towell. It was a serious overdose and appears to have been linked to abuse of alcohol together with the relationship difficulties previously referred to.

(v) Mark Towell absconded from the ward before the Deliberate Self-harm Team had concluded its investigations, stating that he didn't require any follow-up treatment. At the time, Mark Towell was not registered with a GP or involved with any other health professionals so that the assessment of the Deliberate Self-Harm Team could not be more widely disseminated.

(vi) When Mark Towell did make contact with GP(5) on 14th August 2000 he reported an improvement in his outlook. It appears, however, that GP(5) was presented by Mark Towell with a seriously misleading account of his history of drug use.

(vii) There is no information available from the police or elsewhere in relation to the incident of violence which occurred on or about 20th October 2000.

6.1.2001 – 2.5.2001

On 6th January 2001 Mark Towell was responsible for causing criminal damage to two properties. He threw a stick through the living room of his

girlfriend's (GF1) property in Gateshead, from the street below. He then broke a window at his parents' house with his fist, after an argument with his father.

On 8th January 2001 Mark Towell was convicted in respect of two offences of Causing Criminal Damage on 6th January 2001. He received a Conditional Discharge for 12 months.

On 11th January 2001, Mark Towell visited his GP in respect of the injury sustained when he fell off the roof in December 2000.

On 26th January 2001, Mark Towell was admitted by paramedics to the Accident and Emergency Department at Queen Elizabeth Hospital in Gateshead. He had tried to hang himself and had self-harmed by cutting his left wrist. Upon admission he was noted to smell of alcohol and stated that he felt suicidal. He said he had lost both his job and his girlfriend (GF1). He said he did not regret what he had done. The hospital notes state that Mark Towell was unco-operative and angry throughout his treatment for the injury. He was referred to the Deliberate Self-Harm Team at the Tranwell Unit in Gateshead where he saw the same nurse who had interviewed him on the previous occasion. The nurse noted that Mark Towell was a poor historian and difficult to assess due to his level of intoxication. He was "surly and uncommunicative". He described a row he had the previous evening with his girlfriend (GF1). He had been drunk having consumed alcohol and turpentine. The nurse recalled the similarities with the earlier admission of Mark Towell in August 2000, following a row with his girlfriend (GF1). He stated that she was pregnant although he doubted the paternity of the unborn child. He had been laid off work since his fall in December 2000. The nurse observed that Mark Towell seemed to have poor anger/impulsivity control. He claimed he often became violent towards other people both physically and verbally. He told the nurse that he had lived with his adoptive grandparents between the ages of four and nine. Mr and Mrs Towell provided information to the Inquiry Panel which completely contradicted this latter assertion.

The nurse at the Deliberate Self-Harm Team concluded that the self-harm incident was an impulsive act and that there was no obvious plan to commit suicide and no psychotic illness was apparent.

The nurse later spoke with a psychiatric nurse attached to the Mentally Disordered Offender Liaison Scheme, who advised the nurse of Mark Towell's criminal background. The nurse also wrote to GP(5) in Gateshead informing him of Mark Towell's admission.

After Mark Towell had been discharged from the Accident and Emergency Department, he was arrested later the same day for an offence of Criminal Damage at his girlfriend's (GF1) home after a further argument in the course

of which he threw a brick through a window of the property. Mark Towell was remanded in custody over the weekend.

On 29th January 2001 the local councillor contacted the Court cells and spoke to the custody officer requesting that help be arranged for Mark Towell. The police officer indicated that he would refer Mark Towell to the psychiatric nurse of the Mentally Disordered Offenders Liaison Scheme (MDOLS). Before the psychiatric nurse had the opportunity to meet with Mark Towell, his case had been dealt with by the Court and was adjourned until 12th February 2001. He was granted bail with a condition barring him from his girlfriend's (GF1) property in Gateshead. He stated that he would be residing with his parents. His parents were not aware that he was providing their address to the Court as his own.

The psychiatric nurse at the MDOLS liaised with the nurse of the Deliberate Self-Harm Team at the Tranwell Unit and was informed of Mark Towell's recent admission to the Casualty Department.

Later the same day Mark Towell presented himself together with the local councillor at the Housing Service of Gateshead Council stating that he was homeless. Emergency accommodation was arranged for Mark Towell at the Harras Bank Homeless Unit. Whilst at the Housing Service, the local councillor contacted the Emergency Duty Team at Gateshead Social Services and expressed her concerns about Mark Towell. She stated that he was depressed and was having thoughts of jumping from the Tyne Bridge. She thought that this might be linked to his grandfather's death a few weeks earlier. The local councillor requested that a mental health social worker attend the Civic Centre to interview him. The local councillor was advised by the Emergency Duty Team that he would have to refer himself in order to access such help. The local councillor indicated that she would arrange for Mark Towell to see a GP the following day and that she intended to take him to see a duty mental Health social worker as she believed he was in need of counselling. Information relating to the referral to the Emergency Duty Team was faxed to the South & East Community Mental Health Team and then to the Central Community Mental Health Team and to the Gateshead Drug and Alcohol Service.

On 30th January 2001 the Central Mental Health Team telephoned the local councillor who appraised them of Mark Towell's recent difficulties in respect of self-harm, drug misuse, relationships and accommodation. The local councillor indicated that he was seeing GP(5) that morning. The CMHT telephoned Harras Bank Homeless Unit to ascertain what the position was in respect of Mark Towell's accommodation. The CMHT also spoke with GP(5) who had by this time seen Mark Towell and who indicated that in his opinion he was a disturbed and mixed up young man. GP(5) had made an urgent referral for Mark Towell to see consultant psychiatrist(2) at the Tranwell Unit. GP(5) had provided Mark Towell with a note saying that he

was depressed in order to assist in him being allowed to remain at Harras Bank Homeless Unit. GP(5) mentioned the possibility of the Crisis Team becoming involved but on balance believed that there would be some supervision of him at Harras Bank and that if the Hostel staff believed he needed further support until consultant psychiatrist(2) saw him they would let GP(5) know and he would refer Mark Towell to the Crisis Team. The CMHT subsequently telephoned Harras Bank and confirmed that the Hostel were aware of the advice that it should contact GP(5) or the Emergency Duty Team if the need arose. Mark Towell later attended Gateshead East Police Station requesting assistance to attend his ex-girlfriend's home to recover personal items. He refused to wait for assistance to be provided and left.

GP(5)'s handwritten letter of referral to consultant psychiatrist(2) dated 30th January 2001 states, "This lad seems to be very disturbed. He has attempted to hang himself, slashed his wrist and taken an overdose. He broke his girlfriend's (GF1) window and was kept in gaol for this and charged with Criminal Damage. He was adopted and has twin brothers. He resents this and also the death of his grandfather at Christmas this year. He has a girlfriend (GF1) who is pregnant but does not know if it is his. He is very mixed up. I would value your help."

At 11.30 p.m. on 31st January 2001 Mark Towell was admitted to the Accident and Emergency Department at the Queen Elizabeth Hospital in Gateshead. He was complaining of pain in his chest and lower left ribs as a consequence of the fall five weeks earlier. He was provided with analgesic medication and discharged.

On 5th February 2001 the local councillor made a telephone referral concerning Mark Towell to the CMHT via the Social Services Emergency Duty Team. Mark Towell had been "acting out" and had requested that his father take him to the family home. Mark Towell's father had refused. In response he had threatened to smash up the phone box where he was telephoning from. The police had been involved but took no further action after interviewing him. The Warden at Harras Bank Hostel had contacted GP(5) stating that he was wanting to go to the Tranwell Unit and had been "acting out" at Harras Bank. He was said to be "rather high".

Mark Towell was arrested later that day having been found in Durham Road, attempting to throw himself in front of traffic. He was initially taken by police officers to the Tranwell Unit but was referred by the Tranwell Unit to the Accident and Emergency Department at Queen Elizabeth Hospital in Gateshead. In the early hours of 6th February 2001, he was referred to a Senior House Officer in psychiatry (SHO). The Senior House Officer in Psychiatry (SHO) took a full history from him. The SHO spoke to Mark Towell in the presence of police officers. She noted that he was casually dressed and made good eye contact. He appeared "mildly intoxicated".

Mark Towell told the SHO that he believed that his life wasn't going anywhere. He described his difficulties in his relationship with his girlfriend and how he couldn't cope without her. He had wanted to be admitted to the Tranwell Unit. He wanted to be protected from his life in the community. He threatened to kill himself if he wasn't admitted to the Unit for six months. He said he was unwilling to accept out-patient help saying that he wasn't going to "trail" to appointments. He described having taken cocaine to excess over Christmas and having spent his grandfather's money on drugs. He said he had taken £400 worth of cocaine over the weekend and was also occasionally taking cannabis, Diazepam and Temazepam. He admitted binge drinking alcohol when he had available money. When it was suggested that admission to the Tranwell Unit might not necessarily be the best option, he became angry and abusive and stormed out of the Unit. The SHO took advice from the consultant psychiatrist on call and it was agreed that Mark Towell would be referred to his local consultant psychiatrist.

On 6th February 2001 after Mark Towell's departure from the Unit, the SHO made a formal referral of Mark Towell to consultant psychiatrist(2) at the Tranwell Unit. The SHO provided a full account of her consultation with Mark Towell. She concluded that there "was no evidence of any thought disorder and he was cognitively intact … I felt this gentleman is extremely impulsive and aggressive and is likely to be at risk from various suicide attempts. I could, however, not detect any depressive illness and there was no evidence of psychosis at interview. He has a long history of drug and alcohol abuse and an extensive forensic history." The SHO determined that Mark Towell required a consultant's opinion and further assessment in view of his "impulsive behaviour". She telephoned the psychiatric nurse of the MDOLS to advise him of the situation. As he was due in Court on 12th February 2001, it was agreed that the psychiatric nurse of the MDOLS would plan to see Mark Towell and attempt to carry out an assessment.

Hours after leaving the Accident and Emergency Department, Mark Towell, together with the local councillor, referred himself to the CMHT, where he was seen and assessed by two senior Community psychiatric nurses, CPN(2) and CPN(3). The local councillor was present throughout the consultation. Mark Towell led CPN(2) and CPN(3) to believe that he had only attended with reluctance because he had been "brought along". He presented a detailed account of his difficulties and earlier treatment including his excessive alcohol and cocaine use; his unhappiness at living at Harras Bank Hostel; his financial difficulties and depression. It was noted that Mark Towell "gets into many physical exchanges and appears to revel in this to a degree. Poor impulse control and low tolerance threshold are evident from as early as he can recall – but made worse by consumption of alcohol/drugs. Then becomes reckless and irresponsible".

CPN(2) and CPN(3) experienced difficulty in obtaining a precise history which they attributed to the possible effects of Mark Towell withdrawing from cocaine. He described consuming up to 8 grammes of cocaine some weekends. He had only stopped taking cocaine the day before, owing to financial difficulties. Had the money been available he would have used the drug. He believed that his current lifestyle was killing him.

CPN(2) and CPN(3) advised Mark Towell that if he could address his problems with alcohol and drugs this might allow him to then focus on issues of a more substantial nature which caused him distress including his adoptive status and low self-esteem. Mark Towell acknowledged that it would involve a significant commitment and change on his part for any progress to be made. The local councillor expressed concern that Mark Towell might harm his family. Mark Towell and the local councillor were advised by the CPNs that Mark Towell had to take control of his own actions and behaviour. It was not believed that he had a significant mental health problem which would explain his current behaviour and there were no biological symptoms of depression. They did not believe that any psychotic features were present. CPN(2) and CPN(3) believed that Mark Towell's behaviour including his aggression was largely attributable to the disinhibiting effect of alcohol and drugs. He was challenged on a number of difficult issues without any untoward reaction. At the conclusion of the assessment CPN(2) and CPN(3) recommended: a referral to the Drug and Alcohol Team; that Mark Towell return to his GP to have his sutures removed; that they would discuss the situation with his GP.

On 7th February 2001, CPN(2) of CMHT made a telephone referral in respect of Mark Towell to Drug and Alcohol Counsellor(2) of 24/7, which was the successor drugs and alcohol counselling organisation to GADPS. CPN(2) provided a verbal summary of the assessment carried out on the previous day. CPN(2) indicated her view that Mark Towell needed to be seen as a priority for assessment by 24/7. She indicated that the CPNs at CMHT had no plans to see Mark Towell again. On the same day CPN(2) at CMHT undertook a risk assessment on the Trust Standard Risk Assessment Form in respect of Mark Towell. Mark Towell was noted to have a history of self-harm or suicidal behaviour but was not presenting with a significant risk. In respect of violence Mark Towell was assessed as having a history of violence or assault against others and a history of threatening violence and assault against others but was not presenting with a significant risk of current violence. CPN(2) faxed a copy of the notes of the assessment carried out by herself and CPN(3) to 24/7.

On 8th February 2001, CPN(2) of CMHT compiled a further risk assessment form which contained some limited additional information but which did not depart from the assessment of the level of risk in the form completed on 7th February 2001.

On 9th February 2001 CPN(2) of CMHT wrote to GP(5) referring him to her risk assessment and advising him of the referral she had made to 24/7. CPN(2) summarised the difficult factors in Mark Towell's life which had emerged from the assessment. CPN(2) advised GP(5) that CMHT did not plan to see him again. She stated her understanding that Mark Towell was to be seen by consultant psychiatrist(2) in the next two weeks. A copy of this letter was sent to 24/7 and to consultant psychiatrist(2) at the Tranwell Unit.

On 12th February 2001 Mark Towell attended Gateshead Magistrates' Court pursuant to the Order made on 29th January 2001. At the Court he met with the MDOLS psychiatric nurse, for the first time and the local councillor, who introduced herself as a "councillor", attended and took a leading role in the discussions which ensued, stating that Mark Towell was not a "bad lad" and that he just needed help. Mark Towell was still living at Harras Bank Homeless Unit but due to damage he had caused at the Unit he might be evicted. Mark Towell initially denied drug use but when challenged by the local councillor admitted extensive use including cocaine. He explained that he was no longer on speaking terms with his mother but that his father would speak to him. When he fell out with his parents, he would turn to the local councillor.

The psychiatric nurse from the MDOLS made the following written recording in his notes at the end of the interview, "My impression was of a young man estranged from his family as a result of his long term conduct who has recourse to violence with minimal stimulation who will attack males or females and not experience remorse."

The psychiatric nurse from the MDOLS formulated a plan to inform staff allocated to work with Mark Towell of his concern regarding the risk of Mark Towell's recoursing to violence. On the same day the psychiatric nurse from MDOLS compiled a risk assessment form in respect of Mark Towell.
He assessed him as being at risk of self-harm or suicidal behaviour and at risk of threatening the same. He did not consider that this risk was a significant one. He assessed Mark Towell as having a history of violence or assault against others and of threatening violence or assault against others.
He concluded that Mark Towell was presenting with a significant risk of violence against others. He made the following entry, "At risk of attack upon others with minimal provocation. Will damage the property of others in anger. Appears to recognise authority figures and be less likely to attack them (for example will not attack the local councillor, will attack parents' property)."

At the conclusion of the Court hearing on 12th February 2001, Mark Towell was granted bail with a condition of residence at his parents' home.
His parents were unaware that he was providing their address to the Court as his own and he never returned to the family home upon his release.

His case was adjourned for the purposes of a Pre-Sentence Report until 12th March 2001, for sentence.

On 14th February 2001 consultant psychiatrist(2) at the Tranwell Unit, wrote to Mark Towell offering him an appointment on 22nd February 2001. On the same date the local councillor was written to by CMHT advising her that Mark Towell had been allocated to consultant psychiatrist(2).

On 16th February 2001 Mark Towell was arrested having attended his ex-girlfriend's property in breach of his bail conditions. He had allegedly attempted to force an entry into the property. He said that he had taken a large quantity of Valium and had been drinking all day. He was seen in the cells by the psychiatric nurse from the MDOLS. He stated that his ex-girlfriend (GF1) had a "mad delusion" that he had "put her through living hell". Apart from taking the tablets he had had that day, he denied any other drug use since the psychiatric nurse from the MDOLS had seen him on 12th February 2001. Mark Towell complained about his arrest to the psychiatric nurse saying "All this for a poxy £20 window."

At the conclusion of the hearing at Gateshead Magistrates' Court, Mark Towell was granted bail, it being observed by the Court that this was the first occasion upon which bail had been breached.

Later on 16th February 2001, the local councillor contacted the Housing Service at Gateshead Council and sought to have Mark Towell rehoused notwithstanding his rent arrears. A representative of Gateshead Council telephoned the psychiatric nurse from the MDOLS and asked that the psychiatric nurse provide a supporting letter, commenting upon Mark Towell's mental health. The psychiatric nurse stated that because of his limited contact with him he was not able to do so. The psychiatric nurse suggested that a letter from a psychiatrist would be more effective in the circumstances. The psychiatric nurse later established that consultant psychiatrist(2) was due to see Mark Towell.

On 16th February 2001 Mark Towell registered with GP(6) at the Birtley Medical Group.

Later on 16th February 2001, Mark Towell was involved in an incident at Harras Bank Hostel when he threw a metal bucket through one of the windows and used an instrument to force one of the doors. He then assaulted the off duty warden at the Hostel. At the time of the incident, he appeared to be under the influence of unknown substances.

Shortly after midnight on 17th February 2001 the local councillor contacted the Emergency Duty Team at Gateshead Social Services and described the incident at the Hostel the previous evening. Mark Towell had been arrested at her property in the early hours of the morning for offences of Criminal

Damage and Battery arising out of the incident. The local councillor expressed her frustration at being unable to arrange for the Mental Health Services to become involved with Mark Towell. She explained that she had asked to be contacted once the Police Surgeon had arrived but this hadn't happened and that Mark Towell's Solicitor had objected to her being present. The Emergency Duty Team (EDT) social worker indicated that she would liaise with the custody officer at Whickham Police Station and upon doing so telephoned the local councillor to advise her of Mark Towell's continued detention at the police station.

On 20th February 2001, the local councillor made a further referral to the Emergency Duty Team at Gateshead Social Services. She indicated that Mark Towell had arrived at her home and was homeless. He had been evicted from Harras Bank after the damage he had caused there. She requested assistance with securing accommodation for him. Later that day the local councillor telephoned the EDT to say that Mark Towell had been arrested again after throwing a plant pot at a police car and was remanded in custody. Police officers had attended the family home after a report that Mark Towell was outside the premises in breach of his bail conditions. She requested that the CMHT be informed of his arrest. A copy of the EDT referral was forwarded to 24/7.

On 21st February 2001, Mark Towell's case was allocated at 24/7.

On 22nd February 2001 Mark Towell was unable to attend an appointment with consultant psychiatrist(2) at the Tranwell Unit, because he was still remanded in custody. On the same day he was sent an appointment with 24/7 for 2nd March 2001.

On 26th February 2001 Mark Towell was written to by Gateshead Council's Homelessness Section and informed that due to his conduct at Harras Bank Homeless Unit he was not deemed to be homeless. On the same day consultant psychiatrist(2) from the Tranwell Unit wrote to GP(5), Mark Towell's previous GP, advising him of Mark Towell's failure to attend on 22nd February 2001. GP(5)'s surgery subsequently wrote to consultant psychiatrist(2) advising him of the change of GP practice.

On 27th February 2001 the local councillor telephoned Drug and Alcohol Counsellor(2) at 24/7 and indicated that Mark Towell might not be able to attend the appointment with 24/7 on 2nd March 2001 as he was currently remanded in custody and appearing in Court on 28th February 2001.
The psychiatric nurse from the MDOLS subsequently telephoned 24/7 and advised that Mark Towell had missed his appointment with consultant psychiatrist(2) due to being in custody. The psychiatric nurse at MDOLS advised 24/7 that in his opinion Mark Towell was very dangerous and had a significant history of violence. Accordingly, he should not be seen alone.

On 28th February 2001 the local councillor spoke with the psychiatric nurse from the MDOLS and appraised him of the circumstances of Mark Towell's arrest arising from the incident at Harras Bank Hostel. The psychiatric nurse later spoke with Mark Towell in custody. Mark Towell presented as being angry. He said that he was "well gone" with drugs at the time of the incident. Although he was pleased to be remanded in custody he was unhappy that prison was not as violent as he would like it. According to him, it was "boring". He raised his adoptive history as a continuing problem for him. He stated that he had withdrawn from his drug use whilst being in custody without the assistance of medication and did not see his drug use as a problem claiming he had only been on drugs for six months when he was experiencing personal difficulties. He did not want any help from a prison drug worker whilst he was in custody. Mark Towell indicated that he was "fed up" with the local councillor and intended to refuse further visits from her. During the Court appearance, Mark Towell was further remanded in custody until 5th March 2001. The psychiatric nurse contacted Drugs and Alcohol Counsellor(2) at 24/7 and consultant psychiatrist(2)'s secretary to advise them of Mark Towell's remand.

On 2nd March 2001, Mark Towell did not attend his appointment with 24/7. He was still in custody at the time.

On 9th March 2001, 24/7 sent Mark Towell a standard letter inviting him to arrange a further appointment if he required one and advising him that he should contact 24/7 within seven days.

Whilst Mark Towell was in Durham Prison on remand he was seen on 2nd March 2001 by probation officer(2). She was concerned about Mark Towell's attitude to his former girlfriend. He was indicating that whilst the relationship was over he would like the opportunity to "try again". He expressed a lot of anger and violent thoughts towards his adoptive parents. She concluded that he had no ability to reflect on his own behaviour. He had described other violent behaviour on his part but she was unable to ascertain whether these incidents had actually occurred. Mark Towell described a high use of alcohol and drugs, stating that he was drinking 22 cans of lager a day and was taking cocaine on a daily basis.

On 5th March 2001 Mark Towell appeared at Gateshead Magistrates' Court. A Pre-Sentence Report was not available, but a specific sentence report was. This document was compiled as a result of probation officer(2)'s interview with Mark Towell on 2nd March. The document was a standard document including a Risk Assessment in tick box form. As a result of probation officer(2)'s concerns, the assessment indicated that there was a high risk of re-offending, of serious harm to himself and of serious harm to the public.

Probation officer(2) indicated that there should be a direction for a full pre-sentence report and a psychiatric report. She suggested that a condition of

treatment, attached to a Probation Order, might be appropriate. The Court remanded Mark Towell in custody until 12th March 2001, pending the preparation of the reports. Mark Towell was unable to provide a bail address and bail hostels considered him to be unsuitable due to his history of behavioural problems.

Whilst Mark Towell was at Court on 5th March 2001 the psychiatric nurse from the MDOLS spoke to the local councillor who expressed her relief that Mark Towell was in custody and her concern as to the potential risk of violence from Mark Towell in respect of his parents. The psychiatric nurse's discussions with a practitioner at "Turning Point" revealed that Mark Towell was expressing a significant level of hostility and violent thoughts, including threats to kill, towards his mother because of her refusal to allow him to return home. The psychiatric nurse also informed a Police Sergeant at the Police Child Protection Unit, of his growing concern in respect of what he perceived to be the escalating violence and threats by Mark Towell. His ex-girlfriend's (GF1) baby was due in the middle of May. The Sergeant indicated that he would liaise with Social Services. He had already ascertained that there had been a large number of domestic incidents at Mark Towell's girlfriend's (GF1) address.

On 6th March 2001 the psychiatric nurse from the MDOLS spoke with a senior nurse at the Child Protection Unit, and outlined his concerns as to the risk posed by Mark Towell to his ex-girlfriend (GF1) and unborn child. He described Mark Towell as a "dangerous and violent" man. He advised her of the recent history of damage being caused to Harras Bank Hostel and the history of criminal damage to his ex-girlfriend's property. Child Protection nurse(1) agreed to attempt to identify Mark Towell's ex-girlfriend (GF1) and the professionals involved with her and refer the matter to Social Services.

Later the same day child protection nurse(1) was able to establish the identity of the midwife and GP caring for Mark Towell's ex-girlfriend (GF1) and issued a warning that no midwife should visit his ex-girlfriend at home. Contact should only take place at the Clinic. A police escort should be arranged if the midwife was called to the home out of hours. child protection nurse(1) formulated a plan to hold a meeting to discuss the safety of the unborn baby and identified the need to contact the community based services in Wrekenton to "pull the meeting together".

On 7th March 2001 Mark Towell appeared before Gateshead Magistrates' Court and was granted bail. He had been held in custody since 20th February 2001. A condition of his bail was that he was not allowed to enter his ex-girlfriend's (GF1) address in Gateshead without a police escort. He was ordered to reside at a specified address in Birtley. Before leaving Court Mark Towell spoke with the psychiatric nurse from the MDOLS and stated that he no longer wished to be seen by 24/7. Mark Towell did not believe that he

had a drug problem. He was angry and hostile during the meeting. The psychiatric nurse subsequently contacted 24/7 and child protection nurse(1) to advise them of the situation. On the same day a formal referral from child protection nurse(1) was received by the Northumbria Police Child Protection Unit outlining the concerns of health professionals in respect of the risk posed by Mark Towell to his ex-girlfriend (GF1) and her unborn baby. It outlined a history of bail conditions having been breached previously with further offences being committed at his ex-girlfriend's (GF1) home.

On 8th March 2001 the Health Visitor involved with Mark Towell's ex-girlfriend (GF1) spoke with the psychiatric nurse from the MDOLS and advised him that consideration was being given by the Social Services Department to calling a meeting in respect of the risk identified by the psychiatric nurse.

On the same date the psychiatric nurse from the MDOLS spoke with probation officer(2) who had been involved in the preparation of the Pre-Sentence Report in respect of Mark Towell. probation officer(2) indicated to him her concern as to the adrenaline rush he described when assaulting people and his lack of remorse. He later had discussions with social worker(1) from the Social Services Department as to which professionals should be invited to the forthcoming meeting.

On 8th March 2001 the author of the Probation Pre-Sentence Report in respect of Mark Towell, probation officer(2), completed an Assessment Case Recording and Evaluation system form (ACE) which was designed to calculate the perceived level of risk of further offending by reference to various specified factors. The level of such risk was calculated by probation officer(2) to be 80. At the same time it was noted that in relation to Mark Towell's mother and ex-girlfriend (GF1), to whom he had previously shown violence, the danger was "real and immediate".

On 8th March 2001 Mark Towell was arrested for causing a disturbance outside his parents' home but was subsequently released on police bail.

On 9th March 2001 probation officer(2) with responsibility for preparing the Pre-Sentence Report in respect of Mark Towell, spoke with a senior probation officer in a supervision session. The notes of the meeting read "Towell – at Court Monday. Nil report. Asking for psychiatric report. Serious concerns about risk to public. SSD (Social Services Department) calling ACPC (Area Child Protection Committee) planning meeting. probation officer(2) to attend. This will then inform whether or not we need to call a RMM (Risk Management Meeting). Probation officer(2) to alert reception of need to treat this man with caution until we know more about him."

A Pre-Sentence Report was prepared by probation officer(2) for the purposes of the forthcoming hearing at Gateshead Magistrates' Court on 12th March

2001. The Report suggested that Mark Towell's difficulties lay outside the remit of a straightforward Probation Order (subsequently known as a Community Rehabilitation Order) and suggested a four week adjournment for the preparation of a Psychiatric Report. The Report also responded to the request of the Magistrates, made at the hearing on 5th March, that an assessment be made regarding Mark Towell's suitability for a condition of residence. The Report indicated that, during an interview at HMP Durham, Mark Towell had stated that he would not comply with such a condition.

On the same day the psychiatric nurse from the MDOLS spoke with probation officer(2). She told the psychiatric nurse that she had discussed the case with her manager, the senior probation officer. He had recommended seeking an adjournment of the preparation of the Pre-Sentence Report and holding a "high level safety meeting".

On the same day, the psychiatric nurse from the MDOLS interviewed Mark Towell at the address of the local councillor in the presence of her secretary. Mark Towell spoke of how he believed the police were persecuting him and were preventing him from returning to work. The psychiatric nurse explained the role of the Tranwell Unit to Mark Towell and that he didn't believe that it was suitable for Mark Towell to be admitted there. Mark Towell then stated that he was paranoid and had had voices in his head for fifteen years and intended to kill himself. The psychiatric nurse advised him of his forthcoming appointment with consultant psychiatrist(2) at the Tranwell Unit.

At some point on 9th March 2001, Mark Towell visited his GP and was prescribed medication for depression. He referred to his forthcoming appointment with consultant psychiatrist(2) at the Tranwell Unit.

On 12th March 2001 Mark Towell made a further appearance at Gateshead Magistrates' Court when sentence was adjourned pending the preparation of a Pre-Sentence Report and a Psychiatric Report.

On 19th March 2001, as a result of his non-attendance for earlier appointments with the drug and alcohol service and his indications that he was refusing to attend, Mark Towell was sent a formal letter of discharge by 24/7. He was advised as to the opportunity to access assistance in the future.

On 20th March 2001 the local councillor contacted the CMHT duty worker and stated that Mark Towell was currently staying in bed and breakfast accommodation and had financial difficulties. She indicated that Mark Towell was not currently abusing alcohol or drugs but he recognised that this was an area which had caused a lot of problems in the past. She stated that he wanted an appointment with 24/7 to be arranged. The local councillor also suggested that Mark Towell had mental health difficulties and needed an earlier appointment with consultant psychiatrist(2) than 3rd April 2001.

She expressed her concern that Mark Towell was being passed around and not receiving the help he needed. The duty worker at 24/7 indicated that she would attempt to expedite the appointment with consultant psychiatrist(2) but could not guarantee to be able to do this having regard to his commitments. The duty worker further indicated that she would attempt to facilitate a re-referral of Mark Towell to 24/7. The worker discussed the case at length with the local councillor and advised the local councillor that as Mark Towell had already been assessed by the CMHT another such assessment at this stage would not be appropriate. The local councillor requested the duty worker attend the Civic Centre and accompany Mark Towell in speaking with the Housing Service at Gateshead Council. The duty worker suggested that Mark Towell could present himself to the Homeless Office at the Civic Centre who would be able to assist him.

On the same date probation officer(2) wrote to consultant psychiatrist(2) indicating that it would be helpful to have a discussion to ensure clarity of opinion between the respective reports being prepared by them.

On 21st March 2001 the CMHT made an unsuccessful attempt to bring forward Mark Towell's appointment with consultant psychiatrist(2).

On 22nd March 2001 the CMHT made an attempt to obtain a re-referral of Mark Towell to 24/7. 24/7 responded by indicating that as the case had been closed due to missed appointments; a request for a re-referral would have to come from Mark Towell or the local councillor. The same day the local councillor made a telephone referral of Mark Towell to 24/7. Following on from this referral 24/7 made several attempts during the following week to speak to the local councillor on the telephone but were unable to make contact with her so as to discuss the case. She was invited to telephone 24/7, but did not do so.

On 23rd March 2001 the psychiatric nurse from the MDOLS attempted to speak with the local councillor but spoke instead with her secretary who indicated that Mark Towell was present at the local councillor's home and was preparing for a job interview. The psychiatric nurse was informed that Mark Towell was spending his days at the local councillor's home.

On 23rd March 2001 a planning meeting was held under the auspices of the Gateshead Area Child Protection Committee Inter Agency Child Protection Guidelines issued in 1998, in respect of the unborn baby of Mark Towell's ex-girlfriend (GF1). The meeting was attended by: social worker(1) from Gateshead Social Services; the mother of the unborn child; a woman's advocate; a midwife and health visitor; child protection nurse (1); an officer from Northumbria Police; the psychiatric nurse from the MDOLS and probation officer(2), the probation officer assigned to complete the Pre-Sentence Report on Mark Towell.

The meeting was provided with a full summary of the recent history. The principal risks which were identified were those of violence to Mark Towell's ex-girlfriend (GF1) and to his parents. An account of the severity of violence inflicted on his ex-girlfriend was presented to the meeting. The police officer who attended the meeting stated that in his opinion Mark Towell was a "time bomb waiting to go off". The meeting was aware that consultant psychiatrist(2), was shortly to see Mark Towell and it was agreed that a copy of the Minutes of the meeting should be sent to him. There were discussions as to the practical steps which would be taken to afford the ex-girlfriend a measure of protection from Mark Towell. The meeting concluded with an agreement that a risk strategy meeting needed to be organised. Probation officer(2), agreed to request that the appropriate Manager within the Probation Service convene this meeting within the next seven days. The risk strategy meeting was deemed to be necessary owing to the perception of the risk posed by Mark Towell to his ex-girlfriend and also his adoptive mother.

At the time that the meeting on 23rd March was convened, Mark Towell was spending most of his time at the local councillor's home. He was attempting to secure employment for himself.

On 30th March 2001 the notes of the planning meeting which had been held on 23rd March 2001 were received by the psychiatric nurse from the MDOLS.

On 30th March 2001 Mark Towell was written to at the Harras Bank Hostel by the Housing Department at Gateshead Council advising him that he was being considered for exclusion from the Housing Register as a consequence of his conduct at Harras Bank Hostel. It is almost certain that Mark Towell did not receive the letter, as he was no longer living at Harras Bank after his exclusion.

On 3rd April 2001 Mark Towell was seen by consultant psychiatrist(2) at the Tranwell Unit. Mark Towell attended with his father, who remained present throughout the consultation. The referral to consultant psychiatrist(2) came from three sources (a) GP(5), dated 30th January 2001 (b) the SHO, dated 6th February 2001 (c) the Probation Service requesting a Pre-Sentence Report. Consultant psychiatrist(2) had been provided with a copy of the Minutes of the planning meeting, the CMHT assessment and the SHO's assessment. For reasons beyond consultant psychiatrist(2)'s control, there was only limited time available for the consultation, which consultant psychiatrist(2) described as being rushed. In the time available to him, consultant psychiatrist(2) considered himself unable to offer an adequate psychiatric assessment of Mark Towell. He recorded the history of violent and unpredictable behaviour. He also noted the abuse of street drugs and intermittent heavy alcohol use but was unable to offer a recommendation in respect of Mark Towell. A follow-up appointment was made for further assessment on 12th April 2001.

On 5th April 2001 the probation officer(2) prepared the Pre-Sentence Report on Mark Towell for the purposes of the hearing on 9th April 2001. The report outlined the history of Mark Towell's offending and personal history. The report addressed the risk of harm to the public, stating: "A range of offences committed in private and public against both property and people would confirm anxiety and anger are easily aroused in Mr Towell. It is of concern that he finds difficulty in appreciating the consequences of his behaviour upon others and focuses instead on his own feelings preferring to often rationalise incidents of aggression as provoked by others. Recent offending has been exacerbated by drug and alcohol use which has disinhibited his behaviour further. At present he has been offered assistance with his drug use but does not fully acknowledge it as a current problem. Due to his history, current circumstances and high levels of expressed aggression and hostility to others, I would assess he is at high risk of re-offending. In considering his risk of causing serious harm there are features of his offending that suggest violent incidents can develop in a public area and therefore public safety must be at risk. In addition to this a long history of aggression in significant relationships in his life, I believe place those close to him at risk of serious harm. During his last interview Mr Towell also expressed concern that he was likely to cause serious harm, but found it difficult to envisage how he could tackle his problems with anger management." The report concluded "While I have no doubt he would like to have a settled lifestyle, I have reservations that he has the motivation to tackle the difficult issues causing his behaviour and effect long-term change." Due to the absence of a psychiatric report from consultant psychiatrist(2), the Probation Report did not offer a recommendation to the Court in respect of sentence.

On 6th April 2001 a Housing Aid Officer at Gateshead Council Housing Service, wrote to consultant psychiatrist(2) at the Tranwell Unit requesting guidance as to Mark Towell's health and what type of accommodation would be appropriate for him.

On 9th April 2001 Mark Towell attended Gateshead Magistrates' Court when his case was adjourned pending the preparation of consultant psychiatrist(2)'s report. Mark Towell spoke with the psychiatric nurse at MDOLS. He indicated that he was staying in bed and breakfast accommodation which his father was financing.

On 12th April 2001 Mark Towell had an appointment to see consultant psychiatrist (2) at the Tranwell Unit. He did not attend.

On 14th April 2001, the then Head of Services for People with Disabilities at Gateshead Council, wrote to the local councillor as a result of his contact with the CMHT on 20th March 2001 and the absence of a further telephone call from her. Mark Towell was under the care of consultant psychiatrist(2)

who would refer him to a specialist social worker should that prove appropriate. However, this course of action would "obviously require Mark Towell's consent and co-operation which so far has not been forthcoming".

On 18th April 2001, consultant psychiatrist(2) wrote to the Housing Aid Officer at Gateshead Council and stated that he could not provide a report supporting Mark Towell's re-housing due to an incomplete assessment. Consultant psychiatrist(2) also wrote to probation officer(2) advising her that Mark Towell had failed to attend his appointment and indicating his willingness to see Mark Towell again outside his normal hours in order to prepare a report for the Court.

On 1st May 2001, consultant psychiatrist(2) provided his report to Gateshead Magistrates' Court. The report was based on a single interview because of the failed appointments on 22nd February 2001 and 12th April 2001. consultant psychiatrist(2) provided a history of Mark Towell's previous history but was unable to provide a recommendation to the Court because of his limited opportunity to assess Mark Towell. His report concludes "I feel under the present circumstances, I cannot give a recommendation to the Court in this case. I note that the consistent opinion of the various professionals who have seen him has been that he needs to address his illicit drug use before any work can be done on his potential for violence and self-destructive urges."

On 2nd May 2001 Mark Towell appeared at Gateshead Magistrates' Court and was sentenced to a 12 month Community Rehabilitation Order, (formerly known as a Probation Order), in respect of his outstanding offences. The Magistrates gave an informal indication in Court, which was recorded by the duty probation officer, that anger management and drugs and alcohol issues should be addressed but no specific condition was attached to the Order. When interviewed at Court by the psychiatric nurse from the MDOLS, Mark Towell stated that he was in employment again working on a construction site connected with the new Sunderland Metro Link. He gave his parents' address as a contact address. The psychiatric nurse wrote to consultant psychiatrist(2) at the Tranwell Unit, advising him what had happened at Court and that Mark Towell was unwilling to see consultant psychiatrist(2) again. The psychiatric nurse stated that should Mark Towell request a further appointment with consultant psychiatrist(2) this would be arranged through the "usual channels".

Commentary upon Mark Towell's health care and treatment from 6th January 2001 – 2nd May 2001

(i) This period was probably the most disturbed and unstable period in Mark Towell's life up until the murder of Mr Leak. The dominant themes appear to have been unemployment and the profound

difficulties experienced by Mark Towell in dealing with his relationship with his ex-girlfriend (GF1). His jealousy and feelings of rejection were mirrored in other significant relationships, namely his brothers, his mother and his subsequent girlfriend (GF2).

(ii) There was an apparent escalation in Mark Towell's drink and drug problems during this period. These difficulties were closely interwoven with those identified in his personal life.

(iii) There was unanimity amongst the psychiatric health professionals who saw Mark Towell during this period (and on earlier occasions) that he was not suffering from a mental illness. The psychiatric assessment by the SHO is probably the most comprehensive and complete psychiatric assessment of Mark Towell which is available. It was particularly thorough having regard to the early hours of the morning when it was undertaken. No depressive illness was identified. The SHO was actively involved in appropriate communication with other health professionals after the consultation with Mark Towell.

(iv) The difficulty experienced by the health professionals endeavouring to engage with Mark Towell is illustrated by the interview with the nurse of the Deliberate Self-Harm Team who found him to be "surly and uncommunicative". Furthermore, Mark Towell's ability to adhere to any possible course of treatment was seriously compromised by his behaviour such as when he abruptly left the Accident and Emergency Department after indicating that he wasn't willing to "trail" to out-patient appointments.

(v) Mark Towell's unwillingness to engage with the Drug and Alcohol Counselling Service at 24/7 reflected either a lack of will on his part to address his problems with drink and drugs or a lack of appreciation by him as to the extent of these difficulties. It was the local councillor, and not Mark Towell himself, who attempted to gain the re-referral to 24/7 on 20th March 2002. At the end of his period on remand, Mark Towell was rejecting the suggestion of any need for him to attend 24/7 or to see the consultant psychiatrist(2).

(vi) On 6th February 2001 another psychiatric assessment in respect of Mark Towell was undertaken by CPN(2) and CPN(3) of the CMHT. It is important to note, however, that Mark Towell was accompanied to the consultation by the local councillor, who remained present throughout. It represented a second attempt by Mark Towell to gain admission to the Tranwell Unit that day. The assessment undertaken by the CPNs did not reveal any significant mental health problems. The key issues identified were drugs and alcohol. The CPNs did not perceive Mark Towell as being overtly dangerous. The subsequent

extent of the communications by the CPNs with other health professionals represented good practice on their part.

(vii) The tendency on the part of Mark Towell to project blame onto others was again apparent in his perception of the difficulties in his relationship with his girlfriend (GF1), as expressed to the MDOLS on 16th February 2001.

(viii) The Panel consider that the psychiatric nurse from the MDOLS acted appropriately in initiating a sequence of contacts with other professionals as a result of his concerns. His principal concern was the risk he believed Mark Towell posed to his ex-girlfriend (GF1) and to professionals working with him. He did not identify a risk to the public at large.

(ix) The referral of Mark Towell to see consultant psychiatrist(2) was significant for a number of professionals engaged with Mark Towell at the time. The SHO, CPN(2) and CPN(3), GP(5), the Probation Service and the Court had expectations that Mark Towell's mental health needs would be illuminated by the assessment. In the event, the assessment was of limited value and Mark Towell failed to attend follow-up appointments.

(x) There appears to have been no attempt made by the Magistrates' Court to explore Mark Towell's willingness or otherwise to attend for drug and alcohol treatment or any offending behaviour programme to address his aggressive behaviour. Whether Mark Towell would have been willing to co-operate with any such proposal is a matter for speculation. In the event, the Magistrates, having initially determined that a comprehensive psychiatric assessment was appropriate, proceeded to sentence him without the benefit of a detailed assessment having been carried out.

(xi) The Panel was satisfied that the decision to call a planning meeting on 23rd March 2001 held under the auspices of the Gateshead Child Protection Guidelines was entirely appropriate and commends the effective co-operation and communication between the respective agencies in relation to calling the meeting. The meeting was well attended and there were representatives present from the appropriate agencies. The focus of the meeting was the unborn child of Mark Towell's ex-girlfriend (GF1). The meeting addressed the issues of risk in relation to the unborn child effectively.

(xii) The planning meeting went on to consider the risk posed by Mark Towell to his adoptive mother and to the wider public and it was resolved that a risk strategy meeting needed to be convened and that the probation officer present would request her manager to

convene this meeting within the next seven days. The Panel were satisfied that this proposed course of action was appropriate.

(xiii) There are a number of issues relating to the immediate aftermath of the meeting, which it is appropriate to highlight:

- The Pre-Sentence Report prepared by probation officer(2) on 5th April 2001 made no mention of the planning meeting or the intention to call a risk strategy meeting.
- The risk strategy meeting which it had been deemed necessary to call within seven days of 23rd March 2001, was not called by the Probation Service. This was notwithstanding the perception within the Probation Service by 9th March 2001 that a risk management meeting might be required.
- The distribution of the minutes of the meeting to the professionals who attended was not complete. The Police Officer and Child Protection Unit did not receive copies.
- None of the other professionals who attended the meeting on 23rd March 2001 made an enquiry of the Probation Service to establish what was happening or what had happened in relation to the proposed meeting.
- A number of professionals who attended the meeting were in some doubt as to whether they would have been invited to the risk strategy meeting had one occurred and therefore were not surprised when they heard nothing more of the matter. One professional who attended the meeting subsequently believed erroneously that the meeting had actually taken place.

3.5.2001 – 22.9.2001

On 3rd May 2001, following an internal meeting at 24/7 a decision was made to close their case in respect of Mark Towell.

On 8th May 2001, the Social Services Department closed its file in respect of the unborn baby of Mark Towell's ex-girlfriend (GF1).

On the same day, Mark Towell was admitted to the Accident and Emergency Department at Queen Elizabeth Hospital in Gateshead. He reported that he had been out drinking on the previous Saturday and had consumed "a lot" and had been experiencing gastric pain and had vomited blood on his way to work. An endoscopy was undertaken which did not demonstrate any significant problem. He was advised to decrease his alcohol intake. During the admission he referred to a history of depression but provided no details

as to the extent of his history of self-harm and problematical behaviour in the community. The letter of discharge was sent by the Accident and Emergency Department to his previous GP.

On 9th May 2001 Mark Towell's case was allocated by the Probation Service to probation officer(1), who had had some previous involvement with Mark Towell having prepared the Pre-Sentence Report in respect of him on 12th May 1999.

Probation officer(1) later spoke with Mark Towell on the telephone and had a brief conversation during which they were cut off. He indicated that he was currently staying in Bed and Breakfast accommodation in Birtley. Mark Towell's first appointment with probation officer(1) was confirmed for 11th May 2001.

On 11th May 2001 Mark Towell met with probation officer(1). He indicated that he was staying in bed and breakfast accommodation in Birtley and working 12 hour shifts on the Sunderland Metro Construction Site where he indicated there were strict rules in relation to drugs and alcohol including a regime of testing. Mark Towell made it clear that he had no intention of going to see consultant psychiatrist(2) Mark Towell indicated that he realised he had behaved "appallingly" in the past. He thought that his excessive use of cocaine (£200 a day) had exacerbated the situation. He made no mention of his hospital admission on 8th May 2001.

Mark Towell claimed that his experience in Durham Prison had made him realise he had to sort himself out. He indicated that he was back with his girlfriend (GF2) in Bensham. He was still having housing difficulties.

On 18th May 2001 Mark Towell spoke to probation officer(1) again. He explained how he spent "a couple of nights" with his girlfriend (GF2) and his other nights at his girlfriend's mother's (AY) house and at the bed and breakfast. Mark Towell had no problems he wished to discuss. He was working hard. The Probation Supervision Plan identified problems of "violence usually triggered by alcohol/drugs and desperation often prompted by homelessness, feelings of rejection (rooted in early life experiences) and injustice".

On 22nd May 2001 Mark Towell's case was reviewed by probation officer(1) and his manager, the senior probation officer. It was acknowledged that the planning meeting held on 23rd March 2001 had decided that a Risk Strategy Meeting should be called by the Probation Service. Since then, however, Mark Towell had been sentenced to a 12 month Community Rehabilitation Order and the following factors were weighed in their risk assessment:

(i) Mark Towell had reported as instructed.

(ii) Mark Towell had obtained work on the new Metro extension, working long hours.

(iii) It was understood that this job required regular testing for drink/drugs for Health and Safety reasons. Mark Towell had advised the Probation Service that he was passing these tests.

(iv) Mark Towell was maintaining his accommodation at Birtley.

(v) Mark Towell was having no contact with his previous girlfriend and had a new relationship.

(vi) There were no reported further incidents.

In view of these considerations it was believed that the level of risk to the public had reduced from that identified by probation officer(2) on 5th April 2001. There were no immediate concerns although it was recognised that the situation could change rapidly. The risk of harm to the public was medium/high; the risk of harm to staff was medium as was the risk of Mark Towell causing harm to himself.

The decision made at this review was that no Risk Strategy Meeting would be convened but probation officer(1) would maintain weekly contact with Mark Towell and monitor the situation closely. Any signs of changes i.e. a loss of job, changes in accommodation, a change in habits or reports of incidents should lead to the case being discussed with the Team Manager immediately. Probation officer(1) undertook to contact all the agencies who attended the planning meeting in March to let them know of his role and involvement so that any concerns could be relayed to him.

On 23rd May 2001 the senior probation officer, the Team Manager from the Probation Service, wrote to social worker(1) from Gateshead Social Services who had attended and minuted the planning meeting, explaining the outcome of the review and the reasons for not convening a risk strategy meeting. It was explained that the case was "being closely monitored however and should there be any change in Mr Towell's circumstances i.e. he leaves or changes his employment, changes addresses or we receive any information from any source that further incidents have occurred in relation to those people who are at most risk from Mark Towell we will immediately convene a meeting of all the agencies concerned". The senior probation officer invited the social worker to communicate any concerns about the decision to probation officer(1). The letter from the senior probation officer to the social worker made it clear that the letter was not being forwarded to the other professionals who attended the meeting on 23rd March 2001, but that probation officer(1) would be in contact with them to let them know that he was managing the case and that they should refer any concerns regarding Mark Towell to him. The social worker in question informed the Panel that she had never received this letter. Probation officer(1) informed the Panel that due to pressure of work and some difficulty on his part identifying the professional addresses of those individuals who attended the

meeting, he did not make contact with them.

On 24th May 2001 the Housing Service at Gateshead Council wrote to Mark Towell using the Harras Bank address informing Mark Towell that, due to his conduct, his application for housing had been cancelled. As in an earlier instance, it is extremely unlikely that Mark Towell received this letter.

On 25th May 2001 Mark Towell met with probation officer(1) and presented a positive view of his current circumstances. The biggest problem identified in his life was his accommodation. He was still spending his time between his girlfriend (GF2), her mother (AY) and his bed and breakfast address. He was reluctant to give his girlfriend's address as he didn't want her "involved". When pressed about the issue of his accommodation he said he didn't know what he wanted and that he preferred to move around. He related his past violence to his life in Birtley which involved night clubs, drugs and drink, all of which he now avoided. He had realised that he didn't want violence.

On 27th May 2001 (GF1), Mark Towell's ex-girlfriend, gave birth to a baby, the father of whom she stated was Mark Towell.

On 8th June 2001 Mark Towell met with his probation officer(1). He was much less positive than on the previous occasion. He stated that he was still working but was making no progress with his accommodation. He was living with his girlfriend's mother (AY) but was reluctant to give his address. He became angry when he was pressed. Probation officer(1), believed that there was a growing indication that the situation may have been beginning to "crumble". Mark Towell's girlfriend (GF2) was trying to limit their time together. Mark Towell was feeling rejected. He was sleeping on the floor at GF2's mother's home. Mark Towell had had a fight with AY's partner, Mr Leak.

On 14th June 2001 the local councillor telephoned probation officer(1). The local councillor was concerned about Mark Towell. The local councillor said Mark Towell had visited the local councillor's home the previous night very upset having fallen out with his girlfriend (GF2). His girlfriend's mother (AY) had evicted him. Mark Towell's parents were exhausted and were not in a position to carry on paying for Mark Towell's bed and breakfast accommodation as they had been. The local councillor wondered if Harras Bank might provide a flat for Mark Towell. Probation officer(1) replied that as Mark Towell had damaged the hostel and assaulted the warden, he did not think that such an approach would be fruitful. He advised that the private sector was the most likely prospective source of accommodation for Mark Towell. Probation officer(1) agreed to speak with Mark Towell the following day.

On 15th June 2001 probation officer(1) spoke with his manager, the senior probation officer. The senior probation officer believed that Mark Towell

should take responsibility himself for his accommodation. He was in employment and should be able to pay his way. It would not be appropriate to pay for Mark Towell's accommodation unless he was no longer working, in which case the situation could be looked at again.

Mark Towell subsequently telephoned from his workplace to indicate that he was homeless. He was disenchanted with his girlfriend's (GF2) family. He agreed to attend the Probation Office as soon as possible. When he arrived he expressed some optimism of a reconciliation with his girlfriend (GF2) and being readmitted to her home. A long discussion took place between Mark Towell and probation officer(1) in the course of which Mark Towell stated that alcohol made him "a psychopath". He was encouraged to find his own accommodation so that his relationships weren't build on dependency. Probation officer(1) provided Mark Towell with information relating to possible accommodation with private landlords, Housing Associations and Bed and Breakfast addresses.

Mark Towell met with probation officer(1) on 20th June 2001, 29th June 2001 and 6th July 2001. The written records of these meetings have been mislaid and the Probation Service have been unable to locate them. These meetings occurred at an important stage in the course of Mark Towell's supervision by the Service.

On 11th July 2001 a supervision session occurred between Mark Towell's probation officer(1) and his supervisor, the senior probation officer. It was noted that the risk levels were "still reduced". Mark Towell was working full time and living at the YMCA.

On 13th July 2001 Mark Towell telephoned the Probation Service at 8.30 a.m. in an agitated condition. He was advised to call back later. He later attended the Accident and Emergency Department at the Queen Elizabeth Hospital Gateshead complaining of headaches during the past two weeks. He stated that he was otherwise well.

Mark Towell later called at the premises of the Probation Service and spoke with his probation officer's Manager, the senior probation officer. He described having argued with his girlfriend (GF2) and was anxious that out of spite she might have reported him for assaulting her. He denied that any assault had taken place. Mark Towell received an abusive text message from his girlfriend (GF2) during the meeting. He was highly critical of his girlfriend (GF2) and the senior probation officer noted this was "a far cry from the glowing reference he gave her just a week or two ago". He was advised to go home, get some rest and stop sending text messages to GF2. He was helped to write letters to various Housing Associations.

On 14th July 2001 Mark Towell returned to the same hospital complaining of a history of vomiting and lethargy. He was concerned that he might be

suffering from Weil's Disease. He was reassured and prescribed paracetamol. Upon his attendance he gave his address as the YMCA Hostel in Jesmond, Newcastle upon Tyne.

On 20th July 2001 Mark Towell met with his probation officer(1).
He complained that the YMCA was too expensive. He had made no progress with Housing Associations. He had returned to his "old ways" last Saturday night when he had been very drunk, had taken drugs and ended up fighting, slackening his front teeth. He said he was on the verge of giving up and felt like killing himself. He was afraid he might explode. He was advised of the benefits of working and provided with a list of accommodation agencies. Probation officer(1) recorded his view that Mark Towell was capable of random violence. Mark Towell was offered encouragement and support and by the time he left the premises he appeared relatively focused and prepared to keep trying. As Mark Towell had no GP at the time, probation officer(1) advised him to register with a practice. Mark Towell enquired about anger management courses and it was agreed that this would be investigated.

On 21st July 2001 an alleged incident involving considerable violence occurred involving Mark Towell. The injured party was a man who it appears Mark Towell believed might be the father of his girlfriend's (GF2) unborn child. The man alleged that Mark Towell entered his property whilst he was asleep and attacked him whilst he was in bed. He alleged that he was then seriously assaulted by being repeatedly punched and kicked. Mark Towell then threatened to kill the man with a kitchen knife he had found in the man's home. Eventually Mark Towell was said to have calmed down and allowed the man to leave the property and attend hospital where he was treated for two severed tendons resulting from a cut caused by broken glass from a mirror which was lying on the bedroom floor as a result of the disturbance. The man also sustained lacerations and bruises to his face and body. The man made a statement to the police on 25th July 2001. As a consequence, attempts were made by the police to locate and arrest Mark Towell which proved unsuccessful. The Probation Service were not informed by the police of this incident or of the attempts to arrest Mark Towell.

On 25th July 2001 Mark Towell reported to his probation officer(1).
He complained of increasing frustration regarding the lack of progress with his accommodation. For the second consecutive weekend he said he had returned to his "old ways" and had been out drinking, clubbing and taking drugs. At 2.30 a.m. he received a text message from his girlfriend (GF2) questioning their relationship and went around to her property entering through an upstairs window terrifying her. He stated, however, that they parted on good terms. He then went on to relate his version of the incident on 21st July 2002. He described how after he returned from his girlfriend's home, he went to the home of the man in question. He alleged that the man was "always at" his girlfriend's address. They had a drink together, then

argued. He said that the man then pulled a knife on him and cut his arm before he turned the knife on the man. He said both he and the man attended Queen Elizabeth Hospital in Gateshead and when spoken to by police officers both men had indicated to police officers that they had been assaulted by strangers and that they didn't want to press charges. They then returned to the man's property before the man went back to the RVI for further treatment. Mark Towell was clearly worried about possible police action. Probation officer(1) advised him that the relationship with his girlfriend (GF2) was not good for him and that he should consider terminating it and concentrating on work. Probation officer(1) did not subsequently contact the police in relation to the alleged incident.

On 1st August 2001 Mark Towell failed to attend an appointment with probation officer(1).

On 2nd August 2001 Mark Towell attended the offices of the Probation Service and indicated that he had been working late the day before. Mark Towell seemed more settled. He was no longer seeing his girlfriend (GF2) and had met another girl and was considering moving in with her. Mark Towell was advised not to rush the pace of this relationship. Probation officer(1) requested that Mark Towell attend weekly meetings as a consequence of the instability of the situation.

On 8th August 2001, Mark Towell reported to the Probation Office and stated that he was now working on a construction site behind the Central Station in Newcastle upon Tyne.

On 16th August 2001 Mark Towell attended a meeting with his probation officer's Team Manager, the senior probation officer, and stated that he was homeless and had no job. He described having taken a few days off and got back in with "the wrong crowd". He was encouraged to telephone his employer from the Probation Office which he did and arranged to attend the following day. Mark Towell indicated he had left the YMCA Hostel after failing to pay his rent. Mark Towell later spoke with another probation officer as probation officer(1) was on leave and accommodation was identified for Mark Towell at Cuthbert House, a bail hostel in Gateshead.

Upon arrival at Cuthbert House with a probation officer, Mark Towell indicated to the staff at Cuthbert House that he was keen to return to work and get his life back on the "straight and narrow". He had been staying with a male friend whom he stated was a heroin user. He was subsequently assisted by his father and the local councillor in recovering his hard hat and boots from his previous address so that he could start work in the morning.

Later on in the evening, Mark Towell arrived back at Cuthbert House late, in breach of the curfew rule. He sat in the lounge and spoke openly as to how much he enjoyed boxing and bare knuckle fighting and the staff concluded that he was attempting to emphasise that he could handle himself in a fight.

On 18th August 2001 Mark Towell was observed at Cuthbert House with his girlfriend. He went out with her and returned in the evening under the influence of drink and/or drugs. Although his behaviour was noted to be "loud" and "hyper", it was not problematic.

On 19th August 2001 Mark Towell was given a final warning by staff at Cuthbert House having arrived back late at 11.20 p.m. and breached the curfew rule. He was noted to be co-operative and reasonable and said he would not be back as late again.

On 20th August 2001 probation officer(1) telephoned Cuthbert House and was informed that Mark Towell was causing no particular problems. He was believed to be "pushing at the boundaries" within the Hostel arriving home late, but that he could continue to stay so long as he "behaved himself".

On 21st August 2001 a member of staff at Cuthbert House telephoned Mark Towell's probation officer(1) stating that they did not believe Cuthbert House was an appropriate long-term placement for him and that they hoped he could be rehoused within the week. They were concerned that once he knew he was not staying at the Hostel long term, he would lose any incentive to co-operate and would be likely to be aggressive to the staff. Unlike the majority of the residents at Cuthbert House, Mark Towell was not on bail and accordingly there were no sanctions available to staff working there in their contacts with him. It was not thought he would comply with the curfew rule at the hostel. Probation officer(1) later met with Mark Towell who indicated that he had not been to work that day having slept in. He said a workmate was looking for accommodation for him. Probation officer(1) perceived that the impetus to find accommodation was coming from the workmate and not Mark Towell, who seemed content with the status quo.

On 22nd August 2001 probation officer(1) made extensive enquiries of various accommodation options for Mark Towell. The case was later reviewed by probation officer(1) and the senior probation officer who thought that Mark Towell should take more responsibility for his situation. Mark Towell was later seen by probation officer(1) who observed him to be tired, hungry and disappointed at the prospect of a small wage that week and at the difficulty in obtaining accommodation. Mark Towell's mood fluctuated from despair and talk of suicide to anger and talk of robbing people. He appeared to regain his composure and returned to Cuthbert House, before going out for the evening. He returned within the prescribed time limits and did not present any difficulty.

On 23rd August 2001 Mark Towell's probation officer(1) made further energetic attempts to secure accommodation for him and visited Cuthbert House to discuss these options with him. Cuthbert House indicated that he could stay at the hostel for the weekend although there was concern as to what would happen if he went drinking when he received his week's pay.

A Probation Supervision Review held on the same day identified Mark Towell's chaotic lifestyle to be the principal problem, particularly in respect of accommodation. There was some evidence of him drifting back into old patterns of behaviour. Notwithstanding these concerns, he was holding onto a job. Concern was noted that he "may be beginning to crumble" and that "the perpetual state of crisis has prevented any structural work on relationship issues other than offering immediate advice when such issues surfaced".

On 24th August 2001 Cuthbert House staff contacted probation officer(1) and informed him that a girlfriend of Mark Towell had telephoned the previous night to say that he would be staying at her home and wouldn't be returning to the hostel. Mark Towell was informed that he must notify the Probation Service of his current whereabouts as soon as possible. Further efforts were made that day by probation officer(1) to identify accommodation for Mark Towell.

On 27th August 2001 police officers attended the family home following an incident when Mark Towell, whilst being conveyed by his father to Cuthbert House, threw himself from the car stating that he didn't want to return as it was a "dump". He was persuaded to return to Cuthbert House.

On 28th August 2001 staff at Cuthbert House completed a final written assessment of Mark Towell. The following observations were made:

"Mark is a young man with a violent history. His propensity for violence became apparent to hostel staff following an incident when Mark arrived back at the hostel under the influence of alcohol. He was hostile and confrontational to staff, staff felt threatened by his behaviour which was described as baiting staff and gloating and describing his liking for fighting and violence generally. He failed curfew twice prior to him not returning on the last occasion. He often returned under the influence of alcohol and appeared to generate an uncomfortable and hostile atmosphere amongst other residents … It was not felt that it was likely that Mark would be able to sustain appropriate behaviour within the hostel and would have difficulty with imposing restrictions and sanctions."

On 29th August 2001 Mark Towell did not attend an appointment to view accommodation arranged for him.

On 3rd September 2001 probation officer(1) recorded that there had been no contact with Mark Towell since he had left Cuthbert House. Probation officer(1) spoke to his manager, the senior probation officer and it was agreed that if there was no contact by the next day then a warrant would be sought.

On 4th September 2001 probation officer(1) completed an Assessment Case Recording and Evaluation system form (ACE). The level of risk of

re-offending was calculated by probation officer(1) to be 58, which contrasts with the score of 80 calculated by probation officer(2), the author of the Pre-Sentence Report, on 8th March 2001. This represented a significant reduction in the assessed level of risk.

On 5th September 2001, in the light of no contact being made by Mark Towell with the Probation Service after leaving Cuthbert House, the Probation Service issued a warrant for his arrest.

On 6th September 2001 Mark Towell contacted his probation officer(1) by telephone. He stated that he had had an "awful week". He had been back to the YMCA and with assistance from his father had paid off the arrears of rent. He had been laid off at his place of work due to slackness of available employment. He couldn't claim any benefits because he didn't have the requisite number of payslips. His parents were on holiday. He couldn't return to the YMCA for the time being and was staying with a friend in Walker. Probation officer(1) later reviewed the case with his manager, the senior probation officer, and it was agreed that the breach must stand. Concerns were noted as to Mark Towell's loss of work and the company he was keeping.

On 7th September 2001 probation officer(1) collected Mark Towell from the address in Walker. Probation officer(1) was concerned that the persons with whom Mark Towell had been residing had been arrested on serious assault charges. Mark Towell had been present during the incident but according to him was not implicated. Arrangements were made for his attendance at Court on 11th September 2001 in respect of the breach proceedings.

On 10th September 2001 Mark Towell reported to probation officer(1). He was anxious to leave Walker. He feared the repercussions from the incident in which a man was assaulted by his friends. Probation officer(1) discussed the possible accommodation options available to Mark Towell. It was agreed that he would stay at his current address until his forthcoming Court appearance the following day.

On 11th September 2001 there were delays in preparing the requisite documentation for the breach proceedings and it was determined that the case would be held over until the following day. Mark Towell indicated that he was unhappy about the prospects of moving into a bail hostel which had been identified by the Probation Service as having a vacancy for him. An appointment was later arranged with a Housing Agency for him to be interviewed with a view to being provided with accommodation. He indicated that he was willing to attend the interview, but arrived one hour early for his appointment and declined to wait. He said he wasn't interested in shared accommodation and that he would "leave it".

On 12th September 2001 Mark Towell appeared at Gateshead Magistrates' Court and was fined £10 in respect of the breach of the Community Rehabilitation Order. A direction was made that the Order was to continue. On the same day he moved back in with his former girlfriend's (GF2) mother, AY.

On 14th September 2001 Mark Towell telephoned probation officer(1). He appeared to be in good spirits. He was living with his former girlfriend's (GF2) mother (AY), (Mr Leak's partner) and said that he had decided to enlist with the Royal Marines. He was not interested in accommodation in a bail hostel and requested that the appointment which the Probation Service had made for him to visit Byker Bridge Hostel be cancelled.

On 19th September 2001 Mark Towell reported to probation officer(1). Mark Towell had been drinking and appeared to be in a "cheerful" frame of mind although probation officer(1) noted that he was "a little unpredictable". Mark Towell stated he had been to the offices of the Royal Marines and had obtained the necessary paperwork to enlist. He said that he was unsure whether the fact that he was subject to a Community Rehabilitation Order would present a difficulty with his application. He stated that he had been drinking with some older more mature friends and had had a good afternoon. He left the office in a good mood. During the interview he questioned the value of the Community Rehabilitation Order, stating that it was proving an obstacle rather than a help. This was the final contact that Mark Towell had with the Probation Service before the fatal incident on 22nd September 2001.

On 22nd September 2001 Mark Towell killed Arthur Leonard Leak.

Commentary upon Mark Towell's health care and treatment from 3rd May 2001 – 22nd September 2001

(i) Mark Towell's relationship with GF2 shared many of the characteristics which had been evident in his relationship with his ex-girlfriend (GF1). The relationship had commenced in the autumn of 2000 but had then broken down. After Mr Leak's death, GF2 made a statement to the police in which she described Mark Towell's violent conduct to her even during the early stages of the relationship. The violence was allegedly particularly marked when Mark Towell was under the influence of drink or drugs. The relationship was volatile as was evidenced by a number of separations and reconciliations but continued on an intermittent basis. Mark Towell's relationship with GF2 was marked by difficulties in relation to jealousy, violence and his feelings of rejection.

(ii) The Probation Service's assessment of risk, carried out on 22nd May 2001, was based upon a perception of apparent stability. After re-assessing Mark Towell's case on 22nd May 2001, and deciding not to call a risk strategy meeting, the Probation Service do not appear to have re-assessed the potential level of risk in the light of subsequent events, some of which had been identified earlier as potential triggers for the calling of such a meeting. The role of the Probation Service during this period was of particular significance as it was the only agency which had contact with Mark Towell at this time.

(iii) Probation officer(1) sustained high levels of contact with Mark Towell during this period and invested considerable efforts in endeavouring to help with a wide range of problems, for example in relation to work and accommodation. Probation officer(1) was successful in de-fusing a number of incidents when Mark Towell arrived in an agitated condition. It is important to acknowledge that in his dealings with Mark Towell probation officer(1) was presented with a significant burden of demands which he was able to deal with whilst retaining a working relationship with Mark Towell. Notwithstanding the efforts of probation officer(1), Mark Towell's life in the community continued to be erratic and chaotic.

(iv) The incident of violence on 21st July 2001 was clearly a serious one, whoever's account of it is accepted. The incident came to the attention of the Police in that a witness statement was taken from the other man involved on 25th July 2001. No criminal proceedings followed. There was no liaison between the Police and the Probation Service concerning the incident.

(v) The Police records do not reflect the level of violence as subsequently complained of by Mark Towell's two former girlfriends in the course of his relationship with each woman. It appears that much of this violence was not reported.

(vi) Mark Towell's appointment with consultant psychiatrist(2) on 18th April 2001, which he failed to attend, was the last possible occasion when he might have been able to engage with a health professional. After this date he sought no contact with or help from Health Service professionals. The picture which has emerged of his life in the community, however, does not suggest that he had acquired any significant coherence or stability.

4

Psychiatric commentary in respect of Mark Towell

In April 2001 Mark Towell's last contact with psychiatric services occurred. Further input was recommended by the psychiatric services in order to complete an assessment of his mental health needs and if appropriate to then identify potential treatment interventions. Evidence available to the Panel suggests that neither Mark Towell, his family nor professionals directly involved in his case subsequently sought to pursue this line of intervention. The pattern of partial engagement and incomplete interventions has been apparent throughout the recorded contact of Mark Towell with mental health services over many years.

The first contact with psychiatric services appears to have occurred when Mark Towell was in his early teenage years and was said to have involved the Young Persons Unit in Newcastle. Unfortunately no record of this contact has been traced and details are therefore unavailable. The first recorded interventions by mental health services occurred in 1992 when Mark Towell was engaged in a series of sessions with a Community psychiatric nurse based at his General Practitioner. The particular focus of this work was his difficulty in containing his anger. It was clear at this stage that concern was being raised regarding Mark Towell's anger and volatility and his father gave a history of his increasing aggression, including his use of a weapon. His abuse of illicit drugs and alcohol were also identified as problems, as were issues related to his childhood. Further work by the same practitioner was embarked upon in 1993 but terminated after only three sessions because of a perceived lack of genuine engagement on his part. During both sets of treatment sessions it was evident that a full psychiatric assessment would be appropriate and this subsequently occurred later in 1993 when he was assessed by a consultant psychiatrist from the Young Persons Unit. Following this, a report was provided for the courts at the time of Mark Towell's first criminal conviction. This assessment process was curtailed by his failure to attend follow-up appointments and non-attendance for investigations which had been arranged. The psychiatric opinion at this stage focused around his difficulty in containing his temper. No evidence of formal mental illness or a physical cause for his difficulties was identified.

In 1998 his General Practitioner prescribed antidepressant medication after Mark Towell complained of aggressive behaviour and paranoid thoughts but

his next significant contact with mental health services was not until 1999. By this stage his drug and alcohol misuse were the most prominent areas of concern. He had a history of heavy alcohol consumption characterised by binge drinking and was also said to be using a range of illegal drugs. Mark Towell was subsequently assessed by the drug and alcohol service and deemed appropriate for further treatment. This focused solely on his excessive use of alcohol and the use of illicit drugs was not identified as an issue during the assessment. Mark Towell failed to comply with the follow-up appointment offered and was promptly discharged from the drug and alcohol service. Additional contact with mental health services occurred in early 1999 related directly to his difficulty in obtaining accommodation.

In August 2000 the first incident of deliberate self-harm occurred. Mark Towell took a serious overdose which required treatment in hospital. He was seen by a nurse specialising in the assessment of people who self-harm and no further assessment or intervention was thought necessary.

The overdose was seen as an impulsive response to difficulties within his relationship. Also noted at this time was his description of violence towards his girlfriend (GF1). Mark Towell did not want follow-up and because he was apparently not registered with a GP details of this assessment were not disseminated. In the first two months of 2001 Mark Towell had a number of assessments by various members of the local mental health services. He was reviewed again by the deliberate self-harm nurse having been taken to casualty after cutting his wrists and trying to hang himself. The episode was again thought to be impulsive in the context of alcohol abuse and difficulties within the relationship with his girlfriend (GF1). His GP subsequently referred him for a full psychiatric assessment noting that he had a history of disturbed behaviour, deliberate self-harm and difficulties in his relationship. His adopted status and recent death of his grandfather were also thought to be significant. Before this psychiatric assessment had taken place he was once again assessed in the local casualty department, having apparently been trying to throw himself in front of traffic. He was seen at some length by a junior psychiatrist who again noted the principal problems related to alcohol and drug abuse. He was not thought to be suffering from any form of mental illness but a more detailed psychiatric assessment was suggested, particularly given his level of impulsive behaviour. Within a matter of hours of this assessment he was seen by two nurses from the Community Mental Health Team who also took a detailed account of his difficulties and the assessment concluded that Mark Towell first needed to address his problems with alcohol and drugs before any more substantive issues could be addressed, such as his adopted status, low self-esteem and poor self-worth. He was therefore re-referred to the drug and alcohol team. He did not attend the appointment offered as he was remanded in custody and no further intervention from the drug and alcohol service ensued.

In mid February 2001, Mark Towell was also assessed by the mentally disordered offenders worker, a psychiatric nurse. The impression formed from this assessment was that he had a low threshold for resorting to violence. The same worker reviewed him later in February and the issues of concern focused around his drug and alcohol abuse and propensity for violence. On 3rd April 2001 Mark Towell was seen by a consultant psychiatrist at the Tranwell Unit. Mark Towell attended with his father and other sources of information were available at the assessment arising from the previous assessments by the General Practitioner, the junior psychiatrist and the nurses within the Community Mental Health Team. It was accepted that the interview was unsatisfactory and the assessment was rushed and inadequate. The main difficulties identified were Mark Towell's history of violent and unpredictable behaviour and his abuse of illicit drugs and alcohol. Although this last contact with psychiatric services was unsatisfactory to all parties involved, the conclusions reached were entirely consistent with the findings of all previous assessments by mental health professionals. In early 2001 he had been seen at length by a junior psychiatrist and by a number of psychiatric nurses and the key themes to emerge for all these assessments were his misuse of drugs and alcohol, his poor temper control, propensity towards violence and his impulsive, unpredictable behaviour. Although his last assessment was unsatisfactory it is clear from the evidence put before the Panel that mental health services in early 2001 were in a position to conclude that Mark Towell was not suffering from any form of mental illness.

It would be expected that any signs or symptoms of serious mental illness should have become apparent during his repeated contacts. By contrast it was certainly evident to all practitioners that his misuse of drugs and alcohol were a key factor in the difficulties he presented and this was seen as an essential first step to be addressed before any further issues could be explored. These potential future avenues of work included his poor self-esteem, difficulties stemming from his being adopted and his poor temper control.

The issue of personality disorder was not specifically raised during the assessments carried out but it was clear this would have been area for further consideration, had he been engaged in a more detailed period of assessment. There were factors pointing to an abnormal development of his personality and these included his history of disturbed, impulsive behaviour dating back through his adult life into childhood, his difficulty maintaining interpersonal relationships, his repeated conflict with authority and his history of deliberate self-harm. The impact of his significant substance misuse in each of these areas was however evident and complicated the assessment of his personality.

It was evident that local mental health services prioritised people with severe mental illness in the first instance and Mark Towell would therefore not have

attracted this definition. Community Mental Health Teams concentrated their efforts on people suffering from illnesses such as schizophrenia and mood disorders, who were likely to be the most distressed and disturbed individuals. The operational policy relevant to Community Mental Health Teams at the time emphasised the needs of the severely mentally ill and reflected national policy in terms of those patients having "complex needs which may require the continuing care of specialist mental health services working with other agencies". However the aim of the policy was also to prioritise need for services according to a range of diagnoses as set out in the "Interim Matrix Tiered Model". This sets out a range of mental health problems which should be prioritised more according to severity, complexity and risk associated with the disorder, rather than simply according to diagnosis. The group of conditions upon which the Community Mental Health Teams were intended to focus included not only the severely mentally ill but also those with personality disorders of various types. The additional complication of a substance abuse disorder was also intended to be addressed and would not preclude an individual from access to mental health services.

It was clear in this case that even though many of Mark Towell's difficulties revolved around drug and alcohol abuse and possibly personality deficits, this did not exclude him from accessing mental health services. Mark Towell's unwillingness or inability to engage beyond the initial assessment interview in the two contacts with psychiatric services which offered further help, the drug and alcohol service and the consultant psychiatrist, signalled the cessation of any potential interventions from the mental health services. There was no sense in which he was labelled as having any particular diagnosis which would disbar him from treatment.

It is a matter of speculation whether further assessment would have yielded either a specific diagnosis or areas of potential treatment intervention. The inability to complete a thorough assessment leaves this question unanswered. Mark Towell was not thought to be suffering from a mental disorder for which he could be detained in hospital for assessment, neither was he ever remanded in custody for the purpose of preparing a psychiatric report for the court. As such, any detailed assessment of how he could have been helped depended on his cooperation, which was not forthcoming.

Because Mark Towell was not thought to be suffering from any significant form of mental illness and had not, in fact, attracted any specific diagnosis apart from his use of drugs and alcohol, he was deemed to be able to make the choice as to whether or not he accepted help or further assessment. In general terms all adults are assumed to be capable of choosing whether or not they wish to have medical treatment and it is, in fact, essential that people only receive treatments to which they agree. Under certain circumstances the Mental Health Act allows for the compulsory assessment

and treatment of people suffering from particular forms of mental disorder but it is of note that dependence on drugs and alcohol is specifically excluded from the remit of this legislation.

There were therefore no identified grounds on which mental health services, based on the evidence available, were in a position to compel Mark Towell to cooperate with further assessment or any form of treatment. It will remain purely an area of speculation as to whether any further assessment of Mark Towell would have provided a basis upon which he could have received any effective treatment interventions from mental health services.

5

Mark Towell's involvement with the Probation Service

The Probation Service played a unique role in relation to Mark Towell, supervising him during three periods of statutory supervision and a Community Service Order. The Probation Service was the sole agency with which Mark Towell had contact in the period immediately prior to the fatal incident. In these circumstances, it is necessary to consider in some detail the statutory supervision process and how it related to Mark Towell.

1993-1994

The records of the Northumbria Area of the National Probation Service indicate that their first substantial involvement with Mark Towell was as result of his court appearance on 13th July 1993. The service was responsible for preparing a Pre-Sentence Report for the hearing at which Mark Towell was sentenced for a Section 47 Assault (on a Deputy Head Teacher).
The production of the Pre-Sentence Report, by a student probation officer under supervision, was the first contact that the Service had with Mark Towell, and facilitated the building of a body of knowledge about him.
The report was produced after a lengthy interview with Mark Towell.
A home visit was not made but supporting information was provided through two telephone calls to his parents. At the time consultant psychiatrist(1) was involved with Mark Towell and this was acknowledged in the Pre-Sentence report which informed the Magistrates that the consultant psychiatrist(1) thought that Mark Towell was beginning to mature and was talking positively about change.

The Pre-Sentence Report also acknowledged that Mark Towell had frequent aggressive outbursts, constantly lost his temper, had been suspended from school six times, and was ultimately excluded in his final year.
The recommendation in the report, that Mark Towell be place on a Probation Order for a year, was followed by the Magistrates, without the imposition of extra conditions.

Consultant psychiatrist(1) also produced a report for the Court, which indicated that Mark Towell was being seen by a psychiatric nurse(CPN1) to help with his poor temper control.

After the making of the order Mark Towell was seen, by the student probation officer who had prepared the Pre-Sentence Report, on 19th July 1993. The initial assessment used to spell out the strategy for the probation order, acknowledged the work being done by the Psychiatric Services, to help Mark Towell to develop techniques to avoid potentially violent situations and help with anger management. It was believed by the Probation Service to be beneficial not to replicate this work, but to complement it with exploration of reasons for Mark Towell's anger.

There was subsequent contact between the two services and it was recorded in September 1993 that Mark Towell still had problems with temper control and was still getting into fights. Mark Towell was reported as maintaining that neither agency was any use to him. It was suggested that he was playing games and that a firm line would need to be taken in order to engage him in addressing his problems.

Good levels of contact were maintained during the next three months and offending behaviour exercises tried. However in December 1993 it was recorded that Mark Towell still enjoyed fighting and had admitted using steroids. By the end of the order Mark Towell had admitted taking other drugs and attacking his father. In the final summary in July 1994 it was stated that Mark Towell's ability to stay out of trouble would be linked to avoiding drugs.

During this first period of supervision, in 1993/94, the work undertaken by the Probation Service, supported as it was to a degree by the Psychiatric Services, was not able to engage Mark Towell in any committed way to examining his behaviour, which deteriorated. His resistance to the supervision process was accompanied with a drift into drug taking, a factor linked to the likelihood of his further offending.

1996-2001

The Probation Service resumed its contact with Mark Towell when a Pre-Sentence Report was prepared for the Crown Court hearing on 15th March 1996, when Mark Towell received a Community Service Order of 80 hours after pleading guilty to a charge of affray.

The Pre-Sentence Report was prepared on the basis of an office interview with Mark Towell, Crown Prosecution papers, contact with Community Service staff and the Probation Service records.

This Report indicated that Mark Towell's guilty plea effectively acknowledged that he had been the principal player in a serious incident of public violence and disorder. Whilst recognising that Mark Towell might be in danger of

losing his liberty, and taking a sanguine view of the previous period of supervision, the recommendation by the Probation Service, to the Court, was to make a Combination Order. It was suggested that this would combine the punishment of carrying out compulsory community work with supervision which would enable Mark Towell to develop strategies to avoid further offending. By making a Community Service Order the Crown Court did not take up the option of giving Mark Towell the opportunity to undertake this further work.

Further contact with the Probation Service came in 1999 when a Pre-Sentence Report was prepared for the Magistrates Court, Mark Towell being charged with Affray and Criminal Damage. The report was prepared by the same probation officer(1) who wrote the report in 1996. Again the report was prepared following an office interview and on this occasion without sight of the prosecution evidence. At this stage a risk assessment form (adapted from Brearley 1982) was completed. This exercise indicated that Mark Towell was of a medium risk to the public, low risk to staff, and of a medium risk in terms of self-harm.

On 21st June 1999 Mark Towell was placed on a Probation Order which imposed the standard conditions, i.e. that he keep in touch with his probation officer as instructed, be of good behaviour and lead an honest life.

He was seen by a probation officer on the next day to begin the supervision process. Mark Towell reported that he had obtained contract work in the construction industry and that he would be working at sites around the country. On 29th June 1999 a supervision plan was completed which indicated that anger management, alcohol, debt counselling and employment were to be the focus of contact with the service.

On 18th August 1999 it was decided to vary national standard requirements with regard to levels of contact because as Mark Towell was working away and had a job, this was seen as means of significantly reducing the risk of re-offending. On 25th January 2000 Mark Towell reported that he wanted a move of home after a neighbourhood disturbance. It was noted that he was still a low risk due to stable employment, relationship with his girlfriend, no drugs, and low alcohol intake. He was seen three times over the next few weeks, before his final interview on 16th June 2000, when Mark Towell reported that he had been involved in an act of criminal damage breaking a window at his parents' home. He stated that the charge had been withdrawn and that he had paid £100 for the window.

On 8th January 2001 Mark Towell received a Conditional Discharge for two offences of Criminal Damage committed on 6th January 2001. The next time that Mark Towell came to the attention of the Probation Service was as a result of these offences and others subsequently committed in February 2001.

The case was allocated to a probation officer(2), the task being that of preparing a Pre-Sentence Report, which would be used to assist the Court in sentencing Mark Towell for his latest offences. The process of Pre-Sentence Report preparation, which proved to be a protracted one, began on 12th February 2001 when Gateshead Magistrates bailed Mark Towell until 12th March 2001. On 16th February 2001 he was arrested and, whilst having breached his bail conditions, was re-bailed. On 20th February 2001 Mark Towell was arrested again following a further incident and kept in custody. Subsequently he was further remanded in custody on 28th February.

As a consequence he was seen by probation officer(2) in Durham Prison on 2nd March 2001, an interview designed to inform the production of a Pre-Sentence Report, which would be used by the Court ultimately sentencing Mark Towell.

At the appearance of Mark Towell at Gateshead Magistrates Court on 5th March 2001, a Specific Sentence Report was prepared, by a member of the Probation Service's Court Team. This pro forma document provided some basic information; that Mark Towell's pattern of offending indicated drink and drug related violence and criminal damage; that Mark Towell did not have any victim awareness; and that the likelihood of re-offending, risk of self harm and serious harm to the public were high. The report also indicated that probation officer(2) felt that a condition of Psychiatric treatment might be feasible, and suggested the consideration of both Psychiatric and Pre-Sentence Reports.

The case was adjourned until 12th March 2001 by which time the Court requested an assessment for a condition of residence, there was an expectation that the Psychiatric and Pre-Sentence Reports be provided at a later stage. Mark Towell was remanded in custody because he was unable to provide a bail address. Bail hostels considered him unsuitable due to his history of behavioural problems.

On 7th March 2001 Mark Towell was produced at Gateshead Magistrates Court and was granted bail on the condition that he reside at an address in Birtley.

On 8th March 2001 probation officer(2) completed a risk assessment using the Assessment, Case Recording and Evaluation System (ACE) an evaluation process implemented by Northumbria Probation Service in June 1999. This document provided an assessment of criminogenic factors which could influence the possibility of future offending namely accommodation and neighbourhood; employment, training and education; finances; family and relationships; substance abuse and addictions; health; personal skills; individual characteristics; lifestyle and associates; attitudes and motivation/attitude to supervision. On the basis of this assessment Mark Towell was placed in the highest risk category for each of the factors in the

process. This indicated that in the judgement of the person completing this assessment there was a high risk of further offending if these factors were to remain unchanged.

On 9th March 2001 probation officer(2) had discussions with the senior probation officer as part of the Probation Service's line management supervisory processes. The supervisory note recorded that a Psychiatric Report had been requested. The note also recorded, 'Serious concerns about risk to public. Social Services Department calling Area Child Protection Committee planning meeting', Probation officer(2) 'to attend. This will inform whether or not we need to call a Risk Management Meeting.' Probation officer(2) 'to alert reception of need to treat this man with caution until we know more about him.'

On that day probation officer(2) then phoned the psychiatric nurse from the Mentally Disordered Offenders Team, to say that there had been discussions with the senior probation officer who had recommended seeking an adjournment on the Pre-Sentence Report and holding a high level safety meeting.

Also on 9th March 2001 probation officer(2) completed a Pre Sentence Report for the hearing at Gateshead Magistrates Court on 12th March 2001. This two-paragraph report suggested that Mark Towell's difficulties lay outside the remit of a straightforward Probation Order (subsequently known as a Community Rehabilitation Order), and suggested a four week adjournment for the preparation of a Psychiatric Report. The report also responded to the request of the Magistrates, made at the hearing on 5th March 2001, that an assessment be made regarding Mark Towell's suitability for a condition of residence. On this matter the report stated that Mark Towell, during their interview at HMP Durham, had indicated that he would not comply with such a condition.

On 12th March 2001 Mark Towell appeared before Gateshead Magistrates and the case was adjourned until 9th April 2001 to allow for the preparation of a Pre-Sentence Report and a Psychiatric Report. Mark Towell was granted bail.

On 20th March 2001 probation officer(2) wrote to the consultant psychiatrist(2) to liaise on the production of the Psychiatric Report. The letter indicated an appreciation of a discussion in order to ensure clarity of opinion between the respective reports.

On 23rd March 2001 probation officer(2) attended a planning meeting held under the auspices of the Area Child Protection Committee Guidelines. The minutes of the meeting indicate that there was general agreement that a risk strategy meeting should be organised, and that probation officer(2) would request the Probation Service Manager to convene this meeting within seven days.

Probation officer(2) also reported to the meeting that there was to be a further meeting with Mark Towell, this time office based on 28th March 2001, as part of the process of preparing the Report for the Court.

On 5th April 2001 probation officer(2) completed the Pre Sentence Report for the hearing on 9th April 2001. At the beginning of the five-page report the sources of information used in its preparation were outlined. Apart from access to previous Probation Service records and Crown Prosecution information, it was stated that there had been discussions with the Turning Point Drug Referral Project, the Mentally Disordered Offenders Scheme and the Probation Service's Debts and Benefits Officer. The report acknowledged that, at this stage, there had been no discussions between probation officer(2) and the consultant psychiatrist(2) preparing the Psychiatric Report for the Court.

The Report did not mention the planning meeting held on 23rd March 2001, or the Probation Service's commitment to call a Risk Management Meeting.

The Report did however devote three paragraphs to the assessment of risk of harm to the public and the likelihood of re-offending. These paragraphs highlighted a behaviour pattern of violence and aggression; difficulty in appreciating the consequences of his behaviour; and offending exacerbated by drug and alcohol abuse, which disinhibited his behaviour.

The Report indicated that Mark Towell was assessed as a high risk in terms of re-offending. In considering the risk of causing serious harm it was suggested that violent incidents could develop and therefore that public safety must be a risk. It was also stated that those close to him were at risk of serious harm and that Mark Towell himself had also expressed concern that he was likely to cause serious harm, but found it difficult to envisage how he could tackle his problem with anger management.

Given a history of suicide attempts it was assessed that there was a continued risk of self-harm.

Mark Towell had been involved with psychiatric services since January 2001, and as the Court was still awaiting the outcome of a Psychiatric Report, a proposal regarding sentence was not made in this Pre-Sentence Report.

However on 5th April 2001 probation officer(2) also partially completed a 'Think First and One to One Targeting Matrix'. This is an assessment process which enables Probation Service Staff to determine the suitability of offenders for enhanced programmes of supervision, on either a one to one or group basis. The ACE score which had been calculated on 8th March 2001 was an integral part of this matrix.

On 9th April 2001 Mark Towell appeared before Gateshead Magistrates Court and the case was adjourned pending the preparation of the Psychiatric Report.

On 2nd May 2001 Mark Towell appeared at Gateshead Magistrates Court for sentence. The Psychiatric Report indicated that the consultant psychiatrist(2) was unable to give an adequate Psychiatric assessment because Mark Towell had failed to keep an appointment. The Report however did indicate that Mark Towell needed to address his illicit use of drugs before any work could be done on his potential for violence and self-destructive urges.
This Psychiatric Report and the Pre-Sentence Report prepared for 8th April 2001 were available to the Court.

The Court proceeded to sentence Mark Towell, who was given a 12 months Community Rehabilitation Order (CRO), and ordered to pay compensation of £200 with £50 costs. Probation Service records indicate that the Magistrates stressed in Court that the CRO address in particular, anger management, alcohol, and drug problem.

A member of the Probation Service staff saw Mark Towell after sentence. The terms of the CRO were explained to him and a further appointment was made for him to see the duty probation officer on 11th May 2001. In the post Court interview Mark Towell said that he was now in full time employment, working 7am to 7pm Monday to Thursday and Fridays 7am to 3.30pm, also occasional night shift and weekends.

On 9th May 2001 the supervision of Mark Towell's CRO was allocated to probation officer(1).

Probation Service records indicate that probation officer(1) then subsequently saw Mark Towell at the Probation Office on 11th and 18th May 2001.

On 22nd May 2001, the case was reviewed by probation officer(1) and the senior probation officer, in the light of concerns raised at the planning meeting held on 23rd March 2001 which had called for a Risk Management Meeting to be initiated by the Probation Service.

The data relevant to this review was recorded as follows:

Since being sentenced to a 12 months CRO on 2nd May 2001 Mark Towell:

(1) had reported as instructed

(2) had obtained work

(3) had, it was understood from Mark Towell, a job that required regular testing for drink and drugs and that he said he was passing them

(4) was maintaining accommodation in Birtley

(5) had not had any contact with previous partner and was in a new relationship

(6) there were no reports of further incidents.

In the light of this review the level of risk was assessed as reduced, with no immediate concerns, although it was recognised that the situation could change rapidly.

The levels of risk were assessed as follows:

(1) risk of harm to the public - med/high

(2) risk of harm to staff - med

(3) risk of harm to self – low

The plan of supervision as a result of the review was:

(1) Probation officer(1) to maintain weekly contact, situation to be monitored closely

(2) Any signs of change i.e. loss of job, loss of accommodation, change in habits, reports of incidents etc to be discussed with the senior probation officer immediately.

(3) Senior probation officer to write to Social Services Department to explain probation position and action taken.

(4) Probation officer(1) to contact all agencies which attended planning meeting to let them know of Mark Towell's order/involvement so that any concerns can be relayed.

On 23rd May 2001 the senior probation officer wrote to Gateshead Social Services Department outlining the position of the Probation Service, that it was not necessary to call a Risk Management Meeting at that point in time in the light of the factors outlined in the 22nd May 2001 review which were reiterated in the letter. The letter also stated that should there be a change in circumstances, 'i.e. he leaves or changes his employment, changes address or we receive any information from any source that further incidents have occurred in relation to those people who are at most risk from Mark Towell we will immediately convene a meeting of all agencies concerned'.

The letter then went on to say that a copy of the letter was not being sent to any other of the people who attended the meeting on 23rd March 2001 but that probation officer(1) would contact those people to explain the handling of the case. As stated earlier, the social worker in question informed the Panel that she had not received the letter.

Probation Service records then indicate that Mark Towell made visits to the Probation Office on 25th May, and 1st, 8th, 15th June 2001. There is then a gap in the records until the next recorded entry when Mark Towell went to see probation officer(1) on 13th July 2001. He was subsequently seen on the 20th, 25th July; the 2nd, 8th, 16th, 20th (at Hostel), and 22nd August 2001.

On 4th September 2001 because Mark Towell had not been seen since he had left the Hostel on the 23rd August, an application for a Warrant was prepared, as Mark Towell was in breach of the conditions of his CRO. A warrant for Mark Towell's arrest was issued by Gateshead Magistrates on 5th September 2001.

Mark Towell telephoned probation officer(1) on 6th September 2001 who agreed to visit Mark Towell at his address the next day. Probation officer(1) then reviewed the case with his senior probation officer, and it was confirmed that the breach must stand.

On 7th September 2001 probation officer(1) collected Mark Towell from his accommodation and was involved in a search for more permanent accommodation. The warrant was also discussed and it was recorded that Mark Towell would be happy to hand himself in. Probation officer(1) arranged to pick up Mark Towell for the Breach Proceedings on 11th September 2001.

On 11th September 2001 Mark Towell made an unscheduled visit to see probation officer(1) and was in an unsettled frame of mind and with a number of concerns. An administrative delay meant that the Breach would not be dealt with until the next day.

On 12th September Mark 2001 Towell fined £10 for Breach of CRO, the Order to continue.

On 14th September 2001 Mark Towell made a further unscheduled visit to see probation officer(1).

On 19th September 2001 Mark Towell saw probation officer(1) as planned and was described as having been drinking and in a cheerful frame of mind.

Throughout Mark Towell's supervision by the Probation Service in 1999 his employment was seen as a significant rehabilitative factor. When probation officer(2) was allocated to the case in February 2001, however, there were concerns amongst agencies about the escalating problematic behaviour of Mark Towell.

Two significant features emerge during the period in which Mark Towell was being assessed for sentence by the Magistrates Court. The first relates to the planning meeting held under the Area Child Protection Committee Guidelines called on 23rd March 2001, and the decision taken that the Probation Service would call a Risk Management Meeting. The second was the fact that the Court proceeded to sentence without the benefit either of a full Psychiatric Assessment or definitive sentencing proposals from the Probation Service.

The Panel has considered these issues, and with regard to the first matter no satisfactory explanation emerged as to why the meeting, which reflected the

Inter-Agency Risk Management Protocol, was not called within the agreed timeframe. The probation officer(2) who attended the planning meeting was not available for interview by the Panel due to long term absence from work.

With regard to the second matter, the Court's attempt to obtain a full Psychiatric Assessment was frustrated by Mark Towell's failure to keep an appointment with the consultant psychiatrist(2), who as a consequence could not complete the assessment. As the Probation Service's sentencing proposals were also dependent on this assessment the Court effectively sentenced without the benefit of definitive information. On 2nd May 2001 the Magistrates sentenced Mark Towell to a Community Rehabilitation Order, without extra conditions that had the potential to strengthen the focus of the subsequent supervision process, despite acknowledgement that he had specific problems with anger control, and alcohol and drug problems.

After the making of the CRO, further psychiatric input did not materialise.

Probation officer(1), who had previously supervised Mark Towell, and the senior probation officer, line manager, undertook a joint risk assessment on 22nd May 2001, producing a risk profile that differed from the one completed by probation officer(2) and the same line manager on 8th March 2001. Employment was seen as a key positive indicator and interviews were underpinned by a counselling approach, which was needed to deal with Mark Towell's presenting behaviour and mood swings. Probation officer(1) maintained good levels of contact, provided practical support and eventually breached Mark Towell when contact was lost.

The Panel has reviewed the current arrangements for risk assessment in the Probation Service and the wider implications for inter agency working.

In October 2001 the National Probation Service introduced its Offender Assessment System (OASys), which assesses both risk of harm and risk of reconviction. It is the most comprehensive risk assessment process yet devised in the Criminal Justice System, and should significantly improve the quality of this work in the Probation Service. The Northumbria Probation Area began to train its staff in the new system in September 2002, an exercise that was completed in January 2003.

Furthermore, the Criminal Justice and Court Services Act 2000 imposed a duty on the Police and the Probation Services to establish arrangements for the management of offenders considered to pose a serious risk to the community. Multi-Agency Public Protection Arrangements (MAPPA) have been developed within a national framework since August 2001. The system, including Risk Management Conferences, will be managed by the Probation Service and will provide an effective framework for inter-agency cooperation.

6

Mental Health Services configuration for Gateshead

Pre 1998

During the period up until 1998 mental health services in Gateshead were developing with the introduction of Community Mental Health Teams and local management of services, such as Community Mental Health Teams (CMHTs) with associated day care and out-patient clinic provision.

In or about 1992 there was the introduction of a practice whereby GP based mental heath practitioners worked alongside primary care colleagues in the identification and treatment of mental health problems.

1998-2002

In 1998 mental health services for the Gateshead area were provided by Gateshead Health NHS Trust following a merger between Gateshead Health Care NHS Trust and Gateshead Hospitals NHS Trust. The Trust provided acute, community and mental heath services, and provided services to a population of approximately 205,000.

The services provided in relation to mental health included:

- In-patient services provided at the Tranwell Unit at Queen Elizabeth Hospital in Gateshead. The Tranwell Unit provided:
  - three admission wards
  - psychiatric intensive care unit
- Day service provision
- Out-patient clinics

- Assertive Outreach Team
- 24 hour Crisis Team
- Community Mental Health Teams introduced in 1999
- Community Psychiatric Nursing Services
- Supported Living Scheme
- Psychology Services
- Services for Mentally Disordered Offenders
- Rehabilitation Services
- Self-Harm Team
- Adolescent Mental Health Services

The Community Mental Health Teams (CMHTs) at this time were into three geographical areas linked to primary care and Primary Care Group areas:

South East Gateshead – this covered the areas Low Fell, Birtley, Wrekenton, Pelaw, Leam Lane and Felling.

Central Gateshead – this covered the areas Bensham, Shipcote, Coatsworth, Beacon Lough and Low Fell.

West Gateshead – this covered the areas Crawcrook, Rowlands Gill, Ryton, Chopwell, Winlaton, Blaydon, Whickham North, Whickham South, Dunston and Sunniside.

At this time Community Psychiatric Services were provided to the far west of Gateshead i.e. Chopwell, Rowlands Gill/High Spen. In-patient and consultant psychiatrist Services were provided by County Durham and Darlington Priority Services Trust.

During the period up to 2000 the Addictive Behaviours Service provided two distinct service configurations provided and managed separately by health and social services.

The health element was managed by Gateshead Health NHS Trust and provided community detoxification services for those with a drug or alcohol dependency.

The residential rehabilitation service was commissioned by the Social Services Department in Gateshead.

The addictive behaviours services at this stage did not undertake joint working.

In 2000 the community and residential elements of Addictive Behaviour Services became integrated and were managed by one service manager. Primary care community mental health workers were introduced.
The staff in the service continued to be employed by either health or social care and service budgets remained separate.

2002

In 2001 proposals were developed to create a specialised NHS Trust responsible for the development and delivery of mental health services. This was to include the transfer of selected services from Gateshead NHS Trust, South Tyneside Health Care NHS Trust and Priority Health Care Wearside NHS Trust.

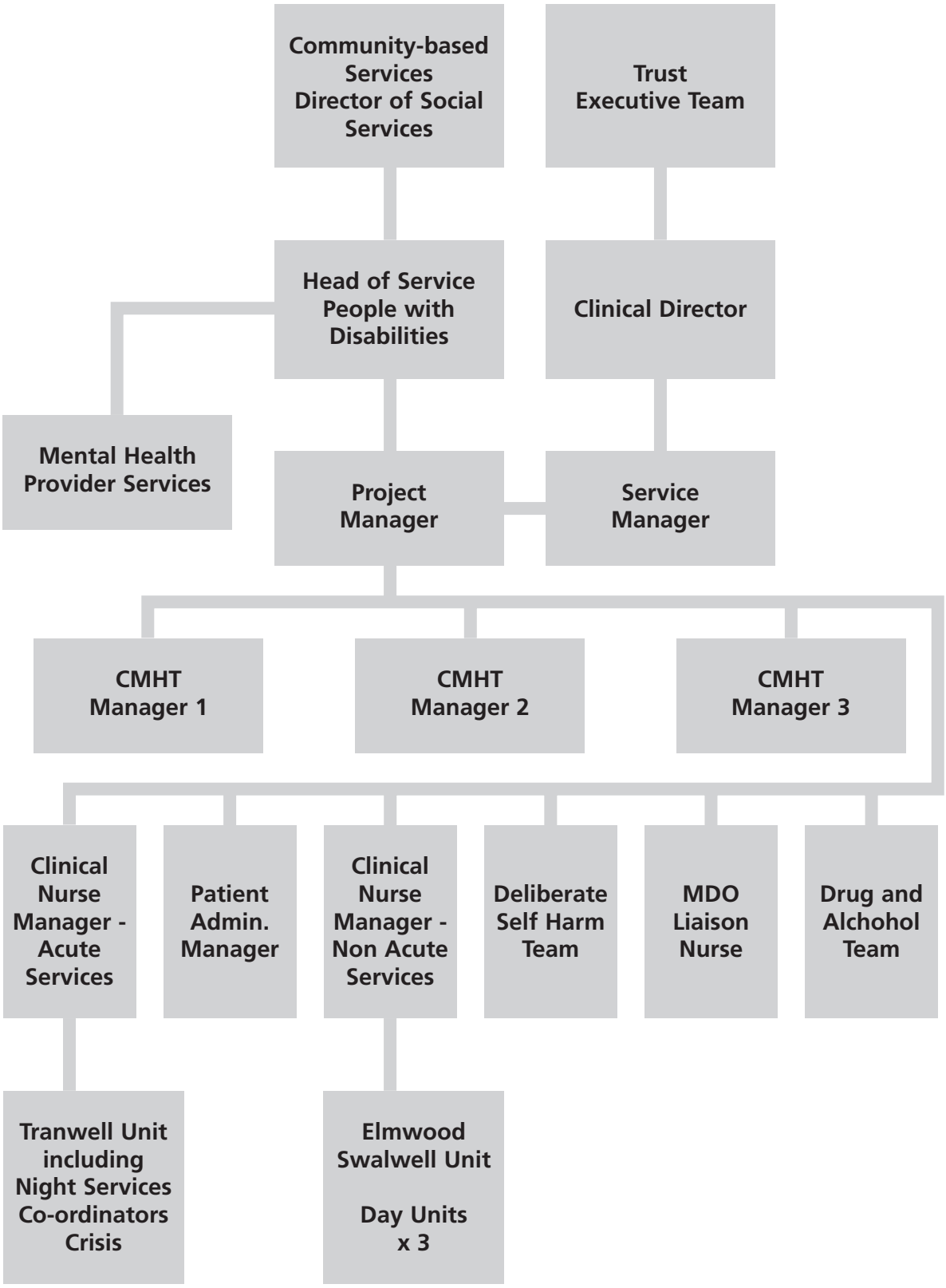
The new organisation formed in April 2002 was named the South of Tyne and Wearside Mental Health Trust and provides:

- Adolescent Mental Health Services to Gateshead, South Tyneside and Sunderland.
- Integrated Adult Mental Health to Gateshead, South Tyneside and Sunderland.
- Substance Misuse Service provision to South Tyneside and Sunderland.
- Mental Health Services for Older People to South Tyneside and Sunderland.
- Learning Disability Services (specialist health services for people with complex needs and/or a mental illness) to Sunderland.

Substance misuse services for Gateshead transferred to Gateshead Primary Care Trust.

Mental health services for older people in Gateshead remained with Gateshead Health NHS Trust.

Integrated Mental Health Services organisational chart 2001



7

Risk assessment

Risk Assessment played an important part in the Panel's considerations in relation to the care and treatment provided to Mark Towell. It is important to understand the framework for risk assessment which was in operation within the various services at the time preceding the offence committed by Mark Towell.

Within the Gateshead Health NHS Trust and the Gateshead Metropolitan Borough Council Policy documentation, there were jointly agreed guidelines for clinical risk assessment for mental health services, referred to as an Interim Policy MH2. This policy was introduced in or about August 2000 and was due to be reviewed in August 2001. It was in fact superseded in September 2001.

In relation to the case of Mark Towell the Panel considered the Risk Assessment policy which was in place prior to the September 2001 amendments.

The policy aimed to:

- Provide all clinical staff with a minimum standard of practice for assessment of clinical risk and associated management of risk of all service users.
- Provide practice guidelines and information on factors which contribute to increased risk within an individual to either themselves or others.
- Provide a minimum standard of recording and communicating clinical risk for all assessing staff and to provide a standard for training in clinical risk assessment and risk management.
- Provide information for quality, monitoring and audit purposes.

The policy was developed for the following staff:

- Qualified nursing staff
- Medical staff
- Occupational therapy staff
- Psychology staff
- Mental Health social workers (guidance only).

In relation to training of staff in risk assessment there were guidelines within the policy which stipulated that:

- The policy applied to all staff.
- That individuals should all be trained in recognition and assessment factors relating to risk.
- Staff should be trained in interview techniques.
- Staff should be trained in recognising the need for introducing appropriated levels of help when required.
- Staff should be trained in managing risk in the community and in hospitals as appropriate.
- Staff should be aware of recording and communication requirements.
- Training was to be provided to staff in evaluation of risk.
- Training was to be provided in relation to the impact of working with those who present with clinical risk. This training included the exploration of dilemmas and conflicts and where to seek personal and professional support.
- The training should include updates every three years.

The policy document described the process to be undertaken by staff and included:

- The development of rapport and the need to sufficiently engage with the individual.
- The need to employ clinical skill such as empathy, active listening, being non-judgemental, and the use of reflective responses.
- The need for sufficient information from all readily available sources which would then be compiled in order to assemble a picture of an individual's risk level. This would include information from other professionals, relatives, friends, carers, police, social workers, past records, self reports, discrepancies in information between reports and presentation and psychological tests such as the Beck depression scale.
- An exercise to check that areas identified in the assessment identified on the Form R have been explored.
- That a level of risk within every initial assessment must be made for all service users and this is to be recorded on the Form R Risk Assessment Pro Forma.

Within the policy document there were several recording forms to assist staff in their assessment of an individual. These were:

- Policy Practice Guidelines for Assessing Clinical Risk checklist (Appendix A of MH2 Policy). This was to be completed prior to form R Policy. This was a checklist of yes or no questions.
- Management Planning and Communication checklist (Appendix C of MH2 Policy). This was to be completed prior to form R. This was a checklist of yes or no questions.
- Form R. This is an identification of personal details, areas of risk identification, Health of the Nation Outcome Score (HoNOS) rating scale, identification of warning signs, identification of the specific current risk, the management plan and who would be informed/communicated with.

Further to the policy in relation to risk assessment in the mental health services in Gateshead, an interagency Risk Management Protocol was introduced in October 1999. The aim of the protocol was to enable a local exchange of information, in order to determine whether an interagency conference for assessing and managing risk posed by an individual was required.

The policy set out details of how the meeting would be instigated by partner agencies to discuss issues in relation to individuals who may present a risk. It described the role of the chairperson and detailed what minutes should be taken and how they were to be considered for circulation taking into account confidentiality issues in the case together with a declaration of confidentiality signed by those present. It was specified in the protocol that if a person was in doubt as to what to do in relation to an individual's case then they should consult further.

The services who had signed up to the protocol were:

- Gateshead Health NHS Trust
- Northumbria Probation Service
- Benefits Agency
- Leisure Services
- Education
- Community Education
- Housing
- Police

- Social Services (including mental health)
- Victim Support

The policy document Mental Health Risk Assessment (MH2) was a transitional arrangement which was guidance for Local Authority staff at an early stage of integration within mental health services. The policy applied to individuals who were in receipt of a service and had been subject to a fuller mental health assessment, and had been accepted onto the Care Programme Approach (CPA). In these circumstances, Mark Towell did not qualify for inclusion on the CPA.

The policy clearly sets out the minimum standard for the process of risk assessment. There is no evidence of any nurse completing the full set of risk assessment documentation in relation to Mark Towell. Multiple risk assessments were undertaken and the appropriate documentation was partially completed, but there was no evidence that any health professionals completed the full set of risk assessment documentation (Appendix A, B and R referred to in Policy MH2). Furthermore there is no evidence of any member of the mental health medical staff completing any of the Mental Health Risk Assessment documentation.

8

The framework for inter-agency working

The Inquiry has shown that at the material time there existed in Gateshead an ethos of inter agency work which, for instance, was made explicit in the Child Protection Guidance 1998. This approach was applied to all aspects of inter agency work regardless of the nature of the client group. Policies and central directives stipulated that agencies should work in partnership and that the respective activities of each agency should be both discrete and interrelated.

All agencies in Gateshead worked within the statutory framework directly affecting their activity. This legislative responsibility was expressed through local policies and procedures, underpinned by central government guidance, primarily issued via the Department of Health and the Home Office, copies of which were made available to the Panel.

The majority of the policies and procedures received by the Panel from Gateshead NHS Trust were joint documents adopted by the NHS Health Trust and the Local Authority, which in some instances also included other agencies, such as the Probation Service and the Police. These policies were up-dated regularly. Policies and procedures were disseminated to staff by each constituent agency through a process of joint and agency training.

9

Training and education of individual practitioners involved in providing services to Mark Towell

As part of the Inquiry terms of reference the Panel was asked to consider the adequacy of the training and education undertaken by those who came into contact with Mark Towell.

In considering this issue it was important to first establish the requirements in respect of each of the professional groups providing care to Mark Towell during his involvement with services in the Gateshead area. The professional groups that came into contact with Mark Towell from whom evidence was received by the panel were:

- Nurses
- Psychiatrists
- General Practitioners
- Probation officers
- Social workers

It was expected that each professional involved in the provision of care would in the first instance have undertaken and completed the appropriate professional training sufficient to meet the requirements of their respective professional body. If a professional body did not stipulate requirements then training should enable an individual to be fit for practice within his or her sphere of responsibility.

Within each of the professional groups it was expected that continuing professional development (CPD) would be undertaken when a practitioner was qualified so as to ensure skills and knowledge levels were updated within the practitioner's sphere of practice. In the case of those working in the Gateshead Mental Health Services and the partner agencies, practitioners were undertaking continuing professional development (CPD) irrespective of

the professional bodies' specific requirements, so as to maintain knowledge and skills for their sphere of practice.

It was evident from the information provided to the Panel by the practitioners who came into contact with Mark Towell had the appropriate qualifications and were engaged in continuous professional development.

Supervision

A further consideration of the Panel was the role played by supervision within the respective agencies.

A critical element of the supervision relationship is the trust and respect between supervisor and supervisee. Without an effective relationship the ability to question, challenge and develop individuals is significantly compromised.

In the evidence presented to the Panel various examples from the organisation of supervision models were described including individual and group processes. Notable instances of good practice included:

- Multi-disciplinary model of supervision within the Deliberate Self Harm and community teams.
- Individual supervision within the Child Protection Service which included case record reviews and discussions on practice issues.

10
Conclusions

1. The responsibility for the death of Arthur Leonard Leak lies with Mark Towell.

2. Mark Towell was a young man who had a propensity for violent behaviour. He appeared to care little about the consequences of his actions. He had a criminal record for offences involving violence, but this was by no means remarkable when compared with the criminal records of some other young men living in the community.

3. It has proved impossible for the Panel to explain Mark Towell's motivation for the murder of Mr Leak. The Panel has closely scrutinised the history of the case and even with the benefit of hindsight it is apparent that the killing of Mr Leak was a completely unpredictable and impulsive act and as such could not have been anticipated or prevented.

4. A review of the history of Mark Towell's life up until his conviction for the murder of Mr Leak reveals a number of recurring themes, namely:

   - jealousy and feelings of rejection in his personal relationships which had a self-fulfilling quality and resulted in homelessness difficulties
   - unfocused anger
   - unwillingness to take responsibility for the consequences of his own actions
   - abuse of drugs and alcohol
   - an absence of motivation on his part to address his difficulties with drug and alcohol misuse
   - an impulsive recourse to violence, particularly in a domestic context, when thwarted or when under the disinhibiting effect of drugs and/or alcohol
   - an unwillingness to engage with the various professionals who sought to assist him

- a tendency to seek help from the Health Service in times of crisis but then to reject any attempt to engage with him in the longer term

5. Towards the end of the chronological account of events as described in this report, Mark Towell's life, viewed both physically and emotionally, was in chaos. His impulsive behaviour and inability to resolve problems without conflict, had resulted in the loss of significant relationships and any stable accommodation. This had become a cycle which was very difficult to break.

6. The history of domestic violence perpetrated by Mark Towell in the course of a number of his personal relationships, was masked by the fact that much of it remained unreported. As a consequence, the various professionals who had contact with Mark Towell were deprived of a potentially useful indicator as to the possible risk that he posed. It is recognised that domestic violence is often a hidden problem within society. The circumstances of this case underline the necessity of appreciating the significance of domestic violence when formulating risk management strategies.

7. Throughout his life Mark Towell was offered help and support by family, friends and a number of agencies. He remained resistant to this help and frustrated the efforts made by a number of professionals to engage him and as a consequence defeated any opportunity to gain insight into his own behaviour and address his problems.

8. Services were made available to Mark Towell and he was able to access these resources. He was seen by the Young People's Unit, a CPN, the CMHT, consultant psychiatrists, a SHO in Psychiatry, the Deliberate Self-Harm Team, the Drug and Alcohol Service, a psychiatric nurse attached to the Mentally Disordered Offenders Liaison Scheme, the Accident and Emergency Department of Queen Elizabeth Hospital Gateshead and a number of GPs. He had contact with the Emergency Duty Team of the Social Services Department and the Housing Service at Gateshead Council. He was also made subject to two Probation Orders, one Community Rehabilitation Order and one Community Service Order.

9. The Panel received evidence from the Health, Local Authority and Probation Services who had endeavoured to offer assistance to Mark Towell. It was clear that the professionals from all these agencies were committed in their attempts to engage him and work with him. There was no indication that his often difficult behaviour prejudiced the willingness of the professionals to offer him care, treatment or supervision as appropriate.

10. Mark Towell's unwillingness to engage with professionals represented a fundamental obstacle to any help which they might have been able to offer him. In times of crisis he sought immediate solutions to his difficulties but was resistant to offering any commitment to receiving help or treatment in the longer term. Examples of how attempts to engage Mark Towell were frustrated by his fluctuating and ambivalent responses include:

    - His rejection of therapy offered to him at an early age by the Young People's Unit at Newcastle upon Tyne.
    - His attendance for therapeutic sessions with CPN(1) which he admitted was only for the benefit of his parents.
    - His surly and uncommunicative response to the nurse at the Deliberate Self-Harm Team.
    - His failure to attend appointments with consultant psychiatrists 1 and 2.
    - His failure to take up the option of drug and alcohol counselling.
    - His leaving the Accident and Emergency Department in February 2001, after his consultation with the SHO, having been advised that an admission was inappropriate, indicating that he wasn't going to "trail" to out-patients appointments.
    - His episodic attendances at the Accident and Emergency Department of the Queen Elizabeth Hospital in Gateshead, on occasions leaving before being discharged and on one occasion removing a plaster cast himself, with a saw.
    - His history of missed appointments with various GPs.
    - His lack of consistency in relation to engaging the professionals attempting to assist him with housing difficulties.

11. The attempts made by various professionals to engage with Mark Towell were not assisted by the selective and sometimes misleading history presented by him to them. This was particularly evident in his self-reporting of the extent of his alcohol and drug use.

12. Many of Mark Towell's contacts with professionals appear to have been brought about by the efforts of others often with little enthusiasm for such interventions on his part.

13. As indicated above, difficulty was experienced in engaging Mark Towell with the appropriate services. Had this been achieved, the work with him would have necessarily eventually involved challenging him in relation to issues relating to his lifestyle and

perceptions. There is no evidence to suggest that if this stage had been reached, Mark Towell would have sustained any commitment in these circumstances.

14. Mark Towell represented a challenge to any service seeking to offer him assistance. It is important in difficult cases, such as this, that services maximise the prospects of engagement with clients. The extent to which this may be achieved, however, is constrained by an individual's right to refuse to engage in such a process.

15. The Panel consider that Mark Towell, notwithstanding his maladaptive, chaotic and anti-social behaviour, fell considerably short of any threshold which could have resulted in his compulsory detention under Part II of the Mental Health Act 1983.

16. The unanimous psychiatric opinion in relation to Mark Towell was that he was not suffering from a psychiatric disorder. This was the view of consultant psychiatrists (1) and (2), the SHO, CPNs (1), (2) and (3), the psychiatric nurse from the MDOLS and the nurse from the Deliberate Self-Harm Team. It would be expected that any signs or symptoms of serious mental illness should have become apparent during his repeated contacts. The lack of any such diagnosis meant that Mark Towell did not qualify for the Care Programme Approach, which offers a co-ordinated package of treatment.

17. The Panel consider that the Magistrates' Court sentencing Mark Towell on 2nd May 2001 would have been assisted by a more comprehensive psychiatric report from consultant psychiatrist(2) than was available. There appears to have been no attempt to explore the possibility of an adjournment for the purposes of the preparation of a more detailed report. In the event, however, that Mark Towell proved unwilling to co-operate with such a psychiatric assessment, then there would have been no powers of compulsion available to the Court.

18. There appears to have been a consensus amongst all the professionals who came into contact with Mark Towell, that the issue of drugs and alcohol was a significant one. The anti-social and violent behaviour which manifested itself, together with the episodes of self-harm, were invariably associated with drink or drug use. Despite consistent advice that he needed to address these difficulties, he did not do so, ultimately stating that he had resolved the problem himself whilst in custody. The final attempts to refer him to 24/7 were made by the local councillor and not Mark Towell himself.

19. The difficulties experienced in engaging Mark Towell in relation to any programme of drug and alcohol counselling were compounded

by the misleading accounts provided by him to professionals as to the extent of his problems. For example, when speaking with the specialist nurse involved in drug and alcohol counselling, no history of drug abuse was volunteered. Similarly, contradictory accounts of his alcohol consumption were presented by him to the Accident and Emergency Department of Queen Elizabeth Hospital and to probation officer(2) on 8th May 2001 and 11th May 2001, respectively.

20. Drug and alcohol services are obliged to recognise that full co-operation and motivation may not be forthcoming from their clients. Systems, therefore, must be as flexible and accessible as possible so as to capitalise on such willingness to engage, as may exist. The Panel heard evidence that a more open policy of referral was developed alongside the organisational changes which resulted in the creation of the 24/7 service, which removed a number of previous obstacles. In a service where there is open access, limited resources and the need to avoid lengthy waiting lists, the challenge posed by those clients who are not willing to engage is an immensely difficult one. Time and resources inevitably become focussed upon those who are willing to engage. Notwithstanding this reality, there is an obligation upon such services not to discharge clients precipitately. The Panel received evidence that the 24/7 drug and alcohol service now review each case on its merits before a client is discharged. This contrasts with the routine letter of discharge sent to Mark Towell. In Mark Towell's case, however, it was made quite clear that he wanted no assistance from the 24/7 service. On 28th February 2001, whilst in prison, he indicated that he had overcome his drug problem by his own efforts and did not want any help from the prison drug worker. On 7th March 2001 he stated unequivocally that he did not wish to be seen by 24/7. In these circumstances, it is extremely unlikely that the changed procedure for discharging clients would have made any material difference in this case.

21. The Probation Service played a significant role in the history of professional assistance offered to Mark Towell. The role of the Probation Service and the extent to which it engaged with Mark Towell was distinctive by reason of the statutory and compulsory nature of the relationship. This was in marked contrast with the position of other professionals. The Probation Service was the only agency with continuing contact with Mark Towell after he had withdrawn from all the various health professionals by April 2001.

22. Notwithstanding the statutory component of the three periods of supervision undertaken by the Probation Service and the efforts of the respective probation officers, there is no evidence that material

progress was made in relation to Mark Towell's maladaptive behaviours. The Panel would wish to acknowledge the strenuous attempts made by probation officer(1) to assist Mark Towell during the final Probation Order, notwithstanding the daily crises which he presented.

23. As the Court did not attach any conditions to the Community Rehabilitation Order, such as the attendance at a Drug Treatment or Anger Management Programme, the sanctions available to the Probation Service in relation to Mark Towell were limited, the most significant being breach proceedings. The Probation Service did commence breach proceedings in this case which came before the Court on 12th September 2001, one week before Mr Leak's murder.

24. The Probation Service undertook an assessment of the risk posed by Mark Towell at the time of the preparation of the Pre-Sentence Report on 8th March 2001. The subsequent re-appraisal of the level of risk on 22nd May 2001, which suggested that it was reduced, reflected the perception on the part of the Probation Service of increased stability in a number of areas of Mark Towell's life.

25. The Panel consider that the decision to call the planning meeting on 23rd March 2001 in respect of the unborn baby of Mark Towell's ex-girlfriend (GF1) was entirely appropriate and represented good practice demonstrating effective inter agency co-operation in relation to risk. The Panel commend the action of the nurse from the MDOLS in initiating the meeting. The meeting was well attended by the appropriate professionals. Appropriate decisions were taken with a view to protecting the unborn child.

26. The decision made at the planning meeting on 23rd March 2001, for the Probation Service to convene a risk management meeting within seven days to consider the risk posed by Mark Towell to other individuals, in particular his adoptive mother, was appropriate. As has been stated, this risk management meeting was not convened. The Probation Service has been unable to provide a satisfactory explanation as to why the risk management meeting was not convened within seven days of the planning meeting. Probation officer(2) was not available for interview by the Panel due to long term absence from work. In the light of the content of the minutes of the 23rd March 2001 planning meeting, the Panel was concerned that none of the agencies formally queried the failure to hold a risk management meeting. The Panel consider that a risk management meeting should have been convened in accordance with the decision made at the planning meeting on 23rd March 2001 and that the other agencies present at the meeting could have taken a more pro-active approach to ensuring that such a meeting did take place.

27. On 22nd May 2001 the Probation Service subsequently determined that the level of risk was being contained and there was no need to call such a meeting. A number of factors were identified by the Probation Service as contributing to what was believed to be a more stable situation. It was recognised that the situation could change rapidly and that any signs of change i.e. a loss of job, changes in accommodation, a change in habits or reports of incidents should result in the matter being discussed with probation officer(1)'s Team Manager, the senior probation officer, immediately. The Panel consider that any apparent stability in Mark Towell's life as identified on 22nd May 2001, was short-lived and that within a matter of weeks there were clear signs that some of the matters which had been highlighted as potential causes for concern were beginning to manifest themselves. It is the Panel's opinion that there were sufficient grounds to justify convening a risk management meeting in the light of the identified risk factors.

28. The Panel conclude that the fact that a risk management meeting was not called in relation to Mark Towell within seven days of the planning meeting on 23rd March 2001 or thereafter cannot be said to have contributed to Mr Leak's subsequent death. As has been stated earlier, the murder of Mr Leak was an impulsive and unpredictable act. The Probation Service was responsible for the statutory supervision of Mark Towell and maintained good levels of contact with him, but Mark Towell's attitudes were such that he did not fully engage with any process of behaviour change and by April 2001 had severed contact with all other agencies who might have helped him. After 3rd April 2001 Mark Towell completely disengaged from all the health professionals and the only remaining agency with any contact with him was the Probation Service. The actual leverage available to a risk management meeting in these circumstances would, in reality, have been extremely limited.

29. The Panel consider that the advantage of holding a risk management meeting would have been to provide professionals with an opportunity to carry out a joint appraisal as to the level of risk. Such a meeting would have had a different emphasis to that of the planning meeting held on 23rd March 2001 which had been focussed upon the unborn child of Mark Towell's ex-girlfriend (GF1). A risk management meeting may have offered additional support to the Probation Service in its management of Mark Towell's case. It would also have reinforced the need for all agencies to maintain awareness in relation to Child Protection and/or Domestic Violence issues.

30. The importance of communication between and within agencies as to the extent of risk posed by identified individuals cannot be

underestimated. The requirement for effective communication as to risk was embodied in a range of policies applicable including:

- The Gateshead Health NHS Trust Inter Agency Information Exchange Policy No. RM 24.
- The Gateshead Area Child Protection Committee Inter Agency Child Protection Guidelines dated May 1998.
- The Gateshead Interagency Risk Management Protocol dated 12th October 1999.
- The Gateshead NHS Trust Policy/Practice Guidelines/Gateshead MBC (Guidelines) for Clinical Risk Assessment Mental Health No. MH2 introduced in or about August 2000.
- The Gateshead Health NHS Trust Mental Health Services Operational Policy Community Mental Health Teams (a joint policy agreed between Gateshead NHS Trust and Gateshead Metropolitan Borough Council Social Services Department.)

31. The Panel concludes that appropriate policies were in place and were supported by operational guidance in relation to inter agency working. A culture of shared understanding and working is essential in order to facilitate effective inter agency collaboration.

32. An example of effective communication between agencies has been highlighted in relation to the calling and conduct of the planning meeting on 23rd March 2001. There were some examples of less effective communication, namely:

(i) That the letter from the senior probation officer to social worker(1) dated 23rd May 2001 was not received.

(ii) That probation officer(1) did not contact the other professionals who had attended the planning meeting on 23rd March 2001, to establish a future point of reference, as had been agreed in his meeting with the senior probation officer on 23rd May 2001.

(iii) That the minutes arising from the planning meeting on 23rd March 2001 were not forwarded to all the professionals who had attended.

(iv) That the Housing Department was not made aware of Mark Towell's various changes of address and as a result wrote to him on occasions at the wrong address.

(v) That the Accident and Emergency Department at Queen Elizabeth Hospital in Gateshead was on occasions unaware of the correct identity of Mark Towell's GP due to his frequent changes of address and GP.

(vi) That there was no effective two-way communication between the Probation Service and the Police during the currency of the Community Rehabilitation Order. The Panel was concerned that neither the Police nor the Probation Service took the opportunity to liaise with each other in relation to the serious alleged incident of violence on or about 21st July 2001, despite the fact that both agencies had some knowledge of what had occurred.

33. The Panel was informed that within the Mental Health Service an information technology system was in an early stage of introduction, which could be used by health professionals to share and record data, including information about risk. This development may become an important tool in effectively facilitating the exchange of clinical information.

34. The itinerant nature of Mark Towell's lifestyle resulted in frequent changes of GPs and periods when he did not have a GP. Had there been a consistent General Practitioner involved in his life it would have been possible for other health professionals to obtain a much more coherent and complete understanding of Mark Towell's problems. The history was characterised, however, by the frequent recourse by Mark Towell to the Accident and Emergency Department of the Queen Elizabeth Hospital in Gateshead. The Panel conclude that systems should be in place to allow effective communication between Accident and Emergency Departments and the Mental Health Services.

35. A robust system of risk assessment is an integral part of an effective system for the delivery of services relating to the care and treatment and supervision of individuals. In relation to the Health and Social Care Agencies who had contact with Mark Towell, an appropriate Risk Assessment policy was in place (MH2). This policy clearly applied to Mark Towell's contact with these services. It is clear, however, that the appropriate documentation necessary to compile a written risk assessment was not fully completed by these agencies. In some instances, particularly in respect of medical staff, no formal risk assessments were undertaken using the Trust policy documentation. It is clear, however, that, notwithstanding this omission, the risks posed by Mark Towell were identified and acted upon and this led directly to the calling of the planning meeting with respect to the unborn child. In any event, no subsequent opportunity for health service professionals to undertake a further risk assessment arose after April 2001 as by then Mark Towell had withdrawn from all services with the exception of the Probation Service.

36. The assessment of risk as undertaken by the various professionals who had contact with Mark Towell was hampered by Mark Towell's unreliable self-reporting, fractured recourse to services and lack of engagement and follow-up contact with these professionals. Had there been a more consistent pattern of attendance and engagement, it might have been possible to assemble a more definitive picture of the risks posed by him. The difficult circumstances of this case underline the importance of effective inter-agency information sharing and communication.

37. Risk assessments were also undertaken by the Probation Service. In June 1999 Northumbria Probation Service produced a "Risk Assessment and Management Policy Strategy and Procedure". Thereafter the Probation Service routinely incorporated risk assessment tools which were used to inform the respective probation officers in relation to their work undertaken with Mark Towell. The Panel was provided with evidence that the appropriate risk assessment documentation was completed by the Probation Service.

38. The Panel concluded that systems were in place to ensure that the various professionals who had contact with Mark Towell had the appropriate initial and continuing training, in order to practise effectively within their respective fields. In this case there was a wealth of well trained and skilled professionals who were able and willing to offer assistance to Mark Towell, had he accepted their offers of help.

39. The Panel was satisfied that supervision arrangements had been established in relation to the staff employed by the various agencies who had contact with Mark Towell.

40. In the provision of health and other services it is inevitable that all agencies have to prioritise their work and are constrained by their respective budgets. It is also inevitable that tensions can arise in the management and allocation of these resources within this process. There is no evidence, however, that Mark Towell's care and treatment was prejudiced by any such issues. As has been stated, various professionals sought to engage Mark Towell and would have been willing to continue to work with him had he been prepared to do so.

41. The Panel was appraised of the significant structural changes in the respective services providing care and treatment to Mark Towell, particularly in the years immediately preceding the fatal incident. These changes undoubtedly had an impact upon the various professionals involved in this case, but there is no evidence that this resulted in any detriment to Mark Towell.

11
Recommendations

1. Strategies should be developed within inter agency working to improve the understanding of domestic violence, often a hidden problem in society, in the management of risk within the community. These strategies should also deal with the well established links between domestic violence and child protection issues.

2. Notwithstanding the history in this case of Mark Towell's failure to engage with the many agencies with which he came into contact, it is important that all organisations provide every opportunity for engagement. Agencies should regularly review their procedures so as to maximise the potential for engagement with reluctant clients and to ensure that cases are not closed inappropriately.

3. The Northumbria Local Criminal Justice Board should establish liaison with the criminal courts to ensure the effective use of Community Penalties, in order to strengthen the assessment, management and supervision of offenders in the community who have proved otherwise difficult to engage.

4. Drug and alcohol misuse is a problem which presents itself to all agencies. The Panel recommends that the Drug Action Team reviews the policy and procedures of all agencies to ensure that there are pro-active and resilient services available for those with drug and alcohol problems. This review should include the strategy for the management of Drug Treatment and Testing Orders imposed by the Courts.

5. In the light of the recent introduction of the risk assessment tool OASys (Offender Assessment System Risk of Harm) the Probation Service should ensure that Offender Supervision Plans are adhered to so that ongoing risk assessment is fully integrated into the supervision process.

6. Inter agency information sharing can work effectively. This was exemplified by the Child in Need planning meeting held on 23rd March 2001. The Panel recommends that there is a system of continuing monitoring, to demonstrate that policies and procedures

for information sharing are understood and acted upon by practitioners and managers within and across all agencies. It is important that this involves not only the Health, Social Care and Probation Services but also the Police.

7. Despite the limitations of any risk assessment system, it is essential that organisations work within an agreed framework. All agencies should audit the implementation of risk assessment policies so as to ensure their consistent and effective use by practitioners. This would be assisted by a programme of joint multi agency training.

8. The Panel recommends that the South of Tyne and Wearside Mental Health NHS Trust explores the most effective use of the electronic information system in relation to internal and external information sharing. This should include both clinical information and formal risk assessments. The effectiveness of systems depends upon the appropriate input and maintenance of information and protocols regarding access. These are a prerequisite for ensuring that all available data can be employed in the subsequent care of any individual.

9. The effective supervision of practitioners is of great importance, particularly in cases involving difficult and challenging individuals. The supervision must include the opportunity to constructively question and challenge staff in order to develop their practice. All agencies must be able to demonstrate that they have robust mechanisms to implement and monitor supervision systems for all practitioners.

10. Appendix B of the Gateshead NHS Trust Policy Practice Guidelines/MBC Guidelines for Clinical Risk Assessment (Interim Policy MH2) should be made more inclusive by incorporating the Child Protection Co-ordinator, the Police and Probation Service within the information sharing process. Protocols should be amended to ensure this happens. This information sharing process must be seen as a priority within practitioner's implementation of the policy.

11. The importance of ensuring the clarity and accuracy of recording and dissemination of information is an essential part of any inter agency meeting. All agencies should ensure that policies and systems are in place to facilitate this. The recently amended Child Protection Guidelines provide a model of good practice.

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