THE REPORT OF THE INQUIRY

INTO THE TREATMENT AND CARE

OF MATTHEW HOOPER

Commissioned by the

Lambeth, Southwark and Lewisham

Health Authority

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CHAPTER 1

INTRODUCTION

1.1 This is the report to the Lambeth, Southwark and Lewisham Health Authority of an independent Inquiry into the treatment and care afforded to a patient, Matthew Hooper, by the mental health services prior to his commission of a homicide while in the community on the 25th December 1995.

1.2 The Inquiry was conducted by a Panel comprising : .

Michael Curwen - a practising barrister and Recorder of the Crown Court on the South Eastern Circuit

Dr Gavin Tennent - a Consultant Forensic Psychiatrist who is a member of the Mental Health Review Tribunal and has served both on the Parole Board and as a Mental Health Act Commissioner

Manny Devaux - a Justice of the Peace and formerly Assistant Director of Social Services at the London Borough of Greenwich who has been a panel member in two other independent Inquiries

1.3 Our **Terms of Reference** were as follows :

1. To examine all the circumstances surrounding the treatment and care of Matthew Hooper by the mental health services from the 1st January 1994, in particular :

(i) the quality and scope of his health, social care and risk assessments;

(ii) the appropriateness of his treatment, care and supervision having regard to :

(a) his assessed health and social care needs;
(b) his assessed risk of potential harm to himself or others;
(c) any previous psychiatric history, including drug and alcohol abuse;
(d) the number and nature of any previous court convictions;

(iii) the extent to which Mr Hooper's care corresponded to statutory obligations, relevant guidance from the Department of Health (including the Care Programme Approach HC(90), 23/LASSL(90) 11, Supervision Registers HSG(94)5 and the discharge guidance HSG(94)27) and local operational policies;

(iv) the extent to which his prescribed care plans were :

(a) effectively drawn up,
(b) delivered, and
(c) complied with by Mr Hooper.

2. To examine the appropriateness of the professional and in-service training of those involved in the care of Mr Hooper or in the provision of services to him.

3. To examine the adequacy of the collaboration and communication between:

(i) the agencies involved in the care of Mr Hooper or in the provision of services to him, and

(ii) the statutory agencies and Mr Hooper's family.

4. To prepare a report and make recommendations to the Lambeth, Southwark and Lewisham Health Authority.

1.4 To assist us in the performance of these tasks we invited a number of persons to give oral testimony. None of them were under any compulsion to provide us with evidence and they were allowed to be accompanied by a representative, although not all took advantage of this facility. The procedure consisted of questioning by the members of the Panel. It was informal and conducted in private.

1.5 We heard from the following witnesses (whose status is wherever possible given as it stood at the material time) :

<u>The Bethlem & Maudsley NHS Trust</u>

Dr George Szmukler - Medical Director
Dr Frank Holloway - Clinical Director of Community Services
Dr Jeremy Christie Brown - Consultant Psychiatrist
Dr Brian Toone - Consultant Psychiatrist
Dr Tom Foster - Senior Registrar in Psychiatry
Dr Tanveer Nayani - Senior Registrar in Psychiatry
Dr Tony Davies - Senior Registrar in Psychiatry
Dr Geoffrey Wolff - Senior Registrar in Psychiatry
Dr Anthony Maden - Consultant Forensic Psychiatrist
Dr David Reiss - Senior Registrar in Forensic Psychiatry
Mr Simon Hughes - Occupational Therapist
Mr Christopher Burford - Clinical Manager, Nunhead Sector
Mr David Watts - Clinical Manager, Nunhead Sector

Southwark Council Social Services Department

Mr Steven McWilliam - Senior Practitioner, Nunhead Team

Ms Sybil Nowell (nee Buchanan) - Approved Social Worker, Nunhead Team

South East London Consortium Housing Association

Ms Sue Wallace - Housing Officer

1.6 Arrangements were made for us to interview Matthew Hooper at Broadmoor, but ultimately he decided not to proceed. His mother, Mrs Hooper, also declined to give evidence. This was entirely understandable, but inevitably it left some gaps in our knowledge of his familial relationships and is likely to have diminished our insight into his behaviour in the community and thought processes. Moreover we would have benefited from hearing Mrs Hooper's views in relation to the level of services which were provided to him.

1.7 We were additionally provided with a large quantity of written material, including documentation concerning the organisation, policies and procedures of the Trust, medical records relating to Matthew Hooper's treatment and care at the Maudsley Hospital and in the community, his Social Services case records, his housing file, documentation held by the Crown Prosecution Service and records maintained at Broadmoor Hospital.

1.8 We are particularly indebted to Brian Morden for his skill and industry in acting as co-ordinator to the Inquiry, collating the documents and organising the oral hearings.

CHAPTER 2

THE BACKGROUND HISTORY

2.1 Matthew Hooper was born on the 13th February 1966. He was his mother's fourth child. The oldest, Paul, was a half-brother from an earlier marriage. There were two full brothers, Mark and Martin.

2.2 The pregnancy was normal, but at birth the cord was found to be wrapped around Matthew's neck. He was separated from his mother for 24 hours. However, we have seen no evidence of peri-natal brain damage.

2.3 No information is available in relation to Matthew's infancy, other than that he attained normal milestones, commenced his education at the age of 5 and attended two primary schools, the first of which he hated.

2.4 Problems began to arise when Matthew moved on to his secondary education in September 1977. He was a poor student and his behaviour was disruptive. He was rude to teachers, became involved in fights and truanted. As a result he was expelled from each of the two schools which he attended. He was able to read and write, but obtained no qualifications.

2.5 On the 3rd June 1981 Matthew received his first criminal conviction. This was for allowing himself to be carried in a motor vehicle taken without authority. He was given a conditional discharge for 12 months.

2.6 From about September 1982 onwards, when he was 16 years of age, he started to suffer from paranoid delusions. He believed that he and his family were in danger because he had in the past informed on some of his friends and that a satellite had been planted in his brain in order to control his thoughts and actions. He also felt that he was being made to receive bodily sensations such as pin pricks and muscle twitches.

2.7 His next conviction was on the 1st October 1982. This was for attempted theft from a woman's handbag and resulted in his being placed under supervision for a period of 2 years.

2.8 In November 1982 he began to hear voices. He was in the back seat of a car when he heard a voice comment that his friend was putting on a seat belt. Thereafter he frequently heard voices commenting on his own actions and in particular telling him that he was a police informer and that his family would be harmed.

2.9 We note that by this time he was smoking cannabis, but nothing suggests that this was a significant factor in the causation of his altered mental state. It is unclear whether he was using any hallucinatory drugs. There is evidence both for and against such usage.

2.10 Further convictions ensued. On the 11th March 1983 he was fined for shoplifting and on the 19th June 1983 he was ordered to carry out 100 hours of Community Service for non-domestic burglary and theft.

2.11 The juxtaposition of the onset of mental illness and the development of Matthew's involvement in criminal activity could well be of considerable significance. In our view his illness was at the very least a contributory factor in the causation of his abnormal conduct and attitude. However, we recognise that it is equally possible to explain his behaviour by reference to his personal and familial circumstances. He was of low intelligence and disadvantaged both economically and socially. His brothers were also getting into trouble in various ways and he is likely to have been keeping bad company.

2.12 In July 1983 Mrs Hooper realised that Matthew was seriously disturbed. At her insistence he was admitted to the Maudsley Hospital on the 4th August 1983. A diagnosis of schizophrenia was then made and he was treated with both oral and depot anti-psychotic medication. His response to the former was poor and he had an adverse reaction to the latter. During the admission he absconded on several occasions and exhibited agitated and aggressive behaviour. He was ultimately discharged on the 12th October 1983, but was still suffering from acute psychotic symptomatology.

2.13 After returning home Matthew attended at the Out-Patient Department on only one occasion, when he was given a depot injection. He received no medication from November 1983 onwards. His behaviour led to rows with his family, who tried to persuade him to return to hospital without success. On the 24th February 1984 he broke down the front door of a house with a hammer in an endeavour to reach an ex-girlfriend's brother in order to question him about his role in the gang of criminals which Matthew believed was persecuting him and his family. This was the first incident of violence and it does seem to have been induced by psychosis.

2.14 Matthew was arrested and re-admitted to the Maudsley Hospital. He was managed principally with oral medication and co-operated with this treatment. On two occasions he attacked other patients, but he gradually settled down and on the 6th April 1984 he was discharged. However, he remained hallucinated and deluded and the prognosis was considered to be poor.

2.15 For a period of about 4 months Matthew was regularly followed up in the Out-Patient Department and continued to take oral medication, but in August 1984 he defaulted upon both attendance and medication. At around this time he committed further offences of shoplifting and assault occasioning actual bodily harm and was remanded on bail pending a court hearing. His behaviour at home deteriorated and he fought with his brothers. He is described as having relapsed into a full-blown psychosis with auditory hallucinations, passivity feelings, ideas of reference and somatic hallucinations.

2.16 In the first week of October 1984 he went out with some friends, one of whom had a leg in plaster and was using crutches for support. He was convinced that this person was involved in the conspiracy against him and that the injury was not genuine. While they were sitting together in the back seat of a car, he prodded the leg to see if it produced pain. When they got out, he knocked away the crutches, kicked the cast and then stabbed the person twice in the back with a 3-4 inch long knife which he had acquired a few days previously. This was a very dramatic and particularly significant incident. There can be no doubt that Matthew was at that time psychotic.

2.17 On the 30th October 1984 he was arrested and taken to Lewes Prison. Assessment of his mental state was undertaken and it was recommended that further treatment should be given. On the 3rd January 1985, apparently as a

result of a court order under Section 37 of the Mental Health Act, he was transferred to the Maudsley Hospital. The outstanding offences were then dealt with at the Maidstone Crown Court on the 1st February 1985 by way of a bind over.

2.18 Matthew remained on a section for 18 months. Until about March 1986 he was detained in the hospital. Thereafter he was allowed to have day patient status, but he defaulted and had to be brought back. In May 1986 he absconded for a period of 3 weeks. Eventually he was discharged on the 23rd July 1986. The discharge summary indicated a poor prognosis and stated that *" his capacity to become very violent when psychotic will always put him and others at risk, when ill - for Matthew Broadmoor may be an eventual reality if compliance fails ... immediate action must be taken should he default from medication."*

2.19 At that stage he was on depot medication, but he also became heavily involved in illicit drug taking, using both heroin and cannabis. In addition he drank to excess. This led to a short voluntary admission in January 1987. Subsequently he became increasingly reluctant to take his medication and in July 1987 there was a further short voluntary admission with a view to trying a different depot, but he refused to pursue this option when he discovered that it had similar side effects. Nothing could then be done, since it was felt that he was not sectionable.

2.20 On the 27th May 1988 Matthew was convicted of an offence of possession of an offensive weapon in a public place and sentenced to 8 months imprisonment. He had taken a container of ammonia to a football match. This was another indication of his propensity to violence, but in themselves the circumstances do not suggest any obvious connection to delusional ideas.

2.21 Following his release from prison Matthew resumed his aggressive behaviour at home. It would appear that by this time the marriage of his parents had broken down and his father had left. The brunt of coping with his problems was borne by his mother. So far as we can tell without having heard from her, her attitude was equivocal. On the one hand we have seen entries in the records which refer to an antipathy to the Maudsley Hospital. On the other she had certainly on a number of occasions in the past encouraged Matthew to obtain help and she now seems to have sought assistance via her General Practitioner, Dr Oldershaw.

2.22 On the 21st November 1988 Dr Oldershaw wrote to Professor Cawley, who had previously been in charge of Matthew's care, requesting a home visit or advice. The letter ends with the prophetic words *" My partner and I feel he will eventually kill someone."*

2.23 Consideration was given to further action, but our impression is that despite the cessation of medication Matthew was not at that point floridly psychotic, so that nothing could effectively have been achieved in the absence of co-operation on his part, which plainly was not forthcoming. In any event he was lost to follow up for over 4 years.

2.24 In the meantime he committed a series of offences involving damage to property. On the 13th January 1989 he was sentenced to 21 days imprisonment for causing damage in a florist's shop with an axe. On the 6th September 1989 for an offence of arson in a public house he was imprisoned for 3 years. This was obviously a serious matter and it follows that for at least 18 months and probably 2 years he was out of circulation (but it cannot be said that he spent the greater part of the period between 1988 and 1993 in prison). There was

then another conviction for criminal damage on the 24th July 1991 which resulted in a fine.

2.25 The motivation behind the offending is not transparent and the extent to which Matthew was actually psychotic is difficult to assess on the basis of the limited available information. The judge at the Central Criminal Court who dealt with the arson presumably had no or insufficient material placed before him to warrant another Section 37 order, and equally there was no incident which provoked an admission to hospital. On the other side of the coin it seems inherently unlikely that Matthew's thought processes had radically altered and we know that he was still subject to hallucinations and that during his imprisonment he was considered to be disturbed.

2.26 In March 1993 a housing officer responsible for the area in which Matthew and his mother were living re-established contact with the Maudsley Hospital because he was annoying his neighbours by moving around late at night and playing loud music. Mrs Hooper was then approached by Dr Jones, a Senior Registrar, with an offer of help. She told him that both she and Matthew were vehemently against medication, but that she thought he needed counselling. It was suggested that he should drop in to the Ivydale Mental Health Resource Centre.

2.27 In fact Matthew did not attend. Discussions took place between Dr Jones and the Social Services Department as to whether anything further could be done and it was decided that there were no grounds for active intervention.

2.28 On the 9th November 1993 Matthew was convicted of aggravated vehicle taking and was ordered to carry out 150 hours of Community Service. This

was the last occasion upon which he was convicted of any offence prior to the homicide.

2.29 The history of events over the period of 11 years leading up to the end of 1993 leads us to the following central conclusions :

(i) Matthew suffered from schizophrenia. His illness varied in its intensity, but was never completely in remission.

(ii) Whether acutely psychotic or not, he was potentially dangerous to members of his family and other persons in the community in which he was living.

(iii) He was not compliant with medication. This undoubtedly increased the risk of acute psychotic breakdown, but it is fair to say that there was no consistent correlation between default and rapid deterioration in the state of his mental health.

(iv) When he was not on a section (and sometimes even when he was), he was liable to be unco-operative with the agencies seeking to help him.

(v) He basically saw himself as a criminal, but this was an over-simplification. The causation of his behavioural problems was probably multi-factorial, including elements of both personality disorder and mental illness.

CHAPTER 3

THE CRITICAL YEARS

3.1 At the beginning of 1994 the position was that Matthew was still living with his mother in circumstances of social isolation and unemployment. His mental state was not being controlled by any medication and he was not allowing the Social Services or any other agency to provide him with assistance.

3.2 On the 10th March 1994 Dr Jones, who was by then a Consultant Psychiatrist on the PACT (Psychiatric Assertive Outreach and Continuing Care) team, reviewed Matthew's case notes and decided that a more assertive approach should be adopted to help him.

3.3 On the 21st April 1994 Dr Jones wrote to Mrs Hooper suggesting that Matthew might consider coming along to a new centre shortly to be opened in Rye Lane, alternatively a home visit by the PACT team could be made. This was followed by a telephone call on the 28th April 1994. Mrs Hooper was told that the type of service being offered by PACT was different from anything in which Matthew had previously been involved. She agreed to give her backing to an offer of a meeting between Matthew and Dr Jones, provided that it emanated from the new centre.

3.4 Dr Jones also contacted Matthew's Probation Officer and learned that he was in breach of his Community Service Order and was being brought back before the court. It was suggested that involvement with PACT might perhaps be made a condition of any further sentence. However, Matthew made it abundantly clear that he wished to have nothing to do with the PACT team and in any case the Order was replaced with a Conditional Discharge for 3 years.

3.5 On the 7th July 1994 Mrs Hooper telephoned Dr Jones to say that she had been threatened by Matthew because he believed that she was orchestrating a family plot against him. Arrangements were made for her to obtain advice at the Ivydale Centre.

3.6 On the 8th July 1994 Matthew was again abusive and threatening to his mother, shouting that all the things which had happened to him were her fault. She locked herself in her room and he then smashed a window. Neighbours called the police and he was arrested. Subsequently he was detained under Section 2 of the Mental Health Act and transferred to the Maudsley Hospital.

3.7 On the 9th July 1994 Matthew was admitted under the care of Dr Toone to ES1, a secure ward for acutely disturbed patients. Upon examination he did not exhibit any signs of psychosis. He was observed for a period of time and then transferred on the 19th July 1994 to an open ward under the care of Dr Christie Brown.

3.8 On the 31st July 1994 he was discharged home, to be followed up under the Care Programme Approach programme. At that stage it appears that he was allocated to the PACE (Psychiatric Acute Crisis and Emergency) team rather than to PACT and he remained a PACE patient at all subsequent times. The reasons why this was seen as appropriate call for further consideration and will be discussed in Chapter 5. Suffice it to say that we have no reason to conclude that Matthew was an unsuitable candidate for care in the community by the PACE team.

3.9 On the 4th August 1994 Matthew was again verbally agressive towards his mother and on this occasion damaged some furniture in the premises. This resulted in his re-admission. However, there continued to be no grounds for long term detention and it was decided that the best way forward was for him to live elsewhere.

3.10 A real difficulty presented itself here. Matthew had for the greater part of his life lived with his mother. Otherwise he had been in prison. He had never had his own accommodation, nor had he shared with other persons. He was ill equipped to look after himself and he was also known to be socially inept and liable to upset his neighbours. Where was he to be housed ?

3.11 One local organisation which was prepared to accommodate mental patients was the South East London Consortium Housing Association (SELCHA). A vacancy was identified in one of its shared houses. In the absence on leave of the Housing Officer responsible for the premises, Sue Wallace, Matthew was interviewed by her manager. It seems unlikely that he appreciated the full extent of the potential problems. In any event he agreed to take Matthew.

3.12 On the 5th September 1994 Matthew was discharged from the hospital. He spent two weeks in a crisis house and moved into his new accommodation on the 19th September 1994.

3.13 Although difficulties did arise in the shared house, the separation of Matthew from his mother initially had the desired effect. No further incident occurred during the remainder of the year. Matthew was reasonably co-operative with the PACE team and in particular with his key worker, Simon Hughes (an occupational therapist). He was believed to be taking the oral Risperidone which was being prescribed for him and his condition appeared to be stable.

3.14 This was however the calm before the storm. On the 25th January 1995 Matthew stabbed his brother Martin. Two weeks earlier someone had stolen his television set and video recorder. On another occasion panels of glass had been broken in his premises. It seems that he attributed these acts to his brother. He went to see

him and was spoken to in a way which he thought to be lippy and cocky. At that point he snapped, impulsively picked up a short kitchen knife which was lying on a table nearby and plunged it into his brother's shoulder. He then walked away, apparently unconcerned as to the consequences and totally unremorseful.

3.15 The incident was plainly very serious. Aspects of it are distinctly reminiscent of the previous stabbing in 1984. It was a sudden explosive act of violence directed against a victim who was irrationally believed to have done Matthew some kind of harm, there was no preceding physical confrontation and a knife was used. On the other hand there was some oral provocation and it is quite possible to explain Matthew's action in non-psychotic terms.

3.16 Mrs Hooper alerted the PACE team to the stabbing and they in turn notified the police. However, Martin was not prepared at that stage to press charges.

3.17 Simon Hughes endeavoured to make contact with Matthew. Although he was not immediately successful, he did speak to his parents and took steps to ensure that he would attend at the next out-patient appointment.

3.18 On the 1st February 1995 Matthew was duly seen and assessed at the hospital by Dr Evans and Dr Bonner (the PACE Registrar and Senior Registrar). He said that he was feeling well and had no particular concerns and that he had not been taking illicit drugs for years. We observe with interest that on examination there were no psychotic features, nor was there evidence of an affective disorder. His behaviour was attributed to an anti-social personality disorder. It was felt that there were no grounds for detention. The decision was therefore to keep him under particularly close supervision and to obtain additional assistance from the forensic team. It should be noted in this connection that the forensic service could not be deployed as a substitute for the PACE team.

3.19 On the 2nd February 1995 Matthew had an altercation with his mother at her home and pushed her down to the floor, causing her to sustain two broken ribs. He was arrested, taken to Peckham Police Station and charged with an assault occasioning actual bodily harm. He was also charged with unlawfully wounding his brother. It appears that both his mother and brother were willing at that point to back a prosecution.

3.20 On the 4th February 1995 Matthew was remanded in custody by the Camberwell Green Magistrates Court and he was then transferred to Belmarsh Prison.

3.21 Thereafter the PACE team was asked whether Matthew should be returned to the Maudsley Hospital. Dr Christie Brown was firmly of the opinion that a forensic assessment was required with a view to referral to the medium secure unit at Denis Hill and that in the meantime he should remain in custody. Arrangements were therefore made for him to be seen by Dr Reiss, a Senior Registrar at the Unit, on the 16th February 1995.

3.22 The report of Dr Reiss, dated the 2nd March 1995, is an important document. It included a detailed history of past events and a description of Matthew's current presentation. The following points were then made :

" It is my opinion that, in view of the length of Mr Hooper's mental illness, his deficits in interpersonal functioning should be seen as the product of his schizophrenia."

" It is my opinion that the offences result from a sensitivity and impulsivity that are a product of a vulnerable personality under stress in the context of long standing mental illness. Since Mr Hooper has been mentally ill from adolescence

it is not possible to make a good case for saying that his offending behaviour is the produce of free will or untreatable personality disorder. The current alleged offences are likely to be related to his mental illness even though they may not be the result of hallucinogenic commands or delusionally driven."

" It is my opinion that Mr Hooper requires treatment for his mental illness in hospital. He requires a period of assessment followed by therapy for his schizophrenia and its associated personality and social problems. I would therefore recommend that, should Mr Hooper be found guilty of the offences he is presently charged with, he be placed under a Hospital Order (Section 37 of the Mental Health Act 1983). In view of Mr Hooper's previous level of disturbed behaviour within hospital, his tendency to abscond and the length of time that treatment and rehabilitation is likely to take he would be appropriately placed within a medium secure unit."

" It is my opinion that if his mental illness is well treated and Mr Hooper is adequately supervised the chances of him committing further serious offences will be considerably reduced. If he is not treated it is my opinion that others will remain at risk from him. I consider that in view of the seriousness of the offences he commits, his history of poor compliance with treatment and lack of insight, the court should give consideration to the imposition of a restriction order (Section 41 of the Mental Health Act 1983) in order to provide him with adequate supervision in the community."

3.23 In essence this assessment is one with which we would concur. Such is however with the benefit of hindsight. Dr Reiss did not have that advantage and nor did any of the other psychiatrists who formed an opinion about Matthew in 1995. For that reason we have borne in mind that there remained room for disagreement and that the views of Dr Reiss were not written in stone. They did however come from

a forensic source in a case in which forensic input was clearly desirable.

3.24 If Matthew was to be treated in a medium secure unit, a bed had to be found for him. At that particular time no bed was available at Denis Hill. The procedure in those circumstances was to make arrangements for a placement elsewhere in the private sector. This would have entailed a delay of at least 9 weeks and it would also have necessitated Matthew's removal to an establishment some distance from the area in which he lived and the PACE team operated. He would nonetheless have been followed up and there would have remained a prospect of repatriation to Denis Hill at a later date.

3.25 On the 3rd March 1995 Dr Reiss sent a copy of his report to Dr Holloway, under cover of a letter which in effect asked for assistance in obtaining a placement. Dr Holloway then initiated action to find a bed, but supervening unexpected events frustrated the intended outcome.

3.26 On the 21st March 1995 Matthew was due to be committed from the Magistrates Court for trial at the Crown Court. However, Mrs Hooper and Martin decided that that they would not after all support the prosecution. As a result the proceedings could not go ahead and no evidence was offered. That was a regrettable state of affairs, because the option of an order for Matthew's detention in hospital was no longer available. There remained no residual power to make such an order.

3.27 In theory the lacuna thereby created could have been overcome by a compulsory admission under Section 3 of the Mental Health Act. In practice the position was more difficult, because the criteria for sectioning Matthew had to be met.

3.28 Matthew was released from Belmarsh Prison on the 21st March 1995. The news of his release reached Simon Hughes on the following morning. He immediately

made a home visit. Matthew was out, but a message was left for him to contact PACE and he telephoned later that morning to say that things were alright. Simon Hughes made arrangements to see him on the next day. Plans were also made for a team review and for an urgent out-patient appointment to review Matthew's mental state and medication.

3.29 Simon Hughes duly visited Matthew on the 23rd March 1995. He said that he was feeling well and that he bore no grudge against his mother and brother, but would keep his distance for a while. This was a promise upon which no reliance could reasonably have been placed. He also indicated that he had taken no medication for a period of 2 months, allegedly without a change in his mental state, and Simon Hughes was not in fact able to elicit any signs of psychosis.

3.30 A further visit was made on the 27th March 1995. Matthew continued to assert that he was not mentally ill and had not been since 1984, that his problems arose out of his behaviour and temper and that he was reluctant to have any involvement with the PACE team. He complained about the fact that his mother would contact the psychiatric services whenever he got aggressive. He reiterated that he was managing well without medication. It is plain that he was completely lacking in insight, an observation made on more than one occasion in his earlier records.

3.31 Dr Reiss wrote again on the 27th March 1995 to Dr Holloway to inform him that Matthew was being followed up by the PACE team and that a medium security private bed was no longer required.

3.32 At review on the 30th March 1995 a decision was taken to refer the case to the Forensic Community Services and it was agreed that a medical assessment was needed. That was undoubtedly true, because on the very same day Matthew wrote an abusive and bizarre letter to his mother the content of which strongly suggests

that he was becoming psychotic.

3.33 The contents of the letter were brought to the attention of the PACE team and Mrs Hooper also informed them that Matthew had been hiding in the bushes outside her home. These matters were communicated to Dr Evans on the 3rd April 1995 upon his return from study leave. It is to be noted that by that time Matthew had been back in the community for 13 days without a medical assessment. This was in our view regrettable, but we recognise that the situation was unusual.

3.34 Dr Evans and Simon Hughes went to see Matthew on the 3rd April 1995. The police were also requested to attend, as difficulties were anticipated. Upon their arrival the door was not answered and they proceeded to break it down, only to find that Matthew was not in fact there. No-one appears to have thought of getting in touch with Sue Wallace, who held a key to the premises.

3.35 On the 4th April 1995 a second attempt was made to see and assess Matthew, but once again he was out. However, later that day he was arrested for driving his car without a licence and taken to Peckham Police Station. Dr Foster (who had taken over as the PACE Senior Registrar) was then enabled to carry out an examination of his mental state together with Dr Hamid, a General Practitioner. Matthew was found to be exhibiting marked irritability, thought disorder and probable delusions of persecution by his mother. He was considered to be suffering from a relapse of his schizophrenic illness and it was recommended that he should be admitted for treatment under Section 3.

3.36 Matthew was again admitted to ES1 under the care of Dr Toone and immediately instituted an application to a Mental Health Review Tribunal seeking discharge.

3.37 He was seen by Dr Toone in the course of a ward round on the 5th April 1995. As

usual he asserted that he was well and without any mental health problems and bitterly complained about the attitude of his mother in involving the psychiatric services. However, Dr Toone felt that this was not obviously delusional, as Mrs Hooper had in fact sought assistance. He concluded that there was currently no evidence of psychotic illness.

3.38 It is clear that Dr Toone was never fully convinced of a connection between the mental illness from which Matthew had in the past been suffering and his recent violent behaviour. While recognising that at times when he was on the edge of psychosis he was likely to be more impulsive, irascible and dangerous, Dr Toone believed that his violence fundamentally stemmed from an underlying personality disorder which would not be susceptible to treatment. In this material respect he differed from Dr Christie Brown. We have already touched upon this subject and it is one which gives rise to considerable difficulty. At this stage we would simply stress that each of the opposing views was genuinely held, could undoubtedly be justified and has been supported by other members of the profession.

3.39 The difference of opinion had practical implications. Dr Toone and his team saw no reason to keep Matthew on a ward for acutely disturbed patients. Their aim was to transfer him to the open catchment area ward as soon as possible. But this was opposed by Dr Christie Brown, who considered that he should not be returned to a less secure environment in the absence of a forensic opinion endorsing such action. It was therefore arranged that Dr Reiss would carry out a re-assessment and that for the time being Matthew would remain on ES1.

3.40 Matthew's behaviour while on ES1 was entirely satisfactory. He also talked about his situation in a rational manner and exhibited no unequivocal signs of thought disorder. This naturally underpinned the view that he could not justifiably be detained for any length of time. He did however abscond from the ward on the

14th April 1995 and had to be brought back by his father.

3.41 Matthew was seen again by Dr Reiss on the 18th April 1995 and on the following day he produced a further short report containing the following conclusions :

" I remain of the opinion that Mr Hooper continues to present a significant risk to the safety of his mother and his brother as well as the public at large. He is a large man who has recently demonstrated his ability to stab someone on impulse. I would consider that his mental state continues to give cause for concern and requires further assessment and treatment, preferably with a form of medication ensuring compliance. His family relationships also require detailed and careful assessment. His ability to live in the community in his present accommodation should be carefully assessed before he is discharged from hospital.

Although he is presently being adequately managed on the locked ward I would be concerned that this may not provide sufficient security and, should Mr Hooper become violent (perhaps if he is frustrated by the result of his Tribunal, or if depot medication is administered compulsorily) he may endanger the safety of staff. I would therefore continue to support an application for him to be placed in conditions of medium security should you consider this to be necessary. His recent absconding episode could suggest that even medium security may not be sufficient for him, as escape is also possible from that environment.

Within the appropriate therapeutic environment Mr Hooper requires an adequate period of treatment and the setting up of an appropriate package of social support and supervision on discharge. His poor response to treatment in the past should be noted and it will be important carefully to assess and monitor his dangerousness."

3.42 Copies of the report were sent to Dr Christie Brown and Dr Toone. For some time thereafter Matthew remained on ES1, but as his behaviour remained satisfactory he was in due course allowed to have a 2 hour pass. This led to no problems and renewed efforts were made to secure his transfer to the catchment area ward.

3.43 On the 12th May 1995 Dr Christie Brown wrote to Dr Toone expressing anxiety about the proposed transfer. Dr Toone responded on the 17th May 1995. His letter included the following passages :

" I do understand your concern. Mr Hooper does have a history of violent behaviour and quite recently attacked a member of his own family. However, I think that his continuing management would better be carried out in the community than in a secure unit."

" Although there appear to be good grounds for a past diagnosis of psychosis, in recent months the evidence for an active continuing psychotic process rests largely on the occasional observation of thought disorder ... However, since admission numerous attempts have failed to illicit further examples of this. He has shown no other evidence of psychotic thinking or experience. He has throughout been compliant with medication and has indicated a readiness to continue to be so."

" I am not clear what a secure unit placement might hope to achieve other than to defer Mr Hooper's reintegration in his own community. I do not think that he has shown any evidence of psychosis for some time."

" ... although I do not think that I can support his continued detention in hospital I would prefer that his discharge be phased through an open ward rather than abruptly into the community."

3.44 On the 18th May 1995 a hospital managers meeting was convened to consider an appeal by Matthew against his continued detention. The managers were provided with the report of Dr Reiss and reports from the teams of Dr Christie Brown and Dr Toone. In addition Dr Toone and his Senior Registrar, Dr Nayani, made oral submissions. Dr Christie Brown was not present, but that was hardly surprising as he was not Matthew's RMO.

3.45 The managers did not consider that Matthew should be discharged. They felt that the criteria for detention continued to be satisfied. Their report to the Trust Board concluded that :

" Managers felt that (Matthew) was suffering from a mental illness under the terms of the Mental Health Act and that, in view of the disagreement as to its severity, it was of a nature to require continuing in-patient treatment for the present. They agreed that, until (Matthew's) compliance can be trusted by his catchment area team, his illness could be interpreted as representing a risk to others, as it is clear that discontinuation of his medication would certainly aggravate his (potentially non-pathological) violent tendencies. They felt, in the light of his previous episodes of non-compliance, that his continued treatment could not yet be guaranteed in the absence of the detaining order."

3.46 However, the managers did concur with the view of the ES1 team that there should be a transfer to the catchment area ward. This placed Dr Christie Brown in some difficulty. On the 24th May 1995 he indicated that he would be prepared to take Matthew onto the ward, provided that the transfer was endorsed by Dr Maden, a Consultant Forensic Psychiatrist. That was a reasonable compromise and it seems to have been approved by Dr Toone.

3.47 Nonetheless, before Dr Maden had an opportunity to assess Matthew and form a

view as to his suitability for a move from conditions of security, the transfer took place. It would appear to have been effected at some time during the last weekend in May 1995. We have not been able to ascertain precisely why this happened. It was probably not specifically requested by either Dr Toone or Dr Nayani. The explanation given to us by Dr Nayani was that the senior nursing staff on ES1 would have been faced with the necessity to find room for psychotic or acutely disturbed patients who were being brought to the hospital from the community and they would therefore have transferred out the least troubled patients. If that was indeed the position over the weekend, we would accept that the move may not have been avoidable. Due account must always be taken of prioritisation of need.

3.48 The premature transfer could have made a difference to the course of events. In his oral evidence Dr Maden accepted that it had influenced his view as to the way forward. He said that " *it is one thing to be recommending medium security for a man in Bellmarsh or even in a locked ward, but ... for a man who is on an open ward and actually not causing any management problems on an open ward, it would be difficult to recommend an immediate move to medium security without some incident or some crisis that, perhaps, led to that decision.*"

3.49 But if Dr Maden was in effect confronted with a fait accompli, it does not follow that this did actually alter the opinion which he would otherwise have expressed. Arguably he would have come to exactly the same conclusion.

3.50 It must also be acknowledged that following Matthew's arrival on the open ward no objection was specifically raised to his transfer. He settled down well and did not create any problems for the staff. He was allowed a 2 hour unaccompanied pass and complied with its conditions. No evidence of psychosis was elicited. Given that he had been taking oral Risperidone for 2 months, this was perhaps to be expected, but it was certainly an encouraging situation. The only fly in the

ointment was that in the course of a ward round on the 7th June 1995 he told Dr Foster that he would not continue to take his medication when he was discharged.

3.51 Dr Maden saw Matthew on the 9th June 1995. He found no sign of any delusions or hallucinations. Matthew's speech and manner were slightly odd in a way that was consistent with schizophrenia, but he did not appear to be thought disordered. On this occasion he said that he was willing to take oral medication as a condition of leaving hospital, although he did not believe that he really needed it.

3.52 Dr Maden reported to Dr Christie Brown on the 12th June 1995 as follows :

" Whilst I endorse most of Dr Reiss' assessment, further information has now emerged and the situation has moved on since February, the main change being in his mental state. There is also a better understanding of the relationship between his offending and his psychosis, suggesting that there has been significant violence in both his family and personal history, independent of his psychotic illness. In view of his settled mental state, further prolonged detention in hospital is neither feasible nor desirable. I would advise a return to the community in the near future, on a period of extended leave from his current detention, in an attempt to encourage compliance with oral medication. He will require a fairly low threshold for re-admission, in the event of relapse.

There is little doubt that the serious assaults on his mother and brother occurred when he was acutely ill. Further, similar assaults are likely should he become ill again. I am concerned that his family may not appreciate the seriousness of his behaviour, given their reluctance to support criminal proceedings. I have not met them but it may be appropriate to give them specific, written warnings about the potential future dangers. Certainly, they will need to be aware of how they can get urgent help, should Mr Hooper's health deteriorate in the future.

In respect of the forthcoming Mental Health Review Tribunal, I have no doubt that Mr Hooper suffers from a mental illness in terms of the Mental Health Act 1983. His illness is currently in remission as a result of treatment with neuroleptic medication. If he is discharged immediately, it is very likely that he will discontinue medication and deteriorate rapidly, becoming a danger to his family. The use of extended leave Section 3 would be a safer and more appropriate way of managing his return to the community."

3.53 This report was of considerable significance, for two reasons. In the first place it was determinative of Matthew's future management. Secondly it spelt out in terms the risk of deterioration in the event of default in the taking of medication and the need in those circumstances for a fairly low threshold for re-admission.

3.54 Upon receipt of Dr Maden's report, Dr Shuriquie (the Registrar on the catchment area ward) prepared a report for the Mental Health Review Tribunal supporting Dr Maden's recommendation of extended leave. It was said that Matthew would be followed up on a regular basis and that the community team and outpatient clinic would ensure that he took his medication.

3.55 The Tribunal hearing took place on the 13th June 1995. The reports of Dr Nayani and Dr Shuriquie were received in evidence, together with a social circumstances report from Ms Buchanan (Matthew's Approved Social Worker), and in addition oral evidence was given by Dr Foster, Dr Shuriquie, Ms Buchanan and Matthew himself. The members of the Tribunal decided that Matthew could not safely be discharged from his section, in particular because he would not continue to take his medication, but they supported the proposal for a gradual increase in leave.

3.56 Thereafter Matthew remained compliant with his treatment and was given periods

of leave. On one occasion he failed to return on time, but otherwise there were no problems. It was therefore decided that he should be discharged from the hospital on the 18th July 1995 and be cared for by the PACE team in the community.

3.57 On the 11th July 1995 a CPA/Section 117 meeting was convened for the purpose of drawing up a discharge plan. The following arrangements were then made :

(i) Matthew was to attend at the Out-Patient Clinic at the Ivydale Centre once in every 2 weeks for medical assessment by Dr Foster.

(ii) He was to be seen once a week by Simon Hughes.

(iii) Sue Wallace was to provide him with assistance in independent living.

(iv) He was to take Risperidone 3 mg twice daily.

(v) He was to remain on his section at least until the next review meeting, which was to be convened on a Thursday in mid-September. Provision was also made for reviews at 3 monthly intervals.

(vi) He was to be placed on the Supervision Register.

3.58 This was by and large a reasonable plan, but it could have been more detailed. No attempt appears to have been made to make provision for specific action in the event that Matthew began to exhibit signs of disturbed behaviour, defaulted on his medication or failed to attend appointments. Nor was the threshold for taking action addressed. These matters were simply left to the discretion of the team.

3.59 The plan involved a material alteration to the pre-existing arrangements for key working. Until that time Matthew's key worker had been Simon Hughes, who enjoyed a close relationship with him. However, Simon Hughes was unwilling to continue this role once Matthew had been placed on the Supervision Register. He felt quite strongly that the responsibility for co-ordinating the care of a patient regarded as dangerous ought to lie elsewhere. In the circumstances it was decided that the key working should be undertaken by the PACE Senior Registrar, who was then Dr Foster.

3.60 For reasons which will be elucidated in Chapter 5, we consider that this important role ought not to have been imposed upon the Senior Registrar. That is not to say that Dr Foster was unequal to the task.

3.61 On the 18th July 1995 Matthew was duly released from the hospital and returned to live at his SELCHA accommodation.

3.62 He was seen by Simon Hughes during the ensuing week, but no note appears to have been made on that occasion.

3.63 The first out-patient appointment was on the 1st August 1995. Matthew failed to attend, but telephoned to say that he had overslept. He indicated that he only had 2 days of medication left and so Dr Foster sent him a prescription for Risperidone covering a period of 4 weeks. He was requested to attend on the 8th August 1995.

3.64 On the 4th August 1995 he was seen again by Simon Hughes and said that things were going along well.

3.65 He failed to attend on the 8th August 1995, but agreed to be seen by Dr Foster at the Ivydale Centre on the following day. On that occasion he appeared to be well.

He assured Dr Foster that he was willing to comply with his medication and had no intention of contacting his mother and brother, although he was in touch with his father. He was spending most of his time watching television and listening to music.

3.66 As Dr Foster was about to take some leave, arrangements were made for the next appointment to be with Dr Shuriquie. This ought to have been in 2 weeks time, but it was in fact fixed for the 30th August 1995. We find here the first signs of a loosening of the CPA plan. It is also to be noted that Simon Hughes did not see Matthew during two of the weeks in August 1995. However, we recognise that a certain amount of flexibility in the arrangements was inevitable over the holiday period.

3.67 Matthew was next visited by Simon Hughes on the 24th August 1995 and then on the 1st September 1995. His mood was euthymic, as was likewise the case when he was seen by Dr Shuriquie on the 30th August 1995. Upon examination he was found to be unkempt and lacking in hygiene, but he reiterated that he had been taking his medication and there was no evidence of thought disorder, abnormal beliefs or disturbance of perceptions.

3.68 The following out-patient appointment was for the 5th September 1995, but once again Matthew failed to attend. We note that this was the third default. It is quite clear that his appearances at the Ivydale Centre were wholly subject to his own whim. No sanction was invoked if he did not turn up, only re-arrangement of the appointment. But it is hard to see what sanction could in fact have been applied short of re-admission to hospital and so long as he was at least partially compliant with the plan and still taking his medication no real cause for concern arose.

3.69 Matthew did attend on the 13th September 1995 and was assessed by Dr Foster. He remained euthymic and had no hallucinations. His sleep and appetite were normal. He said that he was taking his medication and was given a prescription for a further 3 weeks supply. He was then told that Dr Foster would not be seeing him again, as he was leaving the hospital at the end of the month, to be replaced by Dr Wolff.

3.70 Simon Hughes was away in the second week of September 1995 and his next visit to Matthew was on the 15th September 1995. Nothing new was then noted.

3.71 At this point in time the formal CPA review meeting which had been planned for mid-September 1995 should have taken place. However, this did not in fact occur. Instead there appears to have been a discussion in relation to the existing situation and the pending expiry of Matthew's section at one of the weekly PACE meetings. No note of that discussion has been produced, but it was presumably decided that no grounds existed for renewal of the section as Matthew was not exhibiting signs of psychosis or behaving in a manner which would have warranted detention.

3.72 It is unclear why there was no formal review. Dr Foster may have thought that the plan provided for it to be convened 3 months after Matthew's release, in other words in mid-October 1995. In any event a specific date was not fixed and notices to interested parties were not sent out. Whatever be the cause, the omission of this important action is to be regretted.

3.73 On the 20th September 1995, in anticipation of his departure, Dr Foster prepared a handover note. It indicated that Matthew had been diagnosed as suffering from schizophrenia, had left hospital in July 1995 on extended leave and was on the Supervision Register. A summary of his up-to-date circumstances followed. Reference was made to his compliance with medication and to the absence of any

overt psychotic features.

3.74 This note would not have brought home to a new Senior Registrar the risks which were attached to Matthew's release into the community. We think that ideally it should have been more focused upon his dangerousness and the aspects of his behaviour upon which a close eye needed to be kept. We do however accept that the note was in a fairly standard format, that Dr Foster would have expected the file to have been scrutinised by his successor and that this was only one of a large number of cases which he was required to hand over.

3.75 Dr Foster left the PACE team in the last week of September 1995. At about the same time Dr Christie Brown also departed from the hospital. His position as leader of the team was taken over by Dr Davies, a Senior Registrar acting as a Locum Consultant. Thus there was a double change of medical personnel, which inevitably placed the team at a disadvantage. The knowledge of Matthew and the experience of dealing with him which had been built up over a period time at both Consultant and Senior Registrar level was effectively lost and had to be regained. In fact Dr Davies did not have any subsequent involvement in Matthew's care and it was Dr Wolff who, as his key worker, had to get to grips with the case.

3.76 Dr Wolff took up his post at the beginning of October 1995. Before he had any opportunity to see Matthew, the section expired on the 3rd October 1995.

3.77 The expiry of the section constituted a further significant disadvantage for the PACE team. It no longer possessed the power to return Matthew to the hospital for a failure to comply with the conditions as to medication and co-operation upon which his release had been impliedly dependent. The only remaining remedy was a fresh section, which necessarily involved establishment of proper grounds for detention under the Mental Health Act and was likely to require the support of an

Approved Social Worker.

3.78 Matthew should have been seen by Dr Wolff for the first time on the 5th October 1995, but he failed to attend. This was his fourth and arguably most regrettable default to date. As the appointment had to be re-arranged for the following week, it meant that he would be without a medical assessment for an overall period of at least one month.

3.79 Simon Hughes had also been unable to see Matthew for some time, as he had not been at home on each of the two previous weekly visits. Asked why these visits had not been repeated, Simon Hughes explained that this was because no problems had been reported. Had he learned of any suspicious behaviour, he would have re-attended sooner.

3.80 Simon Hughes did however get to see Matthew on the 6th October 1995. On that occasion he said that he was well and that he was taking his medication, but he was found to be more distracted and more guarded than usual. Simon Hughes was obviously concerned, because he made a specific note that the position was to be discussed with Dr Wolff and that there should be close monitoring.

3.81 On the 9th October 1995 Simon Hughes received a message from Sue Wallace to the effect that Matthew was causing annoyance to another tenant by playing loud music at night and by failing to keep the common parts of the premises in a clean condition. The tenant felt generally intimidated by Matthew and Sue Wallace was concerned about his suitability for communal housing. She wanted to pursue other avenues. It was therefore arranged that Simon Hughes and Sue Wallace would see Matthew together on the 18th October 1995.

3.82 On the 12th October 1995 Matthew failed to attend his re-arranged appointment

with Dr Wolff. This was his fifth default and we have no doubt that the time had come to take more positive action to ensure that he was medically assessed. It is clear that both Dr Wolff and Simon Hughes were of the same opinion, since they decided to make a home visit on the 20th October 1995.

3.83 In the meantime Simon Hughes made his weekly visit on the 13th October 1995 and found Matthew to be more relaxed and less distracted, although complaining of tiredness. He was then told that Matthew had run out of his medication two to three days previously. We calculate that it ought in fact to have run out by the 5th October 1995, which suggests that there had not been full compliance, but in any event Simon Hughes arranged for a further prescription to be provided.

3.84 We have seen no note of the meeting with regard to housing on the 18th October 1995, but it may well have taken place, since Sue Wallace sent a memorandum to one of her colleagues on the following day indicating that Matthew wished to be removed from the waiting list for a SELCHA self-contained flat. Presumably it had been agreed that he should stay in his existing accommodation for the time being.

3.85 The home visit by Dr Wolff on the 20th October 1995 turned out to be abortive, as Matthew was not at home. It was therefore repeated on the 27th October 1995. By that time six weeks had elapsed since the previous medical assessment, a state of affairs which cannot be regarded as at all satisfactory but which was basically caused by a reduction in Matthew's co-operation with the PACE team following the termination of his section.

3.86 Matthew told Dr Wolff that he was well, had no complaints and was taking his medication. His speech was normal in form and content, his mood was adjudged to be normal and he did not appear to be suffering from any delusions or other

forms of thought disturbance. In summary Dr Wolff found no signs of psychosis. That was obviously reassuring.

3.87 At that point Dr Wolff proposed that the next out-patient appointment should be in 4-6 weeks time. This constituted a significant relaxation of the existing plan, which provided for assessments at fortnightly intervals. It was an alteration which prima facie ought not to have been made without a formal meeting.

3.88 It is to be noted that by that time a period of 3 months had elapsed from the date of Matthew's release, but there was still no CPA review meeting. The undoubted explanation is the change over from one Senior Registrar to another. Dr Wolff did not realise that the meeting had not been convened in September 1995.

3.89 Whether a review would actually have made any difference is another matter. No doubt attention would have been focused upon Matthew's lack of enthusiasm for PACE intervention and the requirement for continued diligence in monitoring, but we have heard nothing to suggest that there would have been a change of direction in the approach which the team was adopting, which was essentially to deal with Matthew on an ad hoc basis. It seems unlikely that there would have been a much tighter plan, with specific provision for defined action in particular eventualities.

3.90 In any case the plan would rapidly have required revision, as Matthew resolved to sever his relationship with the PACE team completely. He was not at home when Simon Hughes visited on the 3rd November 1995 and he then left a message on the 8th November 1995 saying that he no longer wanted to have any contact with the PACE team.

3.91 On the 10th November 1995 Simon Hughes went to see Matthew as usual and was told in the clearest possible terms that there was to be no further contact. Matthew

was neither hostile nor aggressive, but he would not listen to any argument to the contrary.

3.92 On his return Simon Hughes made an entry in the notes which incorporated the following plan :

" Discuss with Geoffrey Wolff

Issues

(i) supervision register

(ii) monitor for possible relapse

(iii) continuing medication

(iv) liaison with housing support worker Sue Wallis (SELCHA)

(v) any implications for other residents

(vi) any implications for family

? for community ward round asap ? "

3.93 This entry clearly shows that Simon Hughes was alert to the problems which were likely to arise and to the need for preventative action.

3.94 It also seems likely that he did have an immediate discussion with Dr Wolff, as on the same day arrangements were finally made for the CPA review meeting. This was a prompt and appropriate response, but the objective of urgency was defeated as the dates provisionally and then firmly fixed were the 29th and 30th November 1995 respectively, almost 3 weeks ahead, evidently so as to give all the interested parties sufficient advance notice.

3.95 It has to be borne in mind that little could be achieved until the meeting had been

convened and that in the meantime Matthew would probably not be taking any medication. We do not in fact know whether he still had a supply of Risperidone. The last reference to a prescription was about one month earlier. The extent of any remaining medication would have depended upon the degree of compliance in the meantime. But, even if the supply had not yet run out, there was obviously a high risk that Matthew's decision to withdraw from PACE supervision would go hand in hand with cessation of the Risperidone regime.

3.96 Notices in respect of the meeting went out one week later on the 17th November 1995 to Dr Hossain (Matthew's General Practitioner), Glen Mohammed (a CPN on the PACE team), Sue Wallace and Sybil Buchanan. Mrs Hooper was not asked to attend, presumably because she was not in contact with Matthew, and no-one thought to invite his father.

3.97 In the period between the 10th and 30th November 1995 there is no record of any visit to Matthew by any member of the PACE team. Simon Hughes cannot now recall whether he attempted to see Matthew again, but on the whole we think that he had for the time being put the existing plan on hold.

3.98 On the 29th November 1995 Matthew was arrested by the police for possession of a lock knife with a 4-5 inch blade. It appears that this was found in his car. He was taken to Peckham Police Station, charged with an offence of having an article with a blade in a public place and bailed to appear at the Camberwell Magistrates Court on the 3rd January 1996. In fact he failed to appear, but on the 30th January 1996 he was duly convicted of the offence. He subsequently told a Senior Social Worker at Broadmoor that, as the knife had been confiscated by the police, he had purchased another one prior to the time of the homicide.

3.99 Unfortunately the PACE team was not apprised of the discovery and confiscation of the knife. But did that actually make any difference ? Obviously possession of the kind of weapon which had previously been used in the attacks by Matthew upon his friend and his brother would have sounded warning bells. On the other hand it still did not constitute indisputable evidence of psychosis. Thus, while it would almost certainly have amounted to an added reason for a further medical assessment, we doubt that Dr Wolff would have initiated action directed towards re-sectioning Matthew.

3.100 The review meeting duly took place on the 30th November 1995. Dr Wolff and Simon Hughes were present, but of the four invitees the only one who attended was Sue Wallace. Sybil Buchanan was involved in a mental health assessment on that day and no doubt Dr Hossain and Mr Mohammed also had other engagements.

3.101 It was noted at the meeting that Matthew was refusing contact and not taking his medication. Nonetheless, Sue Wallace stated that she had not observed any signs of mental illness. It was agreed that she should keep a watch upon his behaviour and liaise with Dr Wolff and Simon Hughes about his mental state and that Simon Hughes would additionally seek feed back from members of the PACE team who went to the shared house for the purpose of seeing other residents. Dr Wolff also undertook to continue to offer out-patient appointments. Matthew was to remain on the Supervision Register and there was to be a further review in 3 months time.

3.102 These arrangements involved a fairly loose regime of monitoring. Matthew was not to be visited by either Simon Hughes or Sybil Buchanan and there was to be no routine mental state assessment unless Matthew voluntarily went to Ivydale. To a large extent reliance was being placed upon Sue Wallace. Moreover it would appear that nothing was to be done to secure compliance with medication. We are constrained to conclude that the PACE team did not regard active

intervention as a practical option.

3.103 In the early hours of the morning on the 1st December 1995 Matthew was again arrested. It was alleged that he had stolen two cans of drink from a stall at the Bermondsey Market. He was taken to Southwark Police Station and interviewed.

3.104 On this occasion news of Matthew's arrest did reach Simon Hughes and during the course of the morning he telephoned the police station. As a result the station sergeant learned that Matthew was under the supervision of the PACE team and would require the assistance of a responsible adult. He therefore bailed Matthew to return for a further interview on the 22nd December 1995. This was confirmed in a letter to Simon Hughes dated the 1st December 1995.

3.105 At about 6 p.m. on the 2nd December 1995 Matthew made a telephone call to the Maudsley Hospital, which was taken by a Staff Nurse in the Emergency Clinic, asking for the PACE out of hours contact number. He appeared to be pursuing a complaint that Simon Hughes had collaborated with the police to get him arrested. He sounded very angry and his conversation was paranoid in its content.

3.106 On the 4th December 1995 Simon Hughes made an entry in the notes querying whether in the light of recent events Matthew ought to be contacted and medically assessed.

3.107 On the 5th December 1995 Matthew was one of the patients discussed at the daily crisis meeting conducted by the PACE nursing staff. It was noted that a medical assessment was not possible on that day due to sickness, but that the matter would be discussed with Dr Wolff on the following day. In the meantime a home visit was to be made. It was decided that as a precautionary measure all future visits to Mattthew's house, including those to other residents, would be made in pairs.

3.108 Thus within days of the review meeting fresh plans were being made on an ad hoc basis. But no progress was actually achieved. Two visits to the house on the 5th December 1995 proved abortive because Matthew was out and no further attempt was made to contact him.

3.109 At that stage the issue for Dr Wolff was how and when he was to conduct what was on any showing an essential medical assessment. The action which he took was to request Matthew to attend at Ivydale for assessment. Appointments were made for the 12th December 1995 and then the 20th December 1995, but there was in our view little prospect of Matthew attending and unsurprisingly he did not do so.

3.110 However, Dr Wolff knew that Matthew was due to be at Southwark Police Station on the 22nd December 1995 and plans were therefore made for him to accompany Sybil Buchanan (who was to act as the appropriate adult) to the station on that day. Unfortunately Sybil Buchanan was then off work as a result of sickness. For that reason and also because Dr Wolff was unable to get through to the station on the telephone to find out the time at which Matthew would be attending, the visit was cancelled. Plans were instead made for Dr Wolff to see Matthew in the following week together with Steven McWilliam (Ms Buchanan's supervisor).

3.111 Events then took an unexpected turn. At about mid-day on the 22nd December 1995 Matthew arrived at Ivydale and demanded to see Dr Wolff. His interview had inevitably been postponed as a result of the absence of an appropriate adult and he wanted this situation to be rectified. In fact nothing could be done, but Dr Wolff took the opportunity to carry out a mental state examination.

3.112 Matthew was angry and spoke in a raised voice, but he was controlled and polite and his speech was considered to be normal in form and content. There was also no abnormality of form or content in his thinking, nor any thought withdrawal, insertion or broadcasting. He was not suffering from delusions or hallucinations. His mood was not elevated or depressed and although his appearance was a little unkempt, it was no more so than usual. He said that his sleep and appetite were normal.

3.113 Dr Wolff concluded that Matthew was well and that there was no evidence of any psychotic symptoms or neurotic disorder. In those circumstances no grounds for re-sectioning him existed and he could not be detained. Once again he indicated that he intended to have no further contact with the PACE team, but this did not in itself provide an adequate reason to keep him in hospital.

3.114 That was the last occasion on which Matthew was seen by any member of the PACE team before the homicide.

CHAPTER 4

THE HOMICIDE

4.1 At about midnight on the 24th December 1995 Matthew went into his local public house, the Rye Hotel in Dulwich. The victim, John Trinder, was there with some friends. He had been known to Matthew for about 10 years. Initially they were on neutral or good terms, but it was Matthew's perception that since about 1993 Mr Trinder had been persistently rude and abusive towards him.

4.2 The account which we give of the subsequent events is derived from interviews which were conducted with Matthew following his arrest. We cannot vouch for its accuracy.

4.3 Matthew alleges that upon his arrival Mr Trinder shouted that he should get out and stay away. He left the public house and went to sit in his car, where he habitually kept a knife. He denies that he was waiting for Mr Trinder to leave and it is unclear whether he actually saw him do so. In any event he passed Mr Trinder after driving off and at that point he stopped his car and got out. This was on any view a confrontation.

4.4 Matthew then stabbed Mr Trinder some 22 times in the left side of his chest, his left side and in the adjacent region of his back. Whatever may have been said or done by Mr Trinder in the public house or in the street cannot conceivably have justified that action. It was a deliberate and sustained attack. Matthew may not have been intending to kill, but he must at the very least have intended to cause severe injury.

4.5 At the end of the incident he got back into his car and drove off at speed, but his actions were witnessed by local residents. On the 30th December 1995 he was seen in a nearby street pouring inflammable liquid over the car, presumably with the object of destroying evidence which might associate him with the stabbing. However, he avoided apprehension by again driving off. On the 1st January 1996 the vehicle was found in the same vicinity in a burned out condition.

4.6 For several days Matthew stayed away from his home. He was however located by the police and seen with another man in a different car. On the 29th January 1996 he was arrested. Hidden under the carpet in the car was a lock knife identical to the one which had been confiscated on the 29th November 1995. The blades of those knives were similar in size and shape to the blade used to stab Mr Trinder.

4.7 Matthew was held on remand at Belmarsh Prison for a period of several months. During his detention the prison staff observed that he was mumbling and talking to himself most of the time. Other inmates were frightened of him and refused to share his cell. On one occasion he assaulted a member of staff.

4.8 On the 30th September 1996 he was transferred to Broadmoor. He then appeared at the Central Criminal Court on the 15th November 1996. He did not dispute the homicide, nor did he advance a defence of provocation. His plea was one of guilty to manslaughter on the ground of diminished responsibility, which was accepted by the Crown. He was sentenced to detention in Broadmoor under Section 37 of the Mental Health Act and a Section 41 restriction order was made.

4.9 An important issue for consideration is whether Matthew was psychotic at the time of the commission of the offence. This was specifically addressed in a number of reports which were prepared while he was awaiting trial.

4.10 In a report prepared for Matthew's solicitors on the 11th July 1996 Dr Wilkins, a Consultant Forensic Psychiatrist, made the following observations :

" The total picture appears to be of somebody who has had a long standing mental illness dating back to 1983 or 1984. This has shown a limited response to treatment and Hooper's insight has never been good. His compliance, therefore, with treatment has been poor. Over the years there has been an increase in difficulty in engaging him in treatment, increased disorganisation in his psychosis so that overt psychotic symptoms have not been to the forefront whereas aggressive behaviour and violence has increased. I suspect that this is part of the same process where more obvious psychiatric symptoms are replaced by more chaotic and disorganised and sometimes violent behaviour. That is not to say that the original diagnosis was incorrect, but more the natural history of his condition has meant that there has been this change over the years. I have no doubt that the episodes of aggression and violence in the recent past have been psychotically driven and this appears to be the view of the psychiatric teams dealing with him. "

" There is little objective evidence to go on in this case. Hooper's own account is to some extent affected by the fact that he does not believe himself to be mentally ill and presents his behaviour at the time in terms where it is difficult to clarify exactly what his mental state was. However, we know that Hooper was mentally ill and suffering from schizophrenia. We also know that he complied poorly with treatment. We also know that there have been episodes of violence in the past which were almost certainly psychotically driven. He appears to have had paranoid ideas about the victim. In the absence of any evidence to the contrary, it is most likely that Hooper developed paranoid ideas about the victim, believed himself to be repeatedly insulted by him and eventually killed him for that reason. Both in terms of the content of Hooper's beliefs, ie. his paranoid ideas, and the behaviour that was consequent upon this, ie. psychotic disinhibition, this can be

characteristic of psychosis and particularly schizophrenia. Bearing in mind the clear past diagnosis with incontrovertible evidence that he had a diagnosis as schizophrenia, it is most likely that it was this that was the cause of his belief about the victim."

4.11 In a report for the Court dated the 14th August 1996 Dr Petch, a Senior Registrar in Forensic Psychiatry at the Bracton Centre, expressed a somewhat more cautious opinion :

" It is likely that at the time of the offence Mr Hooper was not taking his medication and had relapsed as had occurred on previous occasions. Although he was examined three days before the killing and appeared to exhibit no obvious signs of psychosis, he was noted to be angry. It is possible that at the time of the killing Mr Hooper was relapsing. Whether or not Mr Hooper was psychotic at the time of the offence ... I regard it as highly probable that the illness affected his judgement and control over his actions."

4.12 In a further report for the Court dated the 13th November 1996 Dr Pearson, a Locum Consultant Psychiatrist at Broadmoor, agreed that Matthew's illness would have affected his judgement at the time of the killing. However, he found no firm evidence that Matthew was actively psychotic.

4.13 This diversity of view is unsurprising, given the divergence of opinion among the psychiatrists who saw Matthew in the course of 1995 as to the respective impact upon his behaviour of his mental illness and personality disorder.

4.14 In the final analysis we find it impossible to say whether Matthew was psychotic. Certainly he was not floridly so; we would otherwise have expected Dr Wolff to have observed some significant signs on the 22nd December 1995. It must also

be borne in mind that he was not so obviously insane that as a matter of law he could be acquitted of murder on that ground. He might on the other hand have been on or just over the borderline, so that even a minor incident involving one of his perceived enemies was sufficient to provoke a total loss of control.

4.15 A further question which arises is whether the homicide was foreseeable. With the benefit of hindsight the sequence of events has an air of inevitability about it. Matthew had a propensity to violence, he had used a knife to inflict significant wounds on two previous occasions, he kept a dangerous knife in his car, he had not been taking any medication for a period of several weeks, his activities were not effectively being monitored and the victim was an individual in respect of whom he seems to have been harbouring a grievance. The time had come for the prophecy of his General Practitioner in 1988 to be fulfilled.

4.16 However, Dr Wolff and the PACE team did not possess a crystal ball and they had to assess the situation as it appeared to them at the time. Two important pieces of the jigsaw were missing. In the first place the team did not know or have good reason to suspect that Matthew was carrying a knife; they were not aware of his arrest for having a knife in his car on the 29th November 1995. Secondly they knew nothing of his attitude in relation to Mr Trinder. The assaults earlier in the year had involved members of his family, with whom he was no longer thought to be in contact. Moreover, Dr Wolff at all times believed that Matthew was not psychotic, a belief which was reinforced upon examination on the 22nd December 1995. If the signs of a pending relapse were in fact present, they were subtle and difficult to pick up. Thus, while there was always a background risk of violence, Dr Wolff did not anticipate a homicidal attack at that particular time.

4.17 Of course, even if the outcome could not have been foreseen, there remains the separate issue of whether it could have been avoided. Plainly it would not have

occurred were Matthew to have been in hospital rather than out in the community. We shall therefore discuss in Chapter 5 the factors which influenced the place at which he received his care.

CHAPTER 5

COMMENTARY

The Structure of the Nunhead Community Services

5.1 The broad catchment area served by the Maudsley Hospital was divided into five geographical sectors. Each had a different service configuration. In the Nunhead sector there were two teams, PACE (Psychiatric Acute Crisis and Emergency) and PACT (Psychiatric Assertive Outreach and Continuing Care).

5.2 The bulk of new referrals went to the PACE team, which has been described as the gatekeeper, although in practice it was much more than that. It dealt with most of the acute cases and usually managed them for a period of upwards of one year. Those who had fully recovered would then be discharged back to the care of their General Practitioner. Other clients who had a long and enduring mental illness but had settled down sufficiently to be suitable for a programme of day care would be transferred to PACT. In general terms PACE dealt with individuals who were undergoing a crisis or whose lives tended to be chaotic, whereas PACT provided a service of long term intensive support and rehabilitation.

5.3 This model was innovative, but it has since been adopted elsewhere and we were told that it is currently much favoured. Its disadvantage is that a proportion of the mentally ill fall between the two stools, but there are obvious advantages in having teams which are specifically designed and trained to meet the needs of clients in different categories. In any event we have no reason to conclude that the division of services in this way was prejudicial to Matthew's management.

5.4 Matthew was throughout allocated to the PACE team. The only time at which consideration was given to his possible transfer to PACT was in August 1994 after his release from hospital. At that stage it seems to have been thought that he could be a suitable candidate for PACT. He had certainly been suffering from a long and enduring illness. However, he never saw himself as mentally ill and resented the involvement of professionals in his life. He would not have welcomed efforts to rehabilitate him into the community or have co-operated with a programme of day care. In reality the best that could reasonably have been achieved was to keep him on his medication and under regular supervision and even this eventually turned out to be impossible. For these reasons we do not suppose that transferring him to PACT would have been of any assistance. While the PACT team might have been in a better position to concentrate resources upon his management, it would have been confronted with the same problems and we have little doubt that the outcome would not have been materially different.

The PACE Team

5.5 The team was headed by a Consultant Psychiatrist and had an established staff of practitioners, nurses and other professionals. The practitioners included a Senior Registrar and a Senior House Officer. There was a complement of nurses under a Clinical Leader. Other team members were a psychologist and an occupational therapist and in addition two social workers were attached. Management of the team was consigned to the Clinical Manager of the Nunhead sector.

5.6 The team had a very considerable workload. The catchment area had a relatively high incidence of mental illness and there were numerous referrals, many of which were difficult to manage. The team was working under great pressure. That has to be borne in mind when examining the quality of care given to any one patient.

5.7 Plainly continuity of personnel was an important factor in maintaining the high standard of service which the team aimed to provide. Unfortunately in the latter part of 1995 this vital continuity was significantly eroded. Dr Christie Brown, an impressive team leader, departed at the end of September together with his Senior Registrar, Dr Foster. They were succeeded by locums, Dr Davies and Dr Wolff, who had not previously been involved in the activities of PACE and who had to get to grips with new procedures and a large number of new clients. At that stage the team had also lost its lead nurse, Jane Sayer, and was awaiting the arrival of her replacement, Patrick Tyrrell; in the meantime there was an acting leader. Thus it was a time of change and to some extent of demoralisation.

5.8 Dr Wolff was therefore placed in a position of some difficulty so far as Matthew's management was concerned. His knowledge of Matthew was initially confined to the information in a voluminous case file, much of which would have been hard to digest. He was then afforded very little opportunity to meet Matthew and get to know him as a person. Prior to the 22nd December 1995 he actually only saw him on a single occasion. Moreover Matthew was not known to Dr Davies, who accordingly could not provide first hand insight into his condition and who has no recollection of ever being involved in discussion of his case.

5.9 However, that is not to say that the chain of continuity was totally broken, since Simon Hughes had been participating in Matthew's care for a considerable period of time and had indeed been his key worker. Dr Wolff was able to turn to Simon Hughes for information and assistance and we accept that he did so. This would to some extent have plugged the gap. Nonetheless we feel that Dr Wolff was at a distinct disadvantage when required to make decisions in relation to Matthew's management. It is usually easier to cope with a difficult patient when there has been a personal relationship with him and his presentation is familiar.

Key Working

5.10 The responsibilities of Matthew's key worker were to develop his care plan, keep in contact with him in the community, co-ordinate the services provided for him, convene formal meetings and any urgent reviews and provide a central point of contact for the official network and persons informally involved in his care.

5.11 These duties could technically have been undertaken by any of the mental health workers on the PACE team. In practice, however, it was important that the key worker should be both a senior member of the team and one who was in regular contact with Matthew.

5.12 For a period of approximately one year Matthew's key worker was Simon Hughes, a senior occupational therapist. He was experienced in key working, as he acted in that capacity for 15 to 20 clients and one third of his time was spent in that way. He was also in a position to visit Matthew on a regular basis and prior to April 1995 he saw him on average once a fortnight. Arguably he was the right person to be key working a client even as potentially dangerous as Matthew was known to be, but on the whole we think not. An occupational therapist is not ordinarily qualified to lead a team dealing with a high risk case. In principle we would have expected the key worker to have been a senior grade community psychiatric nurse.

5.13 When Matthew was released from hospital in July 1995 Simon Hughes ceased to be his key worker. He did not consider that he could properly undertake this role for a client on the Supervision Register. The team therefore had to decide who should replace him.

5.14 The Trust operated guidelines in relation to the key working of clients on the Supervision Register. These guidelines were contained in the Trust's Interim Care

Programme Approach and Supervision Register Policy, which is annexed to this report. An important provision was that the key worker should have a relevant professional qualification supplemented by considerable experience of working within a functioning multi-disciplinary community mental health team.

5.15 Dr Holloway told us that a committee developed the Trust's policy in respect of the Supervision Register and that one of the matters under consideration was who should be key workers. He stated that :

" ... it was clear that the key worker would have to be somebody of considerable experience and somebody who would be likely to be within the service for a reasonable length of time, not someone who is going to come and go. So it was clear that, so far as the Supervision Register was concerned, it could not be, for example, a Senior House Officer on a six-monthly rotation.

We had a debate within our committee and also a debate that was taken to the medical committee about the role of medical staff and we did, in fact, state at the end of that debate ...that Senior Registrars and Consultants could become key workers under the Supervision Register."

5.16 In 1995 it appears to have been quite usual for the key working of persons on the Supervision Register to be undertaken by the Consultant or Senior Registrar on the PACE team. They were also the key worker in a number of other cases under the Care Programme Approach. Dr Christie Brown acted in this capacity, as did Dr Foster.

5.17 Dr Foster estimated that his case load of PACE patients was in the region of 40 to 50. He could not recall how many of them he was key working, but it was his recollection that aside of Matthew there was just one on the Supervision Register.

Dr Christie Brown appears to have been looking after two other such cases, who were subsequently passed on to Dr Davies. So when Matthew was placed on the Register, the team was caring for a total of four individuals who were regarded as posing a high degree of risk.

5.18 It was decided that Matthew's key worker would be Dr Foster. At the time this seemed the best way forward, as Dr Foster was both a senior member of the team and enjoyed a relationship with Matthew which extended over a period of many months. There was in all probability no better candidate among the nursing staff. In retrospect, however, we think that it was a step in the wrong direction.

5.19 The post of Senior Registrar on the PACE team entailed the performance of duties which were onerous and time-consuming. Key working would have added to that burden. We doubt that the Senior Registrar, or for that matter any other member of the medical staff, could readily have coped with all the functions which the key worker would be expected to fulfil. Dr Holloway now shares this reservation. He said that :

" ... in the past year I have taken the view personally that I do not feel that Consultants and Senior Registrars, in fact medical staff, are actually usually appropriate to function as key workers under the Care Programme Approach."

" ... I think that it does put medical staff, who have many calls on their time and many different responsibilities, in some difficulties if they are attempting to cover the whole range of a key worker role, for example giving review meetings ..."

5.20 There was in this instance an additional factor which created a special problem for the Senior Registrar, namely Matthew's lack of co-operation. It was planned that he would be seen at Ivydale at intervals of 2 weeks. Had he kept his appointments,

Dr Foster would have been able to monitor his progress and ensured that he was compliant with his medication. As it was, an element of slippage arose. In the 10 weeks between his release and Dr Foster's departure, he was only seen at Ivydale on 3 occasions and one of those involved a deputising doctor. It would have been difficult for Dr Foster in those circumstances to have kept a close eye on what was happening.

5.21 The difficulty which existed at that time was greatly magnified subsequently. Dr Wolff came to the post of locum Senior Registrar without either any knowledge of Matthew or any past experience of key working a patient on the Supervision Register. He was reluctant to take on this role. He told us that :

" I didn't think I ought to have been the key worker. In ideal circumstances I think the key worker ought to be identified as somebody who firstly doesn't have such a large case load and perhaps more time to give to a particular patient and somebody who actually agreed to do it in the first place."

" I felt it ought to have been another member of staff, a community nurse perhaps."

5.22 Dr Wolff discussed the issue of key working of patients on the Register with Dr Davies and Mr Burford (the Clinical Manager of the PACE and PACT teams). In the event, it seems to have been decided that the 4 cases would have to be divided between Dr Wolff and Dr Davies. This would of course have been in line with the increasingly held view that the medical staff could appropriately be involved in key working of persons on the Register, but another material consideration was the shortage of senior nurses.

5.23 Thus Dr Wolff had the unenviable burden of co-ordinating the efforts to maintain

supervision of Matthew during the critical period of time when he was set upon a course of breaking free from the PACE team. It was a task to which he applied himself and we are satisfied that he used his best endeavours to keep in contact with Matthew and liaise with other members of the team. Nonetheless, the level of supervision fell away and ultimately became almost non-existent. No effective steps were taken after the 10th November 1995 to restore contact with Matthew or to re-establish his compliance with medication. We consider that this is likely to have happened irrespective of the identity of the key worker, but Matthew was on any view too awkward a patient for a busy and inexperienced PACE Senior Registrar to manage.

Training

5.24 The Trust's interim policy stipulated that key workers taking on clients on the Supervision Register should have received training in the principles behind the Care Programme Approach and Supervision Register and have received specific training on the assessment and management of risk in psychiatry.

5.25 However, at the time of the events with which we are concerned, medical staff were not given any specific instruction and training in key working, nor were they provided with any documentation setting out the role and responsibilities of key workers. It was expected that they would make themselves aware of those matters and that they would acquire the necessary skills in the course of their employment.

5.26 The situation has since changed. We understand that the attention of new medical staff at the Maudsley Hospital is specifically drawn to the procedures operated by the Trust. Multi-disciplinary training is available and in addition Dr Szmukler and Dr Holloway provide induction training in relation to risk issues.

5.27 Dr Foster and Dr Wolff did not have those advantages. Dr Foster told us that he did not attend any formal course. Dr Wolff likewise said that he was not offered any formal training. They did take steps to make themselves aware of the issues and implications of key working, but their ability to put these into practice may to some extent have been under-developed.

5.28 Simon Hughes received instruction in case management as part of a post-graduate course in mental health interventions between September 1994 and May 1996. However, he did not feel that he had been given sufficient training to be competent to deal with a Supervision Register case. His gave us the following explanation of why he had ceased to be Matthew's key worker :

" At that time I had reservations about Matthew and his dangerousness and the risks associated, and at that time there was conflicting opinion about the sort of nature of his risks. I know that the Trust at that time was getting their training together specifically for the Supervision Register and one of the guidelines, I think, from the government at that time was that the Trust should have training in place and they did not have any training in place at that time. So I did not feel I wanted to take on the key worker role for the Supervision Register."

" I think (the impetus for the change over) was a mixture of my impetus and the recognition of the sort of developments in Matthew's history."

" I think it would be fair to say (that I did not want to take on the leadership responsibility for a man as potentially dangerous as he was)."

5.29 Technically the responsibilities of a key worker in such a case were not different from those applicable to any other CPA client. In practice, on the other hand, they were more onerous. Clients on the Supervision Register were almost by definition

likely to be more difficult to manage within the existing scheme of care. This was certainly true of Matthew and it is unsurprising that Simon Hughes felt vulnerable.

5.30 We have no reason to believe that the nursing staff received inadequate training in key working generally, but in the latter part of 1995 they were not key working the Supervision Register cases.

The Supervision Register

5.31 We endeavoured to ascertain the extent to which Supervision Register cases were actually viewed in a different way. In that connection the following evidence was of particular interest :

5.32 Dr Holloway :

" ... research evidence that is just about to be published in the Psychiatric Bulletin shows, rather worryingly, that there is no evidence that people on the Supervision Register get more services."

" To date our services have not been good at actually altering the level of support ... available to individuals in relation to that risk."

5.33 Dr Christie Brown :

" The Supervision Register, which was really a sort of bolt on addition to the Care Programme Approach Register, simply highlighted the seriousness of the case and set certain limits on the way in which the management could be done ...But it ...gave no powers to the service. It did not allow you any compulsory powers. It

simply said that here is a difficult patient and there would be just a small number of people on the Supervision Register, they must have particularly regular and careful attention. And as a qualified key worker, you must have a very clear plan. But it was really a sort of embellishment of what we were trying to do with everybody who was quite ill."

5.34 The PACE team undoubtedly recognised the fact that Matthew was a high risk case. He was placed on the Supervision Register for that very reason and a plan was formulated which was designed to keep him under close supervision. But he soon made it plain that he would not be co-operating with that plan. What then ensued was less than we would have expected in a Supervision Register case. The plan was not tightened up; if anything, it became looser. Determined efforts were not made to achieve a greater level of contact. There does not appear to have been any sense of urgency, other than at the crisis meeting on the 5th December 1995.

5.35 We should make it clear that a different response is unlikely to have made much difference. Matthew was an impossible person to supervise effectively and we do not suggest that anything short of bringing him back into hospital would have prevented him from going his own way and escaping the net. The point is simply that placing him on the Supervision Register did not actually enhance the services which he received.

5.36 Nor did the PACE team have any additional powers. Once Matthew's section had expired, the team had no entitlement to return him to hospital without a completely fresh procedure under the Mental Health Act for his detention. Equally it could not require him to attend out-patient appointments at Ivydale. It must be borne in mind that Supervised Discharge, which incorporates provision for enforcement of attendance at a specified place for medical treatment (although no power to impose the treatment), was not brought into operation until the 1st April 1996.

5.37 Accordingly the team were well aware of the risks associated with Matthew's poor attendance at Ivydale and compliance with medication, but they could do nothing to correct his default by compulsory means unless and until he was considered to be behaving in such a way as to satisfy the criteria for detention under the Act.

The Care Plan

5.38 Planning for Matthew's supervision in the community was of central importance. He was known to be a difficult person to follow up. For a number of years he had effectively avoided any monitoring or review at all. He did not regard himself as mentally ill and was generally opposed to intervention in his life by either formal or informal carers. He did take advantage of available services when it suited him, but when he was not detained in prison or in hospital he wanted to do exactly as he liked.

5.39 To a large extent, of course, he was entitled to freedom and privacy. Supervision of an oppressive nature was highly likely to be counter-productive. But there was also a recognised element of risk if he was allowed to go his own way. The plan had to strike a balance and lay down parameters for supervision which were not too interventionist but at the same time provided a safety net.

5.40 We think that in a difficult case such as this the plan ought to have made provision not only for out-patient appointments, home visits and reviews at suitable intervals but also for the action to be taken in the event of default in the obligations which Matthew was reasonably expected to meet or a recurrence of disturbed behaviour. That would have provided the basis for a rather more structured approach. While we recognise that there must always be an element of flexibility in any standing arrangements, this has obvious limitations. A plan which is not adhered to and is

replaced by a series of ad hoc decisions which are not founded upon an underlying scheme of action ceases to be a plan at all.

5.41 The plan which was made at the time of Matthew's release from hospital in July 1995 made appropriate provision for weekly visits by Simon Hughes, fortnightly medical assessments and a review in mid-September before the section expired. It also referred to assistance in independent living from the housing officer. But that was as far as it went. The risks were set out and the warning indicators were correctly identified as non-attendance at out-patient appointments and cessation of medication, but there was no statement of what the response to those indicators ought to be, for example that there should be an urgent multi-disciplinary meeting or a reconsideration of the need for detention.

5.42 We have already drawn attention to the slippage which occurred in relation to the frequency of home visits and out-patient appointments. This was very largely due to Matthew's absence at the arranged times. No mechanism existed whereby his attendance could be enforced and the default appears for the most part to have been tolerated. In consequence the level of supervision set out in the plan was significantly diluted. While we commend Dr Wolff for visiting Matthew at home and ensuring that he was medically assessed on the 27th October 1995, the fact that this was the only assessment over a period of many weeks spells out the full extent to which the team's intentions were frustrated.

5.43 It seems surprising in the circumstances that the plan was not formally reviewed at a multi-disciplinary meeting until the 30th November 1995. Plainly a review of some kind did take place in mid-September 1995, when it was decided that the section would not be extended. However, the proper procedure does not appear to have been followed on that occasion. We have seen no sign of any invitations to interested parties such as Sue Wallace, nor a completed CPA form.

5.44 No action was taken to institute a formal review until Matthew severed his links with the PACE team on the 10th November 1995. At that stage the plan had been completely destroyed and both of the warning indicators were glowing red. There was a clear need for a new plan to be formulated as a matter of urgency. Although interested parties had to be notified and a date fixed which was convenient, we consider that a delay of 20 days was too long.

5.45 We would have expected the plan which was made on the 30th November 1995 to have incorporated specific provision for renewed attempts to make contact with Matthew and to secure compliance with medication, but the arrangements were in fact significantly looser than those which had previously applied. No provision was made for regular home visits or for action in the event that Matthew did not attend at Ivydale for medical assessment.

5.46 We are constrained to conclude that this aspect of Matthew's management was deficient. However, we doubt that it actually made any difference to the outcome. No action other than re-sectioning him is likely to have been productive.

Re-Admission to Hospital

5.47 The Mental Health Act lays down the grounds upon which detention in hospital can be effected. They apply just as strictly to someone who has previously been treated in hospital for mental illness as they do to a completely new case. Once Matthew was off his section, he could not be detained again unless the statutory criteria were met. Here lay the problem for the PACE team. It can hardly be said that they were unaware of the desirability of a low threshold for re-admission, but that threshold still had to be crossed.

5.48 Non-attendance at out-patient appointments and home visits was not an indicator of mental disturbance. It implied only that Matthew did not welcome intervention. Non-compliance with medication was a more serious matter, but patients in the community could not be forced to take their medication and in 1995 the sanction of detention for default would have been seen as an invasion of their liberty. Of the various practitioners who gave evidence to us only one, Dr Maden, expressed the opinion that detention for non-compliance was an available option within the ambit of the Mental Health Act :

" ... I would have considered detaining him again at the first sign of non-compliance."

" My own interpretation of the wording of the Act is that ... one could make a judgement as to nature and degree of the mental illness based on a person's attitude towards treatment. I mean, this man never had any true insight into his past mental illness or the things he had done whilst mentally ill, and I would have thought that that, added to a refusal to take medication, would have been sufficient to render ... his mental illness of a nature and degree which required his detention in hospital for treatment."

5.49 Other experienced Consultants such as Dr Szmukler and Dr Holloway clearly felt that Matthew could not properly have been detained for either non-attendance or non-compliance with medication and that the only practicable approach was to continue to make efforts to secure co-operation. We agree that it would have been very difficult indeed for the PACE team to have proceeded in a more coercive way.

5.50 Thus the power of the team to detain Matthew was effectively conditional upon the emergence of evidence of relapse or at any rate pending relapse. Such

evidence had either to consist of directly witnessed signs of psychosis or reliable reports of abnormal behaviour.

5.51 On the two occasions that Matthew was assessed by Dr Wolff he was not found to be psychotic and there is no basis upon which we could conclude that if he had been seen by Dr Wolff in the intervening period between those assessments he would then have been found to be relapsing.

5.52 Reports in relation to Matthew's behaviour did not point to a relapse. He played loud music and was untidy at home, but that was hardly remarkable. Nor was his somewhat unkempt appearance. His criminal activities, which are likely to have been ongoing from mid-November 1995 onwards, were almost entirely outside the knowledge of the PACE team. The telephone call which followed his arrest was disquieting, but not in itself sufficient proof of mental disorder.

5.53 A greater degree of contact might conceivably have thrown up some rather more convincing evidence. However, we think that Matthew was probably quite adept at covering up his illness. While he was intimidating in appearance and overall manner, the psychiatrists who examined him during the course of 1995 were rarely able to elicit any thought disorder or other abnormality. Equally it was exceptional for Simon Hughes to find him other than normal when home visits were made.

5.54 Moreover Mrs Hooper, who re-established contact with Matthew towards the end of 1995, told Dr Wolff in February 1996 that she had not picked up any evidence of illness. That is significant, since she was particularly sensitive to any changes in his behaviour which portended a relapse.

5.55 In the circumstances we cannot say that the PACE team acted inappropriately in allowing Matthew to remain in the community.

Mechanisms for Monitoring

5.56 Given Matthew's reluctance and eventual refusal to engage with the medical staff and Simon Hughes, what other alternatives could have been pursued ?

5.57 The medical staff on the PACE team enjoyed a close relationship with the Social Services in the Nunhead sector. In addition to the secondment to PACE of two Social Workers (one of whom was Sybil Buchanan), the Mental Health team of the Social Services had offices at the Ivydale Centre and were in a position to have regular discussions about clients whose cases were giving rise to problems. The Social Services were therefore a prime candidate for assistance with supervision. However, there was in fact little input from them into Matthew's care during the latter part of 1995.

5.58 Sybil Buchanan, to whom Matthew was assigned, attended the review meeting in July 1995. It appears to have been her view at that time that aside of helping Matthew with an application for independent living there was no role for her to undertake. The care plan did not incorporate any action by the Social Services.

5.59 On the 3rd September 1995 Ms Buchanan had a chance meeting with Matthew in the street outside Ivydale. He informed her that he wanted to have nothing to do with the Social Services.

5.60 Nonetheless, for the purpose of discussing the housing situation Ms Buchanan offered Matthew two appointments at her office. Neither were kept by him. Ms Buchanan made one home visit, but this was also abortive. So she was unable to establish any useful relationship with Matthew at all. She told us that she felt he might have been better suited to a male Social Worker. However, we doubt that anyone else would have established a rapport with him.

5.61 Ms Buchanan did not attend the review meeting on the 30th November 1995, as she had other duties which required her attention. It was arranged that she would act as the appropriate adult in connection with the theft matter, but she was unwell on the 22nd December 1995 when her presence at the police station was required. Subsequently the case was handed over to another Social Worker, Patrick Christie.

5.62 From about the 9th October 1995 onwards Ms Buchanan's supervisor was Steven McWilliam. His involvement in the case was also limited. In October 1995 he attended a meeting convened by Mr Burford to respond to a complaint by Sue Wallace about poor communication with the PACE team. On the 20th December 1995 he received a telephone call from Sue Wallace expressing concern about the effect on other residents of Matthew's loud music and he then discussed this with Simon Hughes. Aside of those two specific occasions when he became directly involved, he would have received reports from Ms Buchanan but would not have had a role to play in Matthew's supervision prior to the homicide.

5.63 The Social Services were at no time utilised by the PACE team as a medium for improving contact with Matthew or monitoring his behaviour. We think that they should have been and that they could have been more pro-active themselves. We do, however, recognise that they were not the lead agency and that their primary function was to address any accommodation and social problems rather than the matter of Matthew's withdrawal from medical supervision. It must also be borne in mind that Matthew was just as opposed to intervention by Social Workers as he was to intervention by doctors. We have no particular reason to suppose that a greater degree of input would actually have yielded dividends.

5.64 In her capacity as Matthew's Housing Officer Sue Wallace had a significantly greater degree of involvement. It might be thought that she was well placed to watch out for any significant alterations in his behaviour.

5.65 Ms Wallace was, however, in an unenviable position for two main reasons. In the first place Matthew was throughout a difficult tenant. He did not pull his weight in the house, he upset the other tenants and he had a generally awkward attitude. Ms Wallace found him both uncommunicative and intimidating. So it would in fact have been very hard for her to observe behavioural changes; he was always in her view behaving in a less than satisfactory way. Nor in any event could she have been expected to pick up the subtle signs of relapse which might have been apparent to a Community Psychiatric Nurse or a Social Worker.

5.66 Secondly Ms Wallace was not a member of the PACE team and her relationship with the team was not particularly good. On two occasions, in April and October 1995, she made strong complaints about the level of communication and meetings had to be convened to address these matters. We were led to understand that there may also have been other occasions when less formal complaints were made. In effect Ms Wallace seems to have thought that she was not getting enough support.

5.67 We therefore consider that it would have been both unrealistic and unfair to have imposed upon Ms Wallace a greater share of the burden of monitoring Matthew's progress. As it was, the plan formulated on the 30th November 1995 placed too much reliance upon her observation of him. She did not in fact get to see him at all in the period between the review and the homicide.

5.68 Another potential source of information and assistance was the police. This would seem to have been insufficiently tapped in Matthew's case. The evidence of any liaison in the latter part of 1995 is limited to the arrangements made for providing him with an appropriate adult.

5.69 One possible explanation for this is that although Matthew had a criminal record and was known to have psychopathic tendencies his management was not forensic.

5.70 There are historical reasons for this. The Denis Hill Unit was originally designed to service the whole of the region and it did not have a catchment area relationship with the four Lambeth and South Southwark districts. Thus funds for community services were channelled into separate clinics. Subsequently the Unit gradually became the clinic for West Lambeth and South Southwark, but it did not have a community or outreach service. The community team in the Nunhead sector did not have specialist forensic input. In 1994 funding was provided for a forensic outreach service in South Southwark, but by then the sector teams were already caring for mentally disordered offenders in the community. A special model was therefore developed, whereby what the forensic team provided was a liaison and consultation service.

5.71 The PACE team responsible for Matthew's care took advantage of that service in the period of Matthew's hospitalisation in 1995, when the reports of Dr Reiss and Dr Maden were obtained. Those reports set the tone for Matthew's later care by identifying the risks and delivering warnings. On the other hand there does not appear to have been any forensic input later in the year and in any event Matthew was not a client of a forensic nurse.

5.72 We feel sure that the members of the team did between them have considerable experience of dealing with offenders in the community, but Matthew's key worker from October 1995 onwards did not possess that depth of experience.

5.73 However, even if there had been a much stronger index of suspicion of criminal activity during the weeks leading up to the homicide, it does not follow that the end product would have been re-admission to hospital. The difficulty would still have been that on the 22nd December 1995 Matthew was assessed by Dr Wolff as mentally normal.

Communication with the Family

5.74 There is no evidence of any liaison with either of Matthew's parents between the time of his release from hospital in July 1995 and the commission of the homicide. They were not invited to attend any of the meetings which took place, they were not requested to provide any assistance in the monitoring process and they were not kept informed of the problems which arose.

5.75 To a large extent this was unsurprising. Although Matthew had kept in contact with his father, Mr Hooper had not been closely involved in his treatment and care. The PACE team had little reason to suppose that Mr Hooper would be willing to participate in the process of supervision or that he would be a useful channel for the passage of information. In the past it had been Mrs Hooper with whom there had been a dialogue and who had given warnings of relapse. However, following the assault by Matthew upon her the position had materially changed. She was no longer thought to be seeing him and one of the team's objectives was to maintain a distance between them and thereby significantly reduce the risk of violence.

5.76 We do nevertheless think that some effort ought to have been made to keep in touch with Mrs Hooper, if only to let her know what was happening. This might at least have altered her perception, expressed to Dr Wolff in February 1996, that she had always been unsupported and ignored.

5.77 Unfortunately Mrs Hooper had over the years developed an ingrained suspicion of the actions of the medical staff at the hospital and it is unlikely that she would have engaged with them. But there was arguably a role for the Social Services here and we consider that occasional visits to her by a Social Worker would not have come amiss.

5.78 Although communication down these lines ought to have been possible, we are satisfied that it would not have prevented the homicide. Mrs Hooper did have a degree of contact with Matthew in December 1995, but she did not observe any signs of a deterioration in his behaviour.

Medication

5.79 Matthew's apparent normality in December 1995, confirmed by Dr Wolff when he came to the Ivydale Centre, raises the interesting question of whether and, if so, to what extent his non-compliance with medication was actually of materiality to his actions.

5.80 Dr Maden clearly thought that medication was crucial and that without it Matthew would relapse quite rapidly and become a danger, in particular to his family. His opinion does, however, lie at the end of the spectrum. At the other extreme it is possible to argue that Matthew's violence stemmed largely from his personality disorder and that the incidence of assaults did not turn upon whether he was or was not compliant.

5.81 On the whole we think that the importance of medication was not that it removed the risk which otherwise existed, but that it did reduce the risk by making Matthew less likely to be volatile. Without medication, he would not necessarily become within a matter of weeks floridly psychotic; on the other hand it was unlikely that he would possess the same degree of judgement and self-control.

5.82 Even Dr Toone accepted that medication was a factor in the equation :

" I do not think you can easily sort of disaggregate the violence which stems from

a psychotic process, for want of a better term, and violence that stems from some abnormality, personality or social, cultural background. I think they are all rather intertwined and I think that, obviously, when he is on the edge of psychosis, he is likely to be more impulsive, more irascible, more dangerous. So I think that it (medication) was important actually, but ... I think that even had he remained on medication he might well have remained a danger for other reasons, but it would have reduced the level of dangerousness."

5.83 It is impossible to say with any measure of certainty that the homicide would have been avoided were Matthew to have been taking his Risperidone, but there would at least have been a respectable chance that he would have managed to contain his anger.

5.84 That being so, we have found it necessary to examine the reasons why Matthew was not on depot medication. Depot would have brought two advantages; it would have been longer lasting in its effect and it would have enabled the PACE team to know whether at any particular time Matthew was compliant.

5.85 There was a time in the mid-1980s when Matthew was in fact placed on depot. However, he complained about its side effects and eventually refused to take it. The argument against depot in 1995 was that he was unlikely to accept it once he was out in the community and there was a better prospect of compliance with a regime of Risperidone, which did not have side effects and which had worked to good effect while he was in hospital.

5.86 During the period when Matthew was on ES1 he complied freely with the oral medication prescribed for him. That encouraged Dr Toone and his team to believe that it was appropriate.

5.87 Once Matthew was on an open ward, a move from oral medication to depot was not really a practical proposition. For that very reason it was not recommended by Dr Maden, despite the fact that essentially he would have preferred Matthew to have been on depot. He told us that were Matthew to have been admitted to the Denis Hill Unit, he would undoubtedly have been put on depot. But when he was on an open ward and heading for rehabilitation in the community, the position was very different. The relationship with him was such that psychologically he would not accept depot and the only hope of compliance lay with Risperidone.

5.88 Thereafter Risperidone was always the preferred medication. Matthew remained compliant on the ward and for some time after his release he maintained that he was continuing to comply. We suspect that he did not always tell the truth in that regard and that before very long he was taking rather less than the prescribed dose. However, there was no conceivable alternative at that stage and the PACE team was quite right to pursue a policy of seeking co-operation rather than embarking upon action which was bound to produce conflict.

5.89 Of course in retrospect we can see that oral medication was doomed to failure and that when it failed nothing could be done to retrieve the situation. However, the same would have applied in the end to depot. Matthew would not have returned to Ivydale for a repeat injection and he could not have been forced to have one. It would only have been a matter of time before he became liable to relapse. The risk of a homicide would not have gone away.

Drug and Alcohol Abuse

5.90 In the mid-1980s Matthew was known to be a drug user. This complicated his treatment and was potentially a serious long term problem.

5.91 Remarkably, when he was re-admitted to hospital on the 9th July 1994, drug abuse was not a feature in his case. Nor did it became a feature subsequently. It appears that he had succeeded in overcome his habit. When he was seen and assessed by Dr Reiss on the 16th February 1995, he stated that he had last used illicit drugs 6 years previously.

5.92 The only evidence to suggest that by the time of the homicide Matthew might have reverted to drug abuse comes from the enquiries conducted by the police into his movements. It was then established that he had been associating with a heroin addict, who stated in interview that Matthew sometimes took drugs to calm himself down. However, that is as far as it went. The use of drugs was infrequent and not such as to make an important contribution to the way in which Matthew behaved.

5.93 This picture is entirely consistent with the findings of the PACE team between July and November 1995. At no stage was there any suspicion on the part of Simon Hughes that Matthew was taking drugs.

5.94 We are therefore satisfied that the homicide was not drug related and we have not embarked upon a review of the services which were available for the treatment of PACE patients with drug problems.

5.95 It is likely that Matthew had consumed a quantity of alcohol on the day of the homicide. This might have had a bearing upon the course of events by loosening his inhibitions. However, he was not an alcoholic and his drinking habits were not a source of any current concern, although he told Dr Reiss that they had in the past given rise to some fights. There was no reason for the PACE team to address that aspect of his lifestyle.

Detention in a Medium Security Unit

5.96 In retrospect there was nothing which the PACE team could have done to prevent the homicide and the die was effectively cast at the time of the decisions which resulted in Matthew's management on an open ward with a view to his subsequent return to the community.

5.97 There were two potential opportunities for long term detention under conditions of security. The first arose when Matthew was arrested for assaulting his mother and brother and charged with offences. Had the criminal proceedings resulted in a conviction, the Court would have been obliged to take account of the detailed report of Dr Reiss and his recommendation that Matthew should be placed in a medium secure unit with appropriate restrictions. The probability is that orders would have been made under Sections 37 and 41 of the Mental Health Act.

5.98 The collapse of the proceedings inevitably frustrated this outcome. The Court was left with no alternative but to discharge Matthew from custody. No residual power existed to detain someone against whom all charges had been dropped. That can be viewed as an unsatisfactory lacuna, but we see no obvious remedy for such a situtation.

5.99 The second opportunity occurred when Matthew was compulsorily detained on the 4th April 1995. Subject to the location of a suitable bed, he could thereafter have been transferred to a medium secure unit if the consensus of opinion had been in favour of that course of action.

5.100 What then stood in the way of endorsement of Dr Reiss's recommendations was the wording of the Act itself. No provision is made in the Act for the detention of a person whose dangerousness is considered to be attributable to an untreatable

personality disorder. Thus the team on ES1 who assessed Matthew and found no convincing evidence of mental illness could not have supported a move into long term security.

5.101 Of course the view held by Dr Toone and Dr Nayani was challenged. We are of the opinion that the challenge was justified, but we also recognise that both sides of the argument had merit. In any case, so long as there remained doubts as to the causation of Matthew's behaviour, he could not readily have been transferred to a medium secure unit.

5.102 The nature of the problem is encapsulated by Dr Szmukler :

" ... it is very difficult to argue for placement in a medium secure unit if you are asymptomatic and co-operating with treatment ..."

5.103 Medium security would have eliminated the risk, but that in itself could not have justified its use for a patient who was not exhibiting clear signs of mental illness. Moreover, Matthew could not have been detained indefinitely and on any showing there would have come a time when his release into the community could not have been avoided. Dr Toone made this point :

" my own feeling was that the main difficulties with Mr Hooper lay in his integration in the community, in persuading him to take medication, to remain in contact with psychiatric services.

That is something which I think could ... only be undertaken by his own sector service ... and I think in a way sending him to a medium secure unit was simply just postponing that issue, and I did not really feel that there was very much to be gained by it."

5.104 The final decision was ultimately entrusted to Dr Maden. This was an entirely appropriate course to adopt in the prevailing circumstances. It was, however, most unfortunate that pending Dr Maden's assessment Matthew was transferred onto an open ward. We cannot say that this action actually altered the outcome, but it would certainly have created difficulty for Dr Maden were he to have been of the opinion that medium security was the best way forward.

5.105 In the event, Dr Maden came to the conclusion that further prolonged detention in hospital was neither feasible nor desirable. That conclusion cannot be criticised.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 While in the community, Matthew posed a serious risk of harm to other persons. His history did not brand him as a likely killer, but there was an obvious danger of an incident resulting in a potentially severe injury to a member of his family or someone in the circle of his acquaintances and contacts.

6.2 Matthew was dangerous for two reasons. In the first place he had a personality disorder which made him anti-social and created a propensity for aggressive and violent behaviour. Secondly he had a longstanding mental illness which at times of exacerbation caused him to suffer from delusions of persecution by perceived enemies and diminished his powers of self control. These two elements were intertwined to the point of making it rarely possible to pin down which of them was responsible for any particular aspect of his criminal and other conduct.

6.3 Any aggravation of Matthew's mental disorder was liable to increase the risk of violence and the danger was therefore greater when he was not on medication, although the occurrence of incidents cannot simply be attributed to the absence of medication.

6.4 Matthew was frequently certifiable, but not always so. He could be detained under the provisions of the Mental Health Act when in a state of relapse, but he could not be held indefinitely. It is noteworthy that on each and every occasion that he was sectioned, he was subsequently released.

6.5 Matthew's case illustrates many of the problems faced by the authorities which

have the obligation to provide care for patients who are identifiably dangerous but not continuously ill and who fail to comply with their recommended regime of treatment.

6.6 If the danger to society posed by individuals such as Matthew is to be contained, it seems to us that a system for dealing with them has to be in place. This entails changes to the existing mental health legislation in respect of the following :

(i) The criteria pursuant to which detention and its renewal are permissible.

(ii) The use of secure units.

(iii) Enforcement of compliance with medication by patients who are cared for in the community.

(iv) Mechanisms for the support and supervision of severely ill patients in the community.

6.7 These points are not novel. Reforms to the statutory framework for dealing with mental disorder are currently under consideration. We do not propose to embark upon a detailed examination of the proposals, as they are already the subject of public debate. Suffice it to say that we endorse the need for a greater degree of confinement and control of patients who pose a risk to the safety of others.

6.8 The fact remains that in 1995 the available powers and options were limited. That explains why Matthew was in the community and why he remained there despite his non-attendance at appointments, non-compliance with medication and overall attitude of non-co-operation.

6.9 We are satisfied that the Trust operated suitable policies and procedures and that the service which it provided was generally of a reasonable standard.

6.10 We think that the PACE team and the Social Services did not perform particularly well in dealing with Matthew during the latter part of 1995, but that was largely due to the enormous difficulties which he created and also partly attributable to circumstantial factors such as staffing changes. Some things could have been done better and these have been identified in Chapter 5, but we do not consider that any of the staff to whom the care and supervision of Matthew was entrusted can be fixed with blame or censure.

6.11 Our **recommendations** are as follows :

(i) The existing provisions of the Mental Health Act should be broadened so as to ensure that those persons who have a history of mental disorder and dangerous behaviour can be more easily detained.

(ii) Secure accommodation should be made available and utilised in the case of all patients whose dangerousness calls for detention under conditions of security.

(iii) There should be machinery whereby the taking of prescribed medication by mentally disordered persons is capable of being enforced in cases with a history of difficult or dangerous behaviour.

(iv) Key workers should possess suitable qualifications and experience and they should be carefully selected.

(v) Medical staff ought not to be required to undertake the responsibilities of key working.

(vi) Key workers should be provided with formal training in the performance of their tasks and they should have access to supervision.

(vii) Care plans for patients on the Supervision Register should be detailed and provide for specific action in the event of default.

(viii) Care plans should generally not be altered without a proper review.

(ix) Reviews should be undertaken without fail at planned intervals and there should be a mechanism for ensuring that such is done.

(x) All interested parties, including informal carers, should be invited to attend review meetings and encouraged to provide input in the form of written observations if unable to attend.

(xi) In complicated cases clinical records should be prefaced by a summary highlighting the problems.

(xii) Statutory provision should be made for patients on the Supervision Register to have an obligation to comply with their care plan and for those patients to be subject to re-admission to hospital in the event that they fail to comply or their actions prevent adequate monitoring in the community.

(xiii) Patients on the Supervision Register should be closely monitored at all times.

(xiv) Regular forensic input should be obtained for all patients in the community with an established criminal record for violence and in these cases there should be close collaboration with the police.