Report of the Inquiry into the Care and Treatment of

Mi̊chéal Donnelly

A report commissioned by

North Essex Health Authority

Essex Probation Service

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APPENDICES

TERMS OF REFERENCE

1. To examine and review the reports of the internal inquiry into the case of Mičhéal Donnelly, including:

   i) The quality and scope of his health, social care and risk assessments.

   ii) The appropriateness of his care, treatment and supervision in respect of :

      (a) his assessed health and social care needs;

      (b) risk assessment of potential harm to others;

      (c) any previous psychiatric history;

      (d) links between the GP and the secondary psychiatric services;

      (e) the nature and extent of any previous criminal involvement or court convictions.

   iii) The extent to which his care corresponded with statutory obligations, in particular the Mental Health Act 1983, relevant guidance from the Department of Health (including the care programme approach) (HC (90) 23 LASSL (90) 11) discharge guidance (HSG (94) 27) and local operation of policies).

2. To assess the internal inquiry reports and their outcomes to ascertain if they reflect sound investigations, to view the evidence presented and to make other recommendations if necessary.

3. To consider any relevant comments made by the Judge in summing up or in sentencing.

4. To examine the inter agency relationships in this case.

5. To produce a report and make recommendations to North Essex Health Authority and other appropriate agencies.

MEMBERSHIP OF THE INQUIRY PANEL

Peter Herbert, Chairman, Barrister, part-time Immigration Adjudicator and non-executive Director of Ealing, Hammersmith & Hounslow Health Authority.

Dr. Chandra Ghosh, Consultant Forensic Psychiatrist, Central Nottinghamshire Health Care Trust; previously a Consultant Forensic Psychiatrist at Broadmoor Hospital.

John Walters, Chief Probation Officer, Middlesex Probation Service and Chair of the NACRO Race Issues Advisory Group for London

INTRODUCTION

1. Mr. Donnelly was charged with criminal damage against his mother's, Dr. Catherine Donnelly's, property on 7 October 1995. He was arrested by Essex police officers and bailed to appear at Colchester Magistrates' Court on 15 November 1995. Mr. Donnelly informed the custody sergeant that he had been diagnosed as suffering from schizophrenia and that he was currently on medication. As a result a forensic medical examiner was called who found him fit to be detained and fit to be interviewed. Mr. Donnelly, whilst in the police station, presented well mentally and was therefore released within a short space of time.

2. On 18 October 1995 Mr. Paul van Schaik, a solicitor, was contacted by the supported housing accommodation at CHAC (Colchester Housing and Care Project), where Mr. Donnelly was residing and agreed to represent him. On the understanding that Mr. Donnelly had a mental health problem Mr. van Schaik contacted Mr. Ian Clift, the Court Diversion worker, on 27 October 1995 and it was agreed that Mr. Clift would prepare a report for Mr. van Schaik.

3. On 15 November at Colchester Magistrates' Court it was decided by the bench that a pre-sentence report would be required on Mr. Donnelly in the first instance upon his guilty plea to the matters of criminal damage against his mother's property – Mr. Donnelly had visited his mother's house to discuss the repayment of a loan he had made to her. Upon his being refused entry because he was not expected, he had thrown flower pots through the windows of her car and taken paint stripper to pour in the goldfish pond outside.

4. A Community Psychiatric Nurse, Mr. Michael Close, had been allocated to Mr. Donnelly's case when he was discharged from The Lakes Hospital on 27 March 1995. He had been admitted following an earlier episode of criminal damage to his mother's property which occurred in February 1995. The Court Diversion Worker, Mr. Clift, who had visited Mr. Donnelly at the Lakes in February 1995, after his admission, had a good working knowledge of his case, having helped change his bail conditions. After discussion with Mr. Clift, Mr. Close arranged for Mr. Donnelly to see Dr. Baloch, the Consultant Psychiatrist who was treating Mr. Donnelly. This took place on 17 October 1995 when the frequency of his medication was increased from every 4 weeks to every 3 weeks. He was clear in disclosing to those working with him that he had resorted to taking cannabis in order to alleviate the side effects of his medication. Subsequently on 24 November 1995 Mr. Donnelly failed to keep his appointment with Mr. Close and therefore did not receive his depot injection. Information was received from his key worker at the Oxford Road Unit (a drop in centre) that he had destroyed the ampoules of injection which he had received from his General Practitioner, Dr. Marfleet.

5. There were discussions at this time, following the adjournment, for the completion of the pre-sentence report between the allocated probation officer Ms. Jacqui Hill, Mr. Ian Clift, the Court Diversion Worker, Mr. Michael Close, the Community Psychiatric Nurse and to a lesser extent with Dr. Baloch the Consultant Psychiatrist. In the meantime Mr. Donnelly missed an out-patient appointment to see the consultant psychiatrist on 21 November 1995 when another appointment was made for 12 December. Mr. Donnelly failed to keep that appointment.

6. He attended Court accompanied by staff from the CHAC accommodation on 13 December 1995. At Court it appeared that Mr. Donnelly was somewhat agitated. He was represented on the day by his solicitor's agent, Mr. Welsh, instructed by Mr. van Schaik. The probation report prepared by Ms. Hill made it quite clear to the Court that the Probation Service was unable to make a recommendation. Due to Mr. Donnelly's mental state it was considered that he would be unsuitable for either a Community Service Order or a Probation Order. Mr. Welsh took the view that it was not necessary at that stage to disclose to the Court the report which had been prepared by the Court Diversion Worker, Mr. Clift. The Court adjourned the matter to 10 January 1996 to obtain a psychiatric report

7. Within a week, on 20 December 1995, Mr. Donnelly had wrecked his flat in the CHAC accommodation slashing his settee with a knife; apparently because of some noise from a neighbouring tenant. This was reported to the General Practitioner, Dr. Marfleet, who attempted to see Mr. Donnelly but could not receive an answer from him. Mr. Donnelly's mother was by this in time in touch with her son with a view to taking him to Eire for a family wedding. She formed the view that it would be unsafe to take Mr. Donnelly to Dublin without his having taken his depot injection and she therefore presented him to The Lakes on 23 December 1995. He was given his depot injection on that day.

8. Whilst in Eire Mr. Donnelly bought a combat type knife which had to be removed from him by one of his brothers. He was also described by his mother as becoming "*violent, threatening and aggressive*" and had made a threat to knife a cousin whilst at the family wedding. Dr. Donnelly described disturbed patterns of behaviour on their return journey by car from Holyhead to Essex. These concerns were communicated by Dr. Donnelly to the duty team and concerns duly passed on to those at the CHAC accommodation who then reported that Mr. Donnelly appeared to be "*fine, calm and settled*" on 2 January 1996. There was, however, a note made by the Probation Service on 3 January 1996 that they had been advised that Mr. Donnelly had bought the combat knife over the New Year period and that he was to be treated "*with great caution*". There are then further reports from Dr. Donnelly about her son's disturbed behaviour when attempting to get access in order to recover his belongings from her house. In particular she stated that he had threatened "*to burn the house down*".

9. By contrast when he was seen by Mr. Close at the Community Mental Health Facility on 8 January 1996 it was noted that his mental state was "*stable*" that he was talking calmly and rationally with no paranoid feelings or evidence of any psychotic features. It was quite clear from the conversations Mr. Donnelly had with a number of professionals working with him that he wanted to decrease his medication or cease taking it altogether due to the side effects.

10. At the adjourned Court hearing on 10 January 1996 there was a number of irregularities. Mr. Welsh, the solicitor who had appeared on 13 December 1995, had made a clear note that a further probation assessment would be required for the adjourned hearing but neither the Probation Service nor the Court records have any record of this. The request for a psychiatric report was filled out on a pro forma normally designed for remands in custody and addressed to prison governors. Dr. Baloch, the Consultant Psychiatrist who had been treating Mr. Donnelly, never received that request and as a result there was no psychiatric report before the Court when it resumed for its hearing on 10 January 1996.

11. There had been some update to the report prepared by the Court Diversion Worker Mr. Ian Clift. There was contact during a brief adjournment on the day by Mr. Donnelly's Solicitor, Mr. van Schaik, with Mr. Clift in order to seek an explanation of some of the phrases used in the report. No one at Court that day appeared to pick up the fact that there was not a psychiatric report from a Section 12 Mental Health Act approved practitioner. Consequently the report prepared by Mr. Clift was accepted by the bench as the source of medical evidence and opinion as to the disposal of Mr. Donnelly. The Probation Service had clearly expressed the view that a Probation Order was inappropriate as they had done on a previous occasion when Mr. Donnelly was before the Court for a similar matter in April 1995. Mr. Clift however recommended a Probation Order which was on the day supported by his solicitor's submissions to the bench. It was indicated in the report prepared by Mr. Clift that the Consultant Psychiatrist had given her support to this recommendation during a conversation she had with Mr. Clift prior to leaving on vacation on 2 January 1996.

12. Colchester Magistrates' Court therefore passed a sentence for the offence of criminal damage and a breach of the conditional discharge relating to the sentence imposed in April 1995 of which Mr. Donnelly was in breach. He was therefore sentenced to a probation order lasting 2 years with a two-part additional requirement:

> "*that deft. attends any courses as directed by probation and that he also receives treatment including injections as required.* "

13. It is a matter of record that on that day neither the Court Clerk, the bench nor Mr. Donnelly's legal representatives nor indeed Mr. Clift were aware that such a sentence was illegal. It appears that this was first identified by Ms. Ann Taylor the allocated Probation Officer who raised the matter with Mr. Cowlin, another Court Clerk, at a meeting of the Colchester Probation Liaison Committee in late January 1996. Ms. Taylor expressed the view that the sentence had been imposed unlawfully as Schedule 1A of the Powers of Criminal Courts Act 1973 had not been complied with and that the ambit of the order may have been too directive in that the condition of treatment stated specifically that it was to include injections. Paragraph 5 of Schedule 1A of the Act refers to the requirement that there be "*evidence of a doctor approved under Section 12 of the Magistrates' Court Act 1983 before attaching a condition of medical treatment to a probation order.*" In the light of the concerns Mr. Cowlin arranged for the matter to be referred back to Court under the provisions of Section 142 of the Magistrates' Courts Act 1980 so that the bench could further consider the case.

14. Whilst the legality of the order itself became an issue in late January a Mentally Disordered Offender Panel met on 11 January 1996 attended by Mr. Clift, Mr. Michael Close, Mr. Alan Ramsey, Ms. Anne Taylor and Mr. Alan Critchley. It is recorded that apologies were received from, Dr. Seewoonarain and Miss Ellie Scrivener (CHAC). It appears from the invitation letter that a copy was received and seen by Dr. Euba the locum Consultant Psychiatrist standing in for Dr. Baloch. He had noted that Mr. Donnelly appeared to be refusing any contact with the Mental Health Services and therefore would not be in attendance. That Panel Meeting although without the presence of a consultant psychiatrist did undertake a risk assessment. It was decided that there would be a joint meeting between Mr. Close and Ms. Taylor and Mr. Donnelly which subsequently took place on 22 January 1996. Furthermore it was decided that Mr. Close was to notify the Probation Officer, Ms. Taylor, after one week if Mr. Donnelly failed to have his injection. It was also part of the plan that there would be a further out patient appointment to see Dr. Baloch. It was noted that there would be continued support from the "*drop in*" facility of the

Oxford Road project and that Mr. Donnelly would continue to receive support from care staff at his accommodation.

15. The day after the Mentally Disordered Panel Meeting Mr. Donnelly attended at the Community Mental Health Facility and received his now 3 weekly injection of 40 mgs of Depixol. The meeting with Ms. Taylor and Mr. Close passed without evidence that Mr. Donnelly was exhibiting any disturbed behaviour. By 5 February 1996 when Mr. Donnelly was given his next depot injection he made it quite clear that he just wanted his injection and to leave. He also stated that for the second time in as many months he had received his box of injections from Dr. Marfleet and then broken them all. It was clear that at this time he was again reluctantly agreeing to continue with his injections. On 20 February 1996 Mr. Donnelly attended at the out-patient clinic and was seen by Dr. Thu, in Dr. Baloch's absence on sick leave. She had available to her a letter addressed to Dr. Baloch dated 15 January 1996 from Mr. Close giving a general update on Mr. Donnelly following the Court hearing, the trip to Eire and the Mentally Disordered Offender Panel Meeting. There was nothing untoward noted by Dr. Thu, as stated in her correspondence to the General Practitioner, Dr. Marfleet, on 22 February 1996 and it was envisaged that there would be another out-patient appointment for Mr. Donnelly within 4 weeks.

16. The last entry by Mr. Close before the fatal arson on 4 March 1996 was to record the fact that Mr. Donnelly had missed a scheduled appointment to receive his depot injection on 23 February 1996. In light of the agreement made at the Mentally Disordered Offender Panel Meeting a note was made to communicate this matter to Ms. Taylor within the next week if no contact was made. Before the week had expired Mr. Donnelly had appeared at Colchester Magistrates' Court on 28 February 1996 where the condition of his Probation Order that he receive specified medical treatment was removed. The opportunity to look afresh at the sentencing disposal did not lead to a decision to adjourn matters in order to have a Consultant Psychiatrist's report prepared. Indeed the bench was told incorrectly that Mr. Donnelly was at that time complying with his medication. By that time the Probation Service would not have received the information from Mr. Close that he had missed his depot injection on 23 February only 5 days earlier and was again expressing great reluctance to take his medication. It seems that Mr. Donnelly's solicitor, Mr. van Schaik, after receiving information from the Probation Service, told the bench that all was well and that in effect Mr. Donnelly was taking and complying with his medication. It was in those circumstances that the bench took the view simply to remove the illegal part of the order.

17. In accordance with the agreement between the professionals at the Mentally Disordered Offender Panel Meeting, Mr.Close telephoned the Probation Service on Friday 1 March stating that no contact had been made with Mr. Donnelly and that his injection was now one week overdue. The message was noted but not picked up by Ms. Taylor until 4 March 1996 by which time the arson had already occurred at Mr. Donnelly's mother's house.

18. The events leading to the arson itself were that Dr. Donnelly had left a message on her son's answerphone stating that she was going to Belgium for the weekend. Mr. Donnelly returned the call and left a message on her answerphone and his mother and younger brother left for Belgium on 1 March. Mr. Donnelly was noticed by a neighbour to be working in the garden at his mother's home over the weekend whilst two of the three lodgers present in Dr. Donnelly's house were still in residence. In the early hours of Monday 4 March 1996 Mr. Donnelly had been, it seems, allowed access to the house and had during the course of the early hours of Monday morning 4 March 1996 started a

number of fires in the premises. One student lodger, a Mr. Gregory Gladwell, was woken by smoke alarms and managed to make his escape whilst the other, Mr. Matthew Bowyer, tragically did not awake and was later carried from the premises unconscious. Mr. Donnelly was still at the scene of the arson when the police and fire brigade arrived and admitted setting it alight. Mr. Bowyer tragically died from his injuries on 8 March 1996. In subsequent interviews Mr. Donnelly admitted setting off the fires.

19. On 12 December 1996 His Honour Judge Greenwood sitting at Chelmsford Crown Court accepted Mr. Donnelly's guilty plea to manslaughter on the grounds of diminished responsibility stating that he was clearly at the time of the offence and at the time of sentence suffering from a mental illness. Accordingly, he sentenced Mr. Donnelly under Section 37 and 41 of the Mental Health Act stating that Mr. Donnelly would reside at Rampton Hospital without limitation of time.

20. Upon being examined by Dr. Seewoonarain a Consultant Forensic Psychiatrist on 11 March 1996 it was clear that Mr. Donnelly had deteriorated to the extent that he had no insight into his mental illness. Although denying any abnormal experiences or psychotic symptoms it was felt that he had a long standing history of antisocial behaviour with violence to others. After the commission of the offence in March it was felt that any delay in transferring him to hospital under section 48 of the Mental Health Act 1983 at that time could have led to an onset of florid psychotic symptoms.

21. Whilst in detention, a few days after the incident, he caused serious damage to his cell to the extent that he had to be removed to a secure protective room and became further disturbed, the next evening damaging his cell again and using a bed frame to attack prison officers. There have since been a number of psychiatric reports prepared on Mr. Donnelly which expressed, inter alia, that he was suffering from "*chronic paranoid schizophrenia*" and continued to do so both at the time of the commission of the offence with significant deterioration in his condition subsequent to 4 March 1996. Indeed it has been of concern that the Inquiry panel, although wishing to see Mr. Donnelly, has not been able to do so on the advice of those having charge for his psychiatric care and his legal advisers.

22. We have been directed under the terms of reference to assess the two internal Inquiry reports and their outcomes which we have endeavoured to do both through the process of analysis and inquiries we have conducted and also through looking specifically at the two reports themselves. During the course of our Inquiry we have been at pains to examine each and every aspect of the care and treatment and supervision offered to Mr. Donnelly during the relevant period. We fully recognise that psychiatry can never be an exact science and that the collaboration of the care services can never be perfect.

23. We acknowledge the hard work, dedication and care of the professionals involved in the care, treatment and assessment of Mr. Donnelly. Nevertheless it is our duty, as commissioned, to examine carefully where gaps, omissions or errors of judgment have materially affected the quality of care given to Mr. Donnelly during this time. We have made allowances for the reasonable exercise of professional discretion which must, however, be balanced against the need to learn from what has occurred with the benefit of hindsight. We have in particular heard from the two families most directly affected by what occurred. We recognise the appalling tragedy that befell Mrs. Bowyer and her family and express our sympathy to them in their loss and the effect that it has had upon them. From a completely different perspective we have also heard from Dr. Donnelly as to her experience of caring for her son and we have drawn assistance from both women in addressing our minds to the crucial issues in this case.

24. We have, we believe, conducted a full and thorough investigation having interviewed a total of 25 witnesses over a period of some 12 days of evidence plus many days spent considering and analysing the information which we received. It is a basic premise of any such inquiry that it must be seen to be independent and fair according to the rules of natural justice and provide answers that would help to explain why this particular tragedy occurred and to make recommendations to avoid the reoccurrence in a similar setting of the same type of scenario. We have attempted to strike a balance between the needs to test recollection, explanations and to make sense of the sometimes contradictory nature of reports and documentation that came before us. We have performed this task whilst bearing in mind the difficulty for individuals of being called upon to recall and recount events now some considerable time ago and to reflect upon documents which at the time of recording were not envisaged as forming the subject matter of any public inquiry.

25. It is necessary, however, where appropriate to make criticisms of individuals or organisations bearing in mind the balancing exercise which we are attempting to achieve. In order to help to ensure that there was a fair and balanced approach the Inquiry had the benefit of learned Counsel supplemented by questioning from the Inquiry panel itself. We are aware that the government is at present considering the whole question of public inquiries both in terms of their manner and format. Having conducted this process over recent months we are aware as to the advantages and disadvantages of such a process. We have taken into account the many and various forms of statutory guidance in relation to mental health.

26. Home Office Circular 12 of 95 dated 9 May 1995 underlines the importance of inter agency arrangements with which we have been concerned in Mr. Donnelly's case. That circular stated that "*the full and timely sharing of information by all agencies having contact with mentally disordered offenders - in the criminal justice system, in health services, in social services and in the independent sector - is essential if each agency is to discharge its responsibilities effectively and to take sound decisions where health, liberty and the safety of the public are all at stake*". Information about an offender's past and current psychiatric state is necessary to enable the criminal justice agencies and the Court to take decisions about charging, prosecution, remand and disposal following conviction.

27. One of the basic problems in Mr. Donnelly's case was the difference of opinion between the Probation Service and the Mental Health Service about the disposal of his case, following his appearance in November at Colchester Magistrates' Court. Such fundamental disagreements between agencies cannot assist the proper disposal of a case. We have also had regard to the Home Office Circular 66/90 which urged that:

> "*Wherever possible mentally disordered people should receive care and treatment from a health and social services authority rather than be cared for within the criminal justice system.*"

28. We have also considered it of importance to set out the content of Home Office Circular 12/95 where it states that:

> "*Legal representatives acting in the defence of mentally disordered suspects have an important role to play in the implementation of effective inter agency arrangements in helping to ensure that the treatment and care needs of mentally*

disordered people are met, that this principle has to inform the culture and practice of legal representatives working in the criminal justice system with mentally disordered offenders."

29. It is evident in our view that many of the initiatives promoted by the Home Office and the Department of Health had not been implemented in North Essex to the extent that incidents such as these were more likely to occur in that context.

30. Some of the Care Programme Approach and full inter-professional working promoted by the Department of Health was introduced into North East Essex in April 1997, more than a year after the fatality of 4 March 1996. The same system failures, the absence of CPA and effective safeguards were previously examined in some detail by the Inquiry investigating the care of Christopher Edwards and Richard Linford. We have benefited from this previous Inquiry in so far as they are relevant and applicable in Mr. Donnelly's case. Where appropriate we have made reference to that Inquiry and even though that was a lengthier and more complex Inquiry, some of the same issues they raise have been underlined by this one.

31. We appreciate that the Government has recently announced a major review of mental health services and we echo the main recommendation of the Christopher Edwards and Richard Linford Inquiry where it states at page 6 that:

"Special consideration should be given to the arrangements for community supervision and support for patients discharged from psychiatric care, including improved powers of return to hospital where compliance with community care is failing. "

32. We would add the obvious and fundamental point that in order for that principle to be applied there needs to be a *"full and thorough exchange of information relating to a patient's care, accommodation and presentation throughout health, social services and the criminal justice agencies without which effective supervision would simply not occur".*

33. In addition we note that the Inquiry recommended that:

"There be a uniform system of risk assessment with a graded response and review system built in to inform each agency on a regular basis of a risk that may exist both to society at large and to an individual from his or her own actions. "

34. We would request that the commissioning agencies, particularly in the light of the recommended audit to be conducted upon receipt of the Christopher Edwards and Richard Linford Inquiry, conducts a needs assessment. This should identify those areas where the recommendations overlap between these two Inquiries and formulate a similar audit, avoiding any unnecessary duplication with the recommendations made in that Inquiry. It is our view that, whilst a care programme approach and the other developments in policy and practice may go a long way to preventing such tragedies in the future, it is only by a continuing review and monitoring of current systems as to their effectiveness and value that real progress can be made.

35. Finally we express our appreciation for the assistance given by Mr. Peter Greenwood the General Services Manager for North Essex Health Authority who provided the administrative assistance and back up for the Inquiry's work. We also received enormous assistance from Counsel to the Inquiry from Miss Tanoo Mylvaganam.

Peter Herbert, Chair
Mr. John Walters, Chief Probation Officer, Middlesex Probation Service
Dr. Chandra Ghosh, Consultant Forensic Psychiatrist, Central Nottinghamshire Health Care Trust

PART 1

ABOUT MIČHÉAL DONNELLY

Chapter 1

Family background and the first signs of mental illness

36. Mičhéal Donnelly was born at a nursing home in Dublin on 14 February 1967. His father was of Jamaican origin and his mother Irish. They were both medical students in Dublin at the time. Mičhéal Donnelly is therefore of mixed race, both by parentage and in appearance. His mother, Dr. Donnelly, placed him with foster parents in County Wicklow and thereafter maintained regular contact with her son until he was 5 years old when he returned to live with her in Dublin. Mr. Donnelly's early life was otherwise uneventful except for the fact that he did not talk until he was 3 years old and he had a problem with enuresis until he was 10 years old. Dr. Donnelly recorded that he was an attractive, responsive and well behaved child until the birth of his two half brothers at which point there is some evidence that he became jealous of his siblings.

37. By the time Mičhéal returned to live with his mother in Dublin she was having a relationship with Dr. Walshe. Mičhéal disclosed to several professionals that he had taken some pleasure in causing his two half brothers pain which appeared to go further than one would reasonably expect from a jealous sibling. The relationship with his stepfather also deteriorated with the birth of his two half brothers. Mičhéal felt that his stepfather favoured his own sons as opposed to himself. In an interview with the consultant psychiatrist, Dr. Kennedy, in November 1996 he however denied any ill-treatment of his brothers.

38. Mičhéal Donnelly started school in County Wicklow at the normal age of 4 and upon moving to live with his mother was sent to Sutton Park, a private school in Dublin. When he was 11 years old the family moved temporarily to Hertfordshire where his stepfather had obtained a job at Shenley Hospital. As a result of his early years Mr. Donnelly had always been close to his foster parents La and Nan Mullally as well as to an aunt. When he moved back to live with his mother he continued regularly to see the Mullallies and their children most weekends and during the school holidays until he was 10 years old when he moved to England with his mother and stepfather.

39. Mičhéal Donnelly attended school in Borehamwood and when he was 12 the family moved to Hornsey in London where he attended the Stationers' Company School. Dr. Donnelly cited one of the reasons for the move as being to ensure that her son had a more multi-racial environment than they experienced in Hertfordshire. Certainly Mr. Donnelly stated that he enjoyed the school's academic ethos and its diverse ethnic mix. He was however referred to an educational psychologist at the age of 14, when no evidence of mental impairment or handicap was found. Mr. Donnelly left school at the age of 16 having passed 6 subjects at O-level with average grades. He then went on to Southgate Technical College to do his A-levels but dropped out after a year soon after his parents moved to Colchester. Mr. Donnelly had stayed in London rather than disrupt his studies and move with the family to Colchester and thereafter continued at Southgate whilst staying briefly with his girlfriend's family and then with various friends and in bedsits. By the age of 18 he had dropped out of his 'A' level course.

40. Mr. Donnelly started drinking alcohol at the age of 11 and by the age of 15 was a regular drinker consuming 3 or 4 pints of beer at a pub once or twice a week. He started smoking tobacco at the age of 16. It was noted that in March 1996 he was smoking 20

cigarettes a day. He was introduced to cannabis by friends at the age of 17. He disclosed to various professionals that the smoking of cannabis was to help him cope with a horrible feeling inside his head which at various times he attributed to the neuroleptic medication that he was receiving from 1988 onwards. He was able to tell Dr. Seewoonarain in March 1996 that he started smoking cannabis regularly after he was 22 years old. He was able to recall in March 1996 that he had been a tree surgeon for a year during his period after leaving Southgate College. He had also, despite the onset of his mental illness in 1988, studied chemistry and biology at Colchester Institute in 1991 and passed those subjects at A level. He was offered a place at Aberdeen University to study forestry but subsequently left after a few weeks claiming that he was unable to tolerate the cold weather.

41. Dr. Donnelly records that her son seemed to have an unusually obsessive interest in war games and military paraphernalia and started killing birds with catapults and air rifles through his back window from an early age. He himself revealed that he had developed an early interest in explosives when he was 16 years old and admitted trying to produce phosgene at home on one occasion.

42. It appears that in about 1985 he was alleged to have attacked his younger brother and was asked to leave the house.

43. In 1986 he was charged with an offence arising after a demonstration at Wapping. His record shows that at Thames Magistrates' Court he received a £50 fine on 2 May 1986 for threatening behaviour. He spent some time in Eire following this conviction but on his return went to stay with the family in Colchester. There were frequent confrontations with his stepfather whose relationship with his mother was at that time breaking up. It was at this point that he moved out of the family home back to bed and breakfast accommodation in Archway in London and spent his year working as a tree surgeon following the hurricane of 1987. On 7 January 1988 at Snaresbrook Crown Court he was fined £100 and ordered to pay £100 costs for the possession of an offensive weapon It was at this time that Mr. Donnelly's behaviour began to alter seriously.

Chapter 2

1988 to 1992, hospital admissions, care and treatment in the community

44. Mr. Donnelly was first admitted to hospital under Section 2 of the Mental Health Act 1983 on 1 December 1988 when it was reported that he had travelled from London to Colchester wearing only his boxer shorts. His mother had reported that he had been paranoid, hallucinating and aggressive and carried knives possibly in the belief that the National Front was after him. A diagnosis of schizophrenia was made by his RMO who was Dr. Baloch. Within a few days he went missing from the ward and was found on his return on 5 December to be eating raw mincemeat and refusing any medication having no insight into his mental illness.

45. It was apparent by 23 December 1988 that Mr. Donnelly was still unwell and was still showing a great reluctance to take the prescribed medication. He was then detained under section 3 of the Mental Health Act as he had refused to remain in hospital as a voluntary patient. On his various weekend leaves he returned to live at his mother's house and began to do odd jobs around the house. Mr. Donnelly's discharge was authorised on 9 February 1989. It was noted in March 1989 that he was attending the Oxford Road Unit, a drop-in centre, and that in terms of his mental health he was looking very well although he was maintained on depot injections every month, administered in the community. He was maintained at that time on 40mgs of Depixol administered from the Oxford Road Unit.

46. Subsequent out-patient appointments, including the one on 17 October 1989, suggest that he continued to keep well, was working at the time as a laboratory technician living with his mother and being compliant with his medication. He was therefore discharged from the out-patient clinic.

47. However, by February 1991 his mental state had deteriorated. In December 1989 he had moved to a bedsit from his mother's house but had been involved in trouble with other residents. It had been noted that he believed they were "*gangsters and Ku Klux Klan*". He was involved in fights which resulted in the police being called and there was a court case pending at that time.

48. It is of note that at that time he was not offered an admission to hospital because it was felt that he was not responsible for the fight since the police had in fact charged the other two people involved. Instead his medication was reduced further and instead of being on Depixol 40mgs every month he was given Depixol 40mgs every 6 weeks. He continued to be seen as an out-patient and it was noted that he had offers of university places from both Aberdeen and Edinburgh to do a degree in forestry starting in the first week in September 1991. He was discharged from the out-patients' clinic on 14 May 1991.

49. By 7 June 1991 it was clear that there were further concerns about his mental health as it was noted that his mother commented:

> "*I am not sure that he is sectionable but he is heading that way.* "

50. At that time he was aged 24 and it was noted that he had lost 14-20lb over the past months as he had taken to eating only at nights. It was noted in the out-patient review that his explanation for the fights were that they were *"due to being racially harassed"*. On 11 June he also asked for a reduction in his medication, in spite of his apparent deteriorating mental health. There is, of course, the possibility that this may have been a symptom of his mental illness at this time. It was also noted that his mental condition was deteriorating.

51. There was a suggestion that he was becoming argumentative at work and claiming racial harassment. Despite this the medical notes demonstrated no evidence of thought disorder and it was suggested that he had no auditory hallucinations despite the fact that he was hearing people calling him *"wog"*. The psychiatrist rang his work and was informed by his manager that his performance had deteriorated considerably and that he was becoming extremely argumentative with the supervisor feeling that he was not coping. Whilst it was possible that he was indeed being racially harassed the supervisor claimed to have no knowledge of it.

52. On 22 June 1991 Dr. Donnelly wrote a strongly worded letter to Dr. Baloch expressing her frustration and disquiet at the way that a domiciliary visit had taken place and that in fact it had exacerbated the situation rather than improved it. This letter in our view sums up some of the mother's frustrations at this time and is useful to note as it contains a view of what the practical effects of living with her son were at that time. She commented,

> " *Mičhéal has spent quite some time this winter reading up on schizophrenia so is very prepared to counter all but the most sophisticated and elegant of assessments.....* "

53. Commenting on his behaviour she stated:

> "*I have the right to live an undisturbed...life on my own terms without being persecuted by a healthy 24 year old man who abuses and shoves and pushes me around. He spends up to 36 hours in bed some weekends...He now has a monk's type cape, boots and a 6 foot stick he wears in the evening to go out for a walk. Once again he is back into knives. He follows me around the house and sneaks up to hear my conversations with his brothers in case I am talking about him. What more of my life do I have to reveal to get my son treated.* "

54. The sense of frustration in his mother's situation was evidenced by her comments which exposed the two parallel feelings that she obviously held at that time for her son when she stated "*I desperately want rid of this appalling creature that tortures and haunts us and disrupts our lives - I also know the chances of him surviving on his own before October are very poor. However, I cannot take the strain on me and our home life any more. My youngest son and myself crying through a Sunday afternoon*".

55. In a later report that was prepared by Rampton Hospital during 1996 it was clear that at that time Mr. Donnelly felt that he was identifying with the Knight Templars. He felt that he was capable of scientific inventions as the Knight Templars had been, although it was quite obvious that he was leading a fantasy, if not a delusional existence.

COMMENT

56. It is important to recognise that none of these symptoms had been picked up during the out-patient reviews. Whilst it is correct that Dr. Donnelly had presented a

great deal of factual information in her letter of 22 June 1991 it does not appear that the possible extent of Mr. Donnelly's delusional existence was picked up at that time.

57. It is acknowledged that Mr. Donnelly had some skill in surpressing his overt symptoms and there is some justification for Dr. Donnelly feeling that he was able to present in a lucid and clear manner for the purpose of out- patient appointments. A more detailed examination of him may have disclosed the underlying and quite disturbed thought processes at work. Clearer links should have been made between reports of his behaviour and his mental illness.

58. On 30 July 1991 he was admitted at the request of his mother and there is a note that the police alleged that he broke into a shop in Turner Road and was found dancing naked upstairs. He admitted to smoking four joints of marijuana between 2pm and 12 midnight that day and had only a brief recollection of breaking a window at his mother's house and going out with only a hat on. The psychiatrist making the admission acknowledged that he was now relapsing in terms of his schizophrenia and the medication was altered to Clopixol 40 mgs every two weeks which did represent an increase in the dosage.

59. Following the admission on 30 July 1991 it was recorded only two days later that there was no evidence of psychosis with Mr. Donnelly's behaviour being noted as appropriate and rational in conversations. He admitted, whilst he was in hospital on 8 August 1991, to taking his injection only because he wanted his freedom and that was the only way he could leave hospital. During the interview with the staff nurse he avoided eye contact and the staff nurse noted that there was a lot of denial and that he appeared to find it very difficult to maintain a conversation. There was also a note that he was very angry with his mother. He admitted to smoking cannabis and that he was in general smoking too much at that time. He was subsequently discharged on 14 August 1991 in spite of these concerns and accommodation was found for him to live in a bed and breakfast.

60. By 20 August 1991 he failed to attend the out-patient clinic and another appointment was sent out. On 3 September 1991 he returned to the appointment and there was evidence of his deterioration with him talking about getting into more and more trouble, missing days from work and having dreams about people getting into the house. At that point an oral anti-psychotic medication i.e. Trifluoperazine 5mgs bd was added to the injection. On 17 September 1991 he was seen at the out-patient clinic and was said to be feeling much better settling into his new accommodation and waiting to start at Aberdeen University.

61. At that appointment his oral and psychotic medication was stopped and he was asked to continue on the injections of Clopixol on a reduced dosage once every 3 weeks. He was then discharged from any further out-patient appointments.

62. In April of 1992 Mr. Donnelly had been involved in a fight with a man whom he said had attacked him. Mr. Donnelly was arrested while holding a knife in his hand pointing towards the other man's head. He was subsequently charged with affray. That autumn Mr. Donnelly left England Eire, as he explained , in order to escape the charge of affray which he faced.

COMMENT

63. The psychiatric services do appear to have maintained an appropriate diagnosis of Mr. Donnelly. At times, however, his medication was reduced when there

was evidence to suggest that his condition had not stabilised or indeed was deteriorating.

64. The strategy for dealing with Mr. Donnelly appears to have been largely a reactive one, responding to the occasions when he was presented by his mother for treatment when there was evidence that his condition within the home was deteriorating.

65. There does not appear to have been a connection made between his deteriorating mental state at this time and his offending behaviour. It would appear that, in spite of the episodes of violence, fights and his carrying and threatening behaviour with knives, Mr. Donnelly was viewed as a relatively low risk by those responsible for his treatment at this time.

Chapter 3

1992 to 1994, residence, imprisonment, and treatment in Eire

66. Whilst in Eire Mr. Donnelly was charged with assault on a member of the Garda and sentenced to a period of custody at Mount Joy Prison in Dublin. His medical notes in Colchester show that a request was received via Dr. Donnelly on 30 July 1993 for a copy of his discharge papers and correspondence to be sent to a Dr. Hughes the visiting psychiatrist for Mount Joy Prison. He was seen by the prison medical services and as a result transferred to the Central Mental Hospital (the national high security hospital) with a transfer being effective on 22 December 1993.

67. There was correspondence from Dr. Mohan of the Central Mental Hospital to Dr. Baloch in March 1994 giving the brief history of what had occurred. It described the deterioration in his mental condition having pre-dated his prison sentence with his condition further deteriorating once the sentence had started. He was said to have become thought disordered and aggressive in nature whilst there was no evidence of overt psychotic behaviour. Whilst at the Central Mental Hospital he was treated with Dolmatil 400mgs bd., and it was stated that there was a good response to oral medication at that time.

68. A psychiatric report was prepared for Mr. Donnelly's solicitors in Dublin pending his court appearance recommending that he was well enough to attend court and have the charge against him dealt with. It confirms the diagnosis as that of a paranoid schizophrenic noting however that he did not demonstrate any evidence of paranoid ideas, hallucinations or aggressive tendencies at the time of the report dated 1 March 1994.

69. Whilst in custody in Eire he was charged with a further offence of assaulting a prison officer. The exact sentence is unclear but the court disposal allowed him to be released immediately. He then returned to Colchester, accompanied by his mother, and was seen by Dr. Baloch in the out-patient clinic on 22 March 1994.

COMMENT

70. Although not a great deal is known about his behaviour or his treatment whilst in Eire it is apparent from the report of Dr. Mohan that Mr. Donnelly's mental health did not dramatically improve whilst in Eire and that it was more than likely that his offending behaviour was a direct result of his deteriorating mental state.

71. There was by now a consistent pattern of association between violent incidents albeit of a fairly minor nature and his deteriorating mental state. One may assume that for him to be detained at the maximum security mental hospital in Dublin the risk assessment conducted there must have, by its nature, placed him in a fairly high risk category.

72. It appears that his treatment and care upon returning to Colchester was not influenced by the information which was available about what had happened in Eire.

73. The pattern of treatment was in general terms reactive to the demands of Dr. Donnelly and the presentation thereafter of her son at the out-patient appointments clinic.

Chapter 4

March 1994 to August 1995
The return to Colchester, hospital admissions and care and treatment in the community

(i) March 1994 to December 1994

74. Upon returning to Colchester from Eire Mr. Donnelly was informed that the charge of affray that he had sought to evade had actually been dropped by the Crown Prosecution Service. By 31 March 1994 however he was seen again urgently at the out-patients at his mother's request. He was described as deteriorating by his mother, having taken to his bed, not doing any work and feeling drained of energy. He did however agree to take an injection of 40mg of Depixol every month. There is also mention made at this time that a community psychiatric nurse was contacted, who agreed to give him his injection. Although there was some slight deterioration in his mental health at this time he continued to be managed through the out-patient clinic.

75. It was noted on 19 April 1994 that when he was seen he was getting depressed and referred to "*Work On*" (a work experience scheme), while waiting to go to the Oxford Road Day Centre and was taking his injection, despite extra pyramidal side effects. He was prescribed Procyclidine for those side effects. He continued to take his injections and appeared to improve once more so that by 19 July 1994 he was discharged from the out-patients' clinic once again. The situation continued to fluctuate in that on 20 September 1994 he appeared to be deteriorating again and there was a referral to the psychiatric services from his GP. He was admitted on a voluntary basis and presented with suicidal thoughts talking about wanting to hang himself and jump off a bridge or take an overdose.

76. Admission was suggested to the unit and an antidepressant was added to his oral anti-psychotic medication. On admission he continued to remain disturbed for a fair length of time, being described repeatedly as being unable to sleep, disturbed in mood, walking up and down, and then isolating himself staying in his room without talking to either his peer group or to other staff.

77. On his admission he apparently had delusional thoughts that other people thought he was "*Jack the Ripper*". This phenomenon about delusions of being thought of as a rapist reoccur later in his forensic history during 1995. It is noted by the care workers at CHAC

78. By 28 September 1994 he was considered to be improving and his auditory hallucinations had disappeared whilst the persecutory delusions were also in remission. He did however say that his mother was putting pressure on him to do A-levels and he appeared somewhat agitated at times. Discharge plans were made but were not implemented straight away and a further review took place on 5 October 1994 when he was described as being not depressed but feeling very unhappy because he had to be on benefits and could not get himself a job.

79. Mr. Donnelly said that he would like to stay at home and that he was not too happy about moving out. However, Dr. Baloch felt that this was not an appropriate arrangement. In spite of that fact he was discharged on 5 October 1994.

COMMENT

80. It is fair to say that there was a mixed pattern in Mr. Donnelly's presentation during this period. There were clearly times when his mental state had deteriorated and clearly other times when he was presenting quite well. Indeed Dr. Donnelly in April 1994 was quite optimistic and was said to feel quite good about the progress her son was making. It is fair to say that this may have been early days given that he had only just returned from spending a considerable period of time in detention whilst in Eire.

81. Whilst there is little to criticise objectively in his treatment and care at this time the pattern continues that he is considered a low risk both to himself and others and the treatment programme seems to be reactive rather than a proactive one.

82. Whilst it was suggested that he move to independent living and leave his mother's house he did in fact turn down one property in June 1994 on the grounds that it was too far from his mother's house to live. The second property nearer by was not taken up because he had changed his mind, having a preference to remain in familiar surroundings.

83. By 19 October 1994 he appeared to be better, claiming that he did not hear any more voices of people talking about him and stated that the plotting against him was only in his imagination, though he was not completely sure about that at the time. By 15 November 1994 he returned asking for an appointment to see Dr. Baloch and said he was doing so because his mother had told him to. On 21 November 1994 he was seen again, and the Registrar, Dr. Vartikovski, said in a letter to the GP, Dr. P. Marfleet, that he was presenting as tense, having spent several hours at home as he did not like to be with other psychotic patients.

84. He complained that the voices were rather unpleasant and asked for more medication especially at night when the voices were most intrusive. He reluctantly agreed to be referred to attend the Abberton Day Hospital 2 days per week. An urgent referral was made and he was seen by Dr. Thu the associate specialist. He continued to receive the Depixol injections 40mgs fortnightly (given at the GP surgery), Trifluoperazine 5mgs tds with another 50mgs at night, together with Lofepramine 70mgs bd. Mr. Donnelly did however admit at that time omitting to take his medication on occasions.

85. His medication was increased which was a reflection of the concerns that those treating him had about his continuing instability. He did however continue to remain treated as an out-patient.

86. When he was seen by Dr. Thu, the associate specialist, during the week of the 2 December 1994 Mr. Donnelly did inform her that he had stopped taking all his oral medication about a week previously. It was noted in a letter dated 2 December 1994 to Dr. Baloch that he had no insight although it was said that he appeared to be mentally stable.

COMMENT

87. There is a continuing pattern of Mr. Donnelly expressing his unhappiness and unwillingness to be bound by the advice and medication that he was being prescribed.

It is fair to say that those professionals encountering Mr. Donnelly found no effective formula at this time to deal with that aspect of his care that was causing concern.

(ii) January 1995 to August 1995

88. Mr. Donnelly was seen by the locum consultant psychiatrist Dr. Sommut on 9 February 1995 when he denied any paranoid ideation or auditory hallucinations. It was noted that his mood was stable although he had admitted cutting up his mother's plant in a temper recently. It was also noted that he presented quite calmly and rationally but was again advised repeatedly as to the need for ongoing medication with which he did not agree at that time.

89. By 9 February Dr. Baloch was informed by the Abberton Day Hospital that it had discharged Mr. Donnelly at his own request on the basis that he had stated he was feeling well without medication. Another appointment was arranged with Dr. Baloch within a further 6 weeks. It was also noted that Mr. Donnelly had commenced an NVQ horticultural training course in Braintree.

COMMENT

90. Another theme that has emerged at this stage was Mr. Donnelly's clear refusal to take his medication which by this time partly related to his mental illness. There were few if any overt signs of side effects of the drugs although this is a repeated complaint that he makes to professionals dealing with him. These appointments pre-date by only a few days further offences against his mother's property.

91. Another feature is that his offending behaviour and his deteriorating mental condition seem not only interlinked but often occur at a time when he is about to start or has just commenced some form of academic course. Whilst such courses would on the one hand be of benefit to an intelligent young man who clearly had an interest in those fields of study it brought an additional pressure which appears to have precipitated a deterioration in his mental condition.

92. It is again a feature of his presentation that he was viewed as a very low risk in spite of the incidence of violence relating to his mental condition which were well known by this time. His presentation to those assessing him appeared by contrast to be on the whole rational, lucid and calm. It is nevertheless of concern that, given his diagnosis, incidents of violence occurred within days of such an assessment being made.

93. Mr. Donnelly was subsequently charged with two offences of criminal damage to his mother's property on 12 and 13 February 1995. He was also charged in connection with an offence of threatening behaviour in April 1992 and a failure to surrender to bail in respect of that matter. On his appearance in Court on 15 February 1995 he was remanded on bail until 1 March on condition that he reside at The Lakes Hospital. He was actually escorted by police officers to The Lakes to fulfil that bail condition. He was admitted to The Lakes on 15 February 1995 and not discharged until 27 March 1995.

94. It was noted that he had stopped taking his depot injections in December as he thought it reduced his will power to refuse cannabis. At Christmas he said he had bought £10 of cannabis and smoked it. He admitted smashing up his mother's home, not according to him, in response to any delusions or hallucinations but because of his mother's attitude to him saying that she was "*very authoritarian and selfish and manipulative*".

95. On 1 March the case was adjourned to 22 March for the defence solicitors to obtain a psychiatric report which was provided by Dr. Baloch. On 22 March there was a further adjournment to 19 April for a pre-sentence report and for the defendant's solicitors to obtain an update from Dr. Baloch. Mr. Donnelly was discharged on 27 March 1995 with the discharge care plan stating that:

(i). "*Mi̊chéal 's mental state needs to be monitored. Needs to continue with anti psychotic depot injection.*

(ii). *Needs to live independently with some supervision.*

(iii). *To have a programme of activities at Oxford Road Day Centre."*

96. Under the proposed programme it was set out that he was to:

"(i). *Live in supervised accommodation in one of the CHAC houses.*

(ii). *For CPN Mick Close to follow him up in the community and also to administer his monthly depot injection.*

(iii). *Attend Oxford Road Day Unit. Has an appointment to see his key worker at Oxford Road (Rosemary Barker) today.* "

97. On 19 April 1995 the court received a pre-sentence report prepared by Mr. R.J. Gamble and an update from the mental health services provided, not by Dr. Baloch, but by Mr. Clift, community psychiatric nurse and criminal justice diversion worker. By this time bail had been varied to allow Mr. Donnelly to move into supportive accommodation and for him to receive regular depot injections from Mr. Close. There was at that time unanimity, by those reporting, on the arrangements that they would make to reduce the risk of him further offending and on that basis Mr. Donnelly was conditionally discharged.

98. It is of importance to note that the probation officer, Mr. Gamble, in his report dated 12 April 1995 stated that:

"*I have consulted with the senior probation officer and other colleagues and in our opinion this is not an appropriate case for a probation order in view of Mr. Donnelly's psychiatric problems and the very high level of support from the mental health services. I am satisfied that mental health staff are fully aware of the link between this man's offending and the maintenance of his monthly injection, and that they have taken the necessary steps to considerably reduce the opportunities for Mr. Donnelly to avoid taking this medication.* "

COMMENT

99. At this time one of the clear factors of work in the care treatment and Court disposal relating to Mr. Donnelly is that there appeared to have been a good degree of agreement between the professionals involved. There was no divergence of opinion between the mental health professionals and those working within the criminal justice system.

100. The bail condition imposed by the Magistrates' Court was a necessity because apparently Dr. Donnelly was unwilling to have her son living at home at that time.

The Court's decision was an extremely sensible one as it enabled Mr. Donnelly's condition to be monitored closely during the period of his admission to The Lakes on a voluntary basis.

101. The accommodation obtained also dealt with one of the concerns of Dr. Baloch in that it did for the first time on a consistent basis remove Mr. Donnelly from 46 Turner Road where there was clearly difficulties in his relationship with his mother.

102. There was an appropriate acknowledgement by the probation service and indeed by the mental health service that a Probation Order or a Community Service Order would have been wholly unsuitable.

103. The treatment and care plan made on his discharge from hospital was entirely appropriate to the circumstances prevailing at the time. It clearly informed the decision of the court to give him a conditional discharge. It is relevant to note that Mr. Clift says quite clearly in his letter to Mr. Donnelly's solicitors dated 28 March 1995 that:

> ***"At the time of the offence this patient was clearly suffering from a mental illness which contributed to him offending in the way that he did. Provided Mr. Donnelly complies with treatment the likelihood of further offending will be minimal. Furthermore owing to the support now in place for him the likelihood is further reduced."***

104. This view in effect reflected the consensus amongst professionals of the level of risk posed either to his mother or anybody else by Mr. Donnelly.

105. On reflection, given Mr. Donnelly's propensity to use cannabis and therefore dilute the effects of his medication and to engage in violent behaviour towards, not only his mother, but others as well, this assessment, in our view, was probably over optimistic and did not take fully into account the seriousness of his behaviour as it is presented in his earlier history and when he was in Eire.

106. There was general agreement between the probation service and the mental health services that the offences were part of a pattern of behaviour connected with a relapse in Mr. Donnelly's mental illness as a direct result of his failure to take medication.

107. The pre-sentence report contained appropriate quotes from Dr. Baloch underlying the fact that his failure to take his medication caused him to become aggressive. The arrangements for the care and supervision of Mr. Donnelly in the community at this time are evidence of an appropriate and consistent approach by both the probation service and the mental health services at this time. This episode stands in stark contrast to the divergence of opinion later in 1995/early 1996.

108. It was part of Mr. Donnelly's bail conditions that he stay away from his mother's house given that the criminal damage charge related to that property. It was noted however by Mr. Close, the community psychiatric nurse, that he was in *"occasional contact with mother who invited him to her home for lunch yesterday"* (despite bail conditions to stay away), an entry made on 5 April 1995. Apparently the damage to his mother's home was

valued at approximately £4,000 and although he asked her to drop the charges she persisted in maintaining them. On his discharge from hospital at the end of March 1995 he had begun attending Oxford Road on Tuesdays and Thursdays and attended the "*Work On*" programme on Wednesdays.

109. In a pattern that was to continue throughout his treatment it was noted on 13 April 1995 in Mr. Close's notes that "*said he would only like to have visits when injection is due and does not feel the need to be seen otherwise.* " By 27 April however there were some problems and it was noted by Mr. Close the CPN that there had been,

> "*Frictions within CHAC accommodation with fellow resident...no longer attending "Work On" as he felt it was slave labour for £5 per day.* "

110. As a result of the "*Work On*" programme ending Mr. Donnelly then went on to attend at Oxford Road for 3 days per week.

111. The initial CHAC accommodation was in a house with 3 other residents, two elderly and one with a learning disability. Subsequently he moved on 11 May 1995 to new CHAC accommodation at 211 Avon Way, Greenstead which was a more appropriate setting, with his own self-contained one bedroom flat.

COMMENT

112. There appeared at this time an appropriate level of co-operation between the probation officer Mr. Ray Gamble who had been preparing a report for Court for the appearance on 19 April. There had also been good communication between Mr. Close and Ms. Barker at Oxford Road not only about the report but the continuing care and supervision of Mr. Donnelly in the community.

113. In May of 1995 his injections consisted of a depot injection of Depixol 40mgs given every 4 weeks. On 11 May 1995 when Mr. Close administered his injection there was no note made of his mental state. However it appears that when he saw the GP, Dr. Marfleet, on 16 May he was displaying quite paranoid ideation, saying that he felt the army were out to attack him. Dr. Marfleet appropriately referred him for screening and the clinical notes made on admission speak of a,

> "*Coloured man, scruffily dressed, mildly agitated. Poor rapport, suspicious, mood scared, thought paranoid delusions; perception third person and hallucination; cognition - grossly abnormal; insight once admission as frightened does not think ill.* "

114. He was admitted on to the Peter Bruff Ward due to there being insufficient beds at The Lakes. The clinical notes make mention that Mr. Donnelly felt that the army was mounting a campaign to persecute him and was of the opinion that those ideas were justifiable and not psychotic. His mother expressed the wish if possible to go with Mr. Donnelly to Eire to celebrate her mother's birthday. There was contact with Dr. Baloch on 18 May with the intention that Mr. Donnelly make his way unescorted to The Lakes with the intention of being discharged into the care of his mother.

115. It was noted that Mr. Donnelly was delighted with this and although he appeared settled it was still noted that he was feeling mildly suspicious of helicopters flying around Greenstead and dead animals lying in the street. It is noted by Dr. Baloch : "*no psychotic*

symptoms and has full insight into his paranoid delusions. " Arrangements were made to see Mr. Donnelly the following week on his return from Eire.

COMMENT

116. Although it was clear from the clinical notes there was still some paranoid ideation present the assessment of Mr. Donnelly does not seem to regard him as any sort of risk either to himself or his mother at this time. In spite of this admission there was no attempt at this stage to increase his medication. This does seem somewhat surprising as the 4 weekly depot injection does not appear to have been maintaining his mental stability at this time.

117. By 25 May 1995 on his return from Eire he was seen in the out-patient clinic by Dr. Baloch and had by this time lost his paranoid ideas and had decided to stay in his flat and attend Oxford Road. It was not felt appropriate to change the frequency or the dosage of his depot injection; something it is clear that Mr. Donnelly did not want. There is a contradiction in the overall findings of Dr Baloch and Mr. Donnelly's presentation at this time.

118. He was seen again on 27 June 1995 in the out-patient clinic by Dr. Baloch and described as "very well." He was now going to Oxford Road only once a week spending some time doing conservation work and gardening at his mother's house. He had also secured a place at Essex University to do a degree in Physics apparently starting in October 1995. Dr Baloch made an entry which states "*says his mother pushes him to do this!* ". A second entry states that he "*has been smoking a bit of cannabis!!*"

COMMENT

119. Clearly Mr. Donnelly's treatment was being monitored and maintained through the out-patient clinic, the community psychiatric nurse and through Oxford Road. By this time there were clear patterns evolving which did not appear to alert Dr. Baloch and ought to have informed the risk assessment more keenly than it did at this time.

120. Firstly, those relapses in Mr. Donnelly's mental health seemed to be occasioned by significant changes such as anxiety caused by being accepted on a course of study, on this occasion to start in October at Essex University.

121. Secondly, that his continued use of cannabis, motivated by the desire to avoid the side effects of his medication, did reduce its effectiveness.

122. Despite these trends being noted by Dr. Baloch they did not lead to any change in Mr. Donnelly's risk assessment nor any alteration in the medication that he was being prescribed.

123. By mid-June 1995 it is apparent in Mr. Close's notes that Mr. Donnelly had settled into a one bedroom furnished flat at Greenstead, the CHAC accommodation supervised by staff. On 7 July 1995 there was an entry that he,

> "*Appears very well mentally, free from all psychotic symptoms. Agreeable to continue depot medication and attendance at Oxford Road.* "

124. On 4 August 1995 Mr. Close was unable to locate Mr. Donnelly either at his CHAC accommodation at Greenstead or at Oxford Road. He noted that he had not been in Oxford

Road all week. He was eventually seen and given his injection and it was stated that there were no symptoms at all whilst his relationship with his mother was described as "*OK*". The last entry for 31 August 1995 by Mr. Close stated "*remains well mentally, preparing to start at Essex University*".

COMMENT

125. It was apparent that Mr. Donnelly was being treated appropriately within the community at this juncture although there was some evidence that he had to be tracked down by Mr. Close in order to have his injections. Despite this appropriate level of support within the community it is clear by this stage that there was a pattern developing with regard to a deteriorating mental state.

126. These factors and a combination of these factors are the main issues which should have been apparent to all professionals dealing with Mr. Donnelly by the end of August 1995. It was clear that although he could be said to appear well mentally at a given point in time his mental health could deteriorate quite rapidly as could be seen from his admission to hospital in May 1995. This realisation was not apparent from the actions, or planning of mental health staff at this time.

PART II

CARE AND TREATMENT IN THE COMMUNITY AND THE CRIMINAL JUSTICE PROCESS SEPTEMBER 1995 TO MARCH 1996.

Chapter 1

Care and treatment in the community September 1995 to March 1996

(i) The Mental Health Services

September 1995 to December 1995

127. What can now be described during the six months leading up to the commission of the homicide on 4 March 1996 is in many respects almost a parallel of what occurred in February to April 1995. The Mental Health Services and the Criminal Justice System dealt with Mr. Donnelly in parallel but on this occasion with dramatically different results. The main difference, however, as one can see from the chronology of events is that with regard to the earlier offence there was a large measure of agreement and a good exchange of information between the Mental Health Services and the Criminal Justice System. In this latter scenario dealing with the period from September 1995 to 4 March 1996 the reverse was true.

128. Mr. Donnelly was referred urgently for assessment for admission to The Lakes on the evening of 22 September 1995 by his mother. He was assessed by the duty Senior House Officer and a staff nurse. In a letter sent by Dr. Baloch and copied to Ms. Rosie Barker of Oxford Road and to Mr. Close it was said that he had been smoking cannabis prior to his assessment and had become quite paranoid saying that he was being followed by drug dealers on the Greenstead Estate and that Israelis, Americans and Muslim fundamentalists were following him. He also thought he had heard a voice in a Southern American accent saying "*boy boy*". It was also recorded that he thought that people in the street were having conversations about him. He felt ecstatic and had intense feelings but denied feeling aggressive or violent in any way. In response to this he was given his depot injection 4 days early and sent home. Arrangements were made for an out-patient's review the following week.

129. There had clearly been a deterioration in Mr. Donnelly's mental state which had onset quite rapidly. By contrast on 31 August 1995 Mr. Close had noted that he "*remains well mentally*".

130. Dr. Baloch subsequently saw Mr. Donnelly in her out-patient clinic on 26 September. It was noted that his paranoid feelings and voices were less prominent and he insisted that he could not give up cannabis and was certain that the depot injection made him feel like smoking cannabis. Dr. Baloch noted that although he was due to start his University course in a week's time she was certain that in his present mental state he would not be able to cope with University studies. As a result of his presentation his depot injection of Depixol 40mgs was increased to be given every 3 weeks rather than monthly. He was also given a 2 week prescription of Chlorpromazine 50mgs tds.

COMMENT

131. Although it was appropriate in the circumstances to treat Mr. Donnelly by way of out-patient appointments and observations it was not clearly recognised that the risks of his offending and the risk to both himself and others was heightened

significantly if he persisted in taking cannabis, which he clearly intended to do. There was also heightened anxiety around the commencement of his university course. These risks were not clearly enough expressed by Dr. Baloch in her correspondence to Dr. Marfleet, copies of which were sent to Ms. Barker at Oxford Road and to the CPN, Mr. Close.

132. Dr. Donnelly, in her evidence to the Inquiry referred to the background to the incident on 7 October 1995 when Mr. Donnelly once again targeted his mother and her property, which resulted in him being charged with criminal damage. Speaking generally about her own safety she stated:

> *"I was aware that he was still very psychotic at the back of it, and I knew that I was often the target of his psychoses, whatever they were. So if I knew he was coming, I would insist that there was someone else present. As I had the lodgers in the house at the time, I did not feel that I was under that much immediate pressure. So he would come round as long as he had let me know beforehand, or if he did not turn up, say, for a week or so, I would go to his place. There was an intercom, so I could ring it and ask if he was there. So that I could keep a fair idea as to what was happening, but I could stay at arms length."*

133. Speaking of what happened on 7 October she stated:

> *"I could see him coming. I knew he was psychotic. So I was secure inside the house. So he stood outside damaging the car whilst I rang the police...I would get this idea from a slightly aggressive and loose way of walking when he was coming down...he was out there somewhere fantasizing, hallucinating about something else...so he was shouting outside at me and I was shouting inside because I was not going to step out whilst he was like that."*

134. It is fair to say that by this time Dr. Donnelly expressed clear frustration with the Mental Health Service for failing to take her complaints about Mr. Donnelly's behaviour seriously enough. She stated:

> *"I was fed up of sitting, telling people things and people then turning and telling me I was paranoid. So I was sitting there waiting for this weight of evidence to become so heavy that somebody would have to sit and assess it all and say, "this fellow really is dangerous. We have to start doing something positive about it. "*

COMMENT

135. In the light of Mr. Donnelly's pattern of behaviour and his deteriorating mental condition there ought to have been a more proactive approach adopted. Having presented with psychotic features and paranoid ideation on 22 September 1995 there was no change in his risk assessment. It was clear from the subsequent events on 7 October that the increase in frequency of the Depixol depot injection as well as the oral medication was simply not acting as a brake upon Mr. Donnelly's deteriorating mental state. That fact ought to have been appreciated after the incident on 7 October.

136. Mr. Donnelly was arrested at 16.25 pm and released at 07.55 pm and given police bail to appear at court on 15 November 1995. He was charged with criminal damage to his mother's car, having smashed all the car windows, and poisoned the fish pond with paint stripper. There was joint work noted between the Oxford Road project and Ms. Turrell of

CHAC who was responsible for contacting Mr. Donnelly's solicitor Mr. Paul van Schaik to arrange for Mr. Donnelly's representation before Colchester Magistrates' Court on 15 November.

137. There is a detailed explanation contained in the notes of CHAC made by Ms. Turrell on 8 October 1995. Apparently Mr. Donnelly had just started his course at university and his explanation was that he had lent some money from his disabled living allowance to his mother which she was only able to pay back to him in small amounts. He stated that he lost his temper and broke the pay phone. His mother had changed the combination locks to 46 Turner Road and as he was unable to get in he lost his temper and threw some flower pots at the car windows.

138. It was also noted that Mr. Donnelly had mentioned that someone had been in his flat because the kettle had been filled really high and the switch on the wall had been turned off. He was assured that no one had been given permission to enter his flat. There is also a note made that having spoken to Mr. Donnelly "*he could be entering a paranoid phase - smashing of objects is an outward sign that he is not so good at the moment -he is due to see Dr. Baloch on 17 October.*" There was a note made in the Oxford Road records that on 12 October Mr. Close "*feels no evidence of psychotic disorder prior to this period.*"

139. Echoing this sentiment there is a letter sent from Mr. Close to Dr. Baloch dated 12 October 1995 where he updates her on the criminal damage charge committed on 7 October 1995. He also reminds her appropriately that Mr. Donnelly received a two year conditional discharge after his last court appearance in April 1995 and states the date of his next Court appearance. Mr. Close expressed the fear that the damage to the public telephone box at Mr. Donnelly's accommodation after a conversation with his mother and his conduct generally could jeopardise his placement at CHAC although he stated that the staff continued to be tolerant and supportive.

140. The letter is of note because it states quite clearly Mr. Close's overall impression of Mr. Donnelly at this time. Mr. Close states in his letter,

> "*He has willingly accepted the monthly injections of I/M Depixol 40mgs from myself for the past 6 months but also continues to smoke cannabis regularly. Apart from some mild paranoid ideation at times he remains well mentally and the wild episodes do seem to be a consequence of the poor relationship with his mother, rather than due to any deterioration in his mental state.*"

141. It was also noted that Mr. Close had been in discussion with the Court diversion worker Mr. Clift at this time.

COMMENT

142. The observation made by Mr. Close was a serious error of judgement given the general deterioration in Mr. Donnelly's condition which had been evidenced by his assessment on 22 September 1995 only some 2 weeks previously. The assessment contradicted the assessment made by professionals in the earlier part of 1995 when the link was clearly established between a deteriorating mental condition and the offending behaviour against his mother's property.

143. Significantly Mr. Close failed to make any link between the taking of cannabis, the start of his university course and the violent outbursts against his mother at this

time. There appeared from this letter of 12 October 1995 to exist a compartmentalised view of Mr. Donnelly's mental health.

144. There was a disassociation between Mr. Donnelly's cannabis smoking and his offending behaviour which was seen to stand independently of his presentation, which was perceived as being that "*he remains well mentally*". This was a serious misjudgement as it prevented any proper risk assessment of Mr. Donnelly at this time. It is clear that it was this underlying error of judgement which led to some of the failures to pass on relevant information which were apparent in Mr. Close's work with Mr. Donnelly during this period.

145. Similarly despite the commission of the offence on 7 October 1995 the Mental Health Services remained in a reactive position regarding Mr. Donnelly. When a comparable situation had arisen in February 1995 he had been bailed to attend as an in-patient at The Lakes which he did for several weeks until his discharge on 27 March 1995. In spite of the fact that on this occasion he obviously had independent living accommodation there was no difference in his presentation in October as he had presented with paranoid delusions, was regularly smoking cannabis and had the increased anxiety associated with the start of his university course. The failure by the psychiatric services to take a more proactive stance in relation to Mr. Donnelly's treatment clearly gave out a signal to other professionals that there was no undue risk posed by Mr. Donnelly remaining in the community at this time.

146. On 13 October 1995 Mr. Close noted that he had been unable to contact Mr. Donnelly all week and there is an indication here that this was the start once again of a pattern that was to repeat itself whereby Mr. Donnelly, partly due to his university course, but more probably due to his deteriorating mental state deliberately set out to avoid meeting Mr. Close.

147. When Mr. Close eventually saw Mr. Donnelly on 16 October 1995 he was "*smiling, spontaneous and willing to discuss recent events, concerning damage to his mother's car.* " Mr. Close noted that he *"displayed no remorse or regret about his actions, except that he probably won't get his money back from mother.* " Mr. Close also noted that he was no longer attending Oxford Road due to the university attendance and was denying taking any cannabis for the past 3 weeks. It was once again said that he "*remains well mentally, no evidence of any psychotic phenomena. Not concerned about court case.* " He was given his 40mgs of Depixol on that day but was still refusing to take the oral medication that had been prescribed when he had seen Dr. Baloch on 26 September.

COMMENT

148. It is clear that there was a tendency for Mr. Close not to look behind the responses he received from Mr. Donnelly, accepting on occasions their apparent rationality. One explanation for this is that he accepted that his relationship with Mr. Donnelly had a specific and limited role. Mr. Close stated in oral evidence,

> "*He was never the sort of chap that wanted to open up and discuss in any detail about his affairs. He saw my coming to visit, as, I suppose, like a control, the fact that I was actually administering injections...it was a question of having to probe him, trying to engage him as best as I could at that stage.*"

149. Some of the contacts with Mr. Close were very short and limited for the purposes of giving injections only. The level of relationship was one it seems where it

was quite possible for Mr. Donnelly to mask his presentation in the relatively short periods of interaction he had with Mr. Close. It was therefore inappropriate for Mr. Close to suggest as he did on several occasions that Mr. Donnelly was "*well mentally*", on the basis solely of his observation of his manner. A very different picture would have emerged if this assessment had been informed by the observations of those who had spent more time with him.

150. On 21 October 1995 Ms. Turrell at CHAC wrote that "*he seemed really spaced out - tired - happy one moment - sad the next - he said his pattern is to feel like this over the next 5 days - he is angry about his medication today and telling me how he thinks he is taking it for the benefit of others to keep him "quiet*".

151. In that note there was clear evidence of paranoid ideation as it stated:

> "*Says the traffic is driving him crazy i.e. the noise. He also expresses the wish, probably unrealistically, to apply for a council flat.*"

152. In response to his presentation and continuing concerns the care workers at CHAC arranged for him to meet a therapist who specialises in anger management which would hopefully take place the following week.

COMMENT

153. The referral for the anger management course does not appear to have been known to Mr. Close, Mr. Clift or Dr. Baloch at this time. It is one of the first indications of a lack of consistency and an absence of the proper dissemination of information between the various agencies at this time.

154. Whilst not being critical of the motive behind this proposal, the possibility that Mr. Donnelly may benefit from an anger management course ought to have been directed by Dr. Baloch rather than come at the instigation of his care workers at CHAC.

155. On 23 October 1995 one of the care workers mentioned that:

> " *Mičhéal had woken me up at 1.30am on Saturday night in a distressed state - having bad nightmares and concerned that people were trying to get into his flat.* "

156. A note was made that they would be contacting the Mental Health Services as there was concern over his medication and paranoia. As a result of that entry Ms. Turrell spoke to Mr. Close regarding his present state. The note had been made that Mr. Close "*stated in general not much he can do while Mičhéal continues smoking cannabis.* "

157. This must be seen in contrast with a failure to record this telephone conversation and the information contained in it by Mr. Close in his own notes. Mr. Close next saw Mr. Donnelly several days later on 3 November 1995 and recorded the following:

> "*Says he has not used cannabis for the past few weeks.*

COMMENT

158. This appears to be the first of several examples where information received concerning Mr. Donnelly's paranoia and disturbed state of mind was not passed on either to the GP or to the consultant psychiatrist. Each item of information may not

have been of the most serious nature when viewed in isolation but together as a series of observations they were of crucial importance. There was a pattern developing whereby significant information was neither acted upon or passed to the relevant authorities.

159. It appears that Mr. Close was aware that the smoking of cannabis continued to be a problem. He then appeared, inappropriately, to accept Mr. Donnelly's assertions that he was no longer using cannabis which he stated repeatedly. Mr. Donnelly was assessed by everyone as an intelligent young man who would have some awareness of what not to say to those professionals dealing with him.

160. On 3 November 1995 Mr. Close noted the following:

"Remains well mentally no evidence of any psychotic symptoms... experiencing difficulty in coping with university studies and doubtful whether he will continue course."

COMMENT

161. No connection was made by Mr. Close as to the significance of the statement relating to Mr. Donnelly experiencing difficulty coping with his university studies. Again the significance of this is that his failure to cope with the university course was probably an indication of his deteriorating mental state and the anxiety caused by this failure would increase the risk of his offending and quite possibly aggravate his mental state on the basis of his past history.

162. On 26 October 1995 it was noted by CHAC that Mr. Donnelly was complaining that he had been called "*rapist*" by various persons in Colchester since an alleged rape on campus. On 27 October 1995 the workers at CHAC went so far as to encourage Mr. Donnelly to ring the incident room of Colchester Police Station and obtain a description of a white male 6' tall with 2-3 days growth of stubble who was the alleged rapist. This information was specifically obtained to allay Mr. Donnelly's fears.

COMMENT

163. The significance of this is that the information was not passed on to Mr. Close or to the consultant psychiatrist responsible for his care. If this information had been passed on it ought to have rang alarm bells as a further example of paranoid ideation, given that Mr. Donnelly had previously claimed that people thought he was a rapist. There was again a recurring symptom of his deteriorating mental state whose significance was not picked up by the professionals concerned.

164. Mr. Donnelly had an appointment to see Mr. Clift the court diversion worker on 3 November and saw him on the same day that he saw Mr. Close at the Community Mental Health Teams' offices at Holmer Court. In oral evidence to the Inquiry, referring to 3 November 1995 when he saw Mr. Donnelly, Mr. Clift said that he felt that he was very suspicious and very tense. He agreed that his perception differed quite clearly from that of Mr. Close in that it was evident to him that Mr. Donnelly was bordering on paranoia on that day.

COMMENT

165. This is an example of the very natural difference of opinion that can occur when two professionals see the same person on the same day at the same office. It is a cause for concern that, because of the absence of a risk assessment and the failure to

use relevant information that was held by CHAC, the perception of Mr. Donnelly was that he did not represent any greater risk.

166. Mr. Donnelly attended the out-patient clinic on 31 October 1995 and was seen by Dr. Velasco, Registrar to Dr. Baloch. On that occasion he complained of feeling drowsy, lethargic and being unable to concentrate after receiving his Depixol injection every 3 weeks. It was noted that he had started his course in business management and physics on 10 October but he said that he could not attend university for a week after his depot and requested that the dose be reduced. That request was not acceded to because the Registrar formed the view that he was still complaining of problems with his sleep with early insomnia and expressing some paranoid ideas. It was also noted by the Registrar that he had heard people in the street calling him rapist. It was also recorded for the first time that Mr. Donnelly had felt that when he was cycling car drivers deliberately passed quite close by him to try and intimidate him. Although it was noted that the Registrar was unable to elicit any other psychotic symptoms these matched the information that was being given to CHAC at the time.

167. There was further evidence of his deteriorating mental condition provided in the notes from CHAC dated 9 November 1995. There is an entry that he had been sleeping at his mother's house on the previous night due to traffic noise keeping him awake. Most significantly he was still talking about the ill-effects of his depot injections i.e. suicide and depression etc. It is also noted that he was not to go back on Procyclidine to lift his mood and that he was convinced he was being persecuted by Socialist Workers Party members at university. It is also noted that he was very determined to come off his depot injections and that his mood was very changeable.

COMMENT

168. None of this presentation formed the basis for information that was provided either to Mr. Close or to the consultant psychiatrist or the GP. Again viewed in isolation it may not be significant but taken together there is clear evidence that even on medication Mr. Donnelly was suffering from paranoid delusions. Mr. Donnelly often referred to his mental illness as a depression. Clearly the care workers at CHAC had probably the longest and most consistent opportunity to discuss matters of concern to Mr. Donnelly and to view his behaviour in general terms. Not only was this information not forwarded by them but it does not appear that Mr. Close had as high a level of liaison with them as he should have done.

169. One of the factors which may explain the lack of exchange of information was the response by Mr. Close when contacted on 23 October. He stated that there was not much he could do whilst Mr. Donnelly continued to smoke cannabis. Secondly, without having a full appreciation of the significance of the various symptoms the care workers at CHAC would not have much idea what information they should have passed on and why. Contrasting this situation after the commission of the offence with what had occurred in February and March 1995 the clear difference is that Mr. Donnelly's presentation was continually monitored whilst an in-patient at The Lakes whereas the same degree of monitoring was not in place or communicated as before after the incident on 7 October 1995.

170. The care workers at CHAC were however providing a positive role as is evidenced by the support given to Mr. Donnelly set out in a note dated 13 November 1995. It was noted that one of the care workers intended to go to Colchester Magistrates' Court with Mr. Donnelly that Wednesday 15 November 1995. It was noted that he was going to resume

"one to one" sessions with Ms. Barker his key worker at the Oxford Road Unit and was contemplating contacting Ms. Mary Humm in order to go on a "*Work On*" programme and acquire a craft skill. Mr. Donnelly repeated the comments made to Mr. Close stating that he felt that he could not sustain the level of concentration and commitment to complete his university course but intended to explore the options open to him through the Colchester Institute of possibly attending an access course. He evidently still had quite a lot of hostility at this time to his mother as he expressed the view that he did not wish to see her but had asked the workers to help him book a Christmas dinner with the Salvation Army. It was also noted that he was hostile to the idea of pleading guilty to criminal damage at that time.

171. On 15 November 1995 Mr. Donnelly did attend court represented by Mr. van Schaik and pleaded guilty. By 20 November 1995 it was clear that Mr. Donnelly had expressed his objection to continuing with medication through the action of breaking his depot injection ampoules. He had received those from his General Practitioner the same day as he attended at court on 15 November 1995. Ms. Barker, his key worker at Oxford Road, had noted that he would not accept his injection and that he felt that the legal system was "*taking the piss*". There was also clear antipathy towards attending for probation assessment that Wednesday.

172. This message was appropriately communicated on 24 November 1995 to Mr. Close who noted it in his own log. By the 24 November 1995 it was clear that Mr. Donnelly had not attended for his depot injection as was noted by Mr. Close.

COMMENT

173. The deliberate action of Mr. Donnelly in destroying the ampoules given to him by his General Practitioner which were to be administered by Mr. Close was a more serious development and a clear demonstration of his intent not to be medicated. This fact coupled with the evidence of a gradually deteriorating mental state, as evidenced by continuing examples of paranoia observed by the care workers at CHAC ought to have precipitated a more proactive approach to Mr. Donnelly's care at this stage.

174. On 1 December 1995 Mr. Close eventually located Mr. Donnelly at his home in the CHAC accommodation. Mr. Close was told not surprisingly that Mr. Donnelly had been deliberately avoiding him, that he no longer wanted his injection, even the reduced amount. Mr. Close noted that he would not pressurise him into accepting medication against his will. Amongst other things Mr. Donnelly complained he was feeling tired and lethargic in the weeks after the injection and had difficulty concentrating. It was noted that there were no psychotic features detectable and he denied any paranoid feelings. Again he reiterated that he had not smoked cannabis during the past few weeks. There is then the important entry in Mr. Close's notes that there would be:

> "*no further visits arranged until after Court case on 13 December. Did not attend out-patients clinic to see Dr. Baloch last week, does not feel the need for our service.* "

175. As a result of this view being expressed by Mr. Donnelly a letter was then written by Mr. Close to Dr. Baloch and Mr. Clift dated 4 December 1995.

176. The letter confirmed the delay in locating Mr. Donnelly and his view that he did not wish to continue medication and also his views of the difficulties it was causing him. It also contained the information that he had transferred his studies to a more manageable

course at the Colchester Institute and had resumed periodic contact with his mother again. He also stated that he had not smoked cannabis for the past few weeks and gave the date for his next Court appearance. Most importantly it stated he missed an appointment at Dr. Baloch's clinic "*because he does not feel the need to accept any help from ourselves*".

COMMENT

177. The letter of 4 December 1995 marks a clear opportunity for Mr. Close to provide a full picture to Dr. Baloch. The information presented does unfortunately give a less than full picture of Mr. Donnelly's presentation at that time. There is no indication of the paranoid ideation which the care workers at the CHAC accommodation had told him about. Neither did it contain the information that he had deliberately destroyed the ampoules of his injection and stated not only to Mr. Close but to all those who had connection with him that he was refusing to take his medication. It is of course possible that if a fuller picture had been presented to Dr. Baloch the psychiatric services may have taken a keener interest in Mr. Donnelly at that time. The final entry on the letter to Dr. Baloch was to have a significant impact, as it was the reason Dr. Euba gave for not attending the Mentally Disordered Offenders Panel Meeting called by Mr. Critchley of the Probation Service, where all professionals were meant to attend on 11 January 1996.

178. Whilst it is fair to say that Mr. Close did appraise Dr. Baloch of some of the relevant facts and maintained a reasonably good level of communication, he omitted crucial facts in relation to the presentation of Mr. Donnelly. It is obvious from the letter of 4 December 1995 and the preceeding one, dated 12 October 1995, that Mr. Close's assessment of Mr. Donnelly's mental state was based on short interviews and on self-reportage. Despite information which was contradictory to his own assessment, Mr. Close did not make the link between the aggressive behaviour and a deteriorating mental state. His failure to either acknowledge that link or his refusal to accept that connection meant that he did not seek a psychiatric assessment. This would have been the obvious step to take in order to review Mr. Donnelly's care plan and to seek psychiatric guidance as to how he should be managed in the community.

179. A telephone message was received by Mr. Close, from one of the care workers at CHAC on 11 December 1995 that Mr. Donnelly had broken a window at his accommodation over the weekend. They were not sure at that point whether it was deliberate damage. Mr. Donnelly's explanation was that "*I was throwing things at the building and missed and hit the window*".

180. On 19 December there is a note by the care workers at CHAC that Mr. Donnelly had "*trashed the flat*". There was apparently broken glass everywhere with a message left for Mr. Close "*to follow up and if necessary to arrange for specialists to see Mícheál asap*". It was clear that the disturbance had been frightening enough for it to be recorded that one of the tenants had been too frightened to leave her flat in the early hours of the morning due to the disturbance emanating from Mr. Donnelly's flat.

181. Following a conversation with Mr. Close it was recorded in the CHAC file that Mr. Close had to have authority from Mr. Donnelly before he could have an input. There was contact made with Mr. Donnelly's GP Dr. Marfleet regarding Mr. Donnelly's condition. It was envisaged that if there were any reoccurrences regarding Mr. Donnelly's behaviour then the CHAC caseworkers would phone the GP for advice and assistance.

182. The fact that he had smashed up his flat was also information which Mr.Donnelly gave to the Oxford Road Unit. There is also information given to Oxford Road that he had walked out after his Court appearance which mirrored the recollection of his solicitor's agent Mr. Welch who recorded him as being difficult to deal with on the day.

183. By this time his sentencing had been adjourned from 13 December to 10 January 1996 in order for a psychiatric report to be obtained. As a result of the concerns passed to Dr. Marfleet, he visited the CHAC accommodation on 20 December but could get no reply. He had also by this time failed to attend to see Dr. Baloch at the out-patient clinic on 12 December. On 21 December Mr. Close noted that he had a discussion with Mr. Clift who told him that the court had requested a psychiatric report before sentencing. A case discussion had also been arranged for the Mentally Disordered Offenders Panel meeting on 11 January 1996.

184. There is also a file note by Mr. Close that he had had discussions with Mr. Clive Burgess, the project worker at CHAC, who had passed on the information that Mr. Donnelly had wrecked his flat earlier in the week and had virtually broken everything.

COMMENT

185. There were clearly signs conveyed to Dr. Baloch, Mr. Close and Dr. Marfleet that Mr. Donnelly's mental health was far from well at that time. There was also clear evidence that he was deliberately avoiding taking medication and avoiding being monitored through the out-patient clinic. The letter from Dr. Baloch does not reflect the seriousness of the situation in that it does not take a proactive stance with Mr. Donnelly and insists on him being monitored closely through the out-patient clinic. This omission coupled with Mr. Close's decision not to act upon the information received from the CHAC accommodation on 19 December 1995 and request an assessment by the Mental Health Services amounted to a serious omission in the care and supervision of Mr. Donnelly in the community.

186. Even allowing for the fact that Mr. Close viewed Mr. Donnelly's violent and offending behaviour as attributable to his relationship with his mother this does not explain the reason why no action was taken when he extensively damaged his flat in the weekend of 19 December 1995. Mr. Donnelly's presentation of continuing paranoid delusions which had been identifiable since the 8 November 1995 ought in our view to have precipitated a formal forensic psychiatric assessment of Mr. Donnelly.

187. This assessment was particularly necessary as Mr. Donnelly had not received a depot injection since 3 November 1995. Mr. Donnelly's behaviour was clearly that of somebody who was out of the control of the Mental Health Services, in that he had successfully avoided any medication and yet no action had been taken under the Mental Health Act to assess his mental health needs, given the paranoia that he was displaying, as well as the violence to property.

188. The violence to property was all the more significant because the damage to his accommodation at 211 Avon Way had nothing to do with the dysfunctional relationship with his mother, to whom his excessive behaviour had been attributed by Mr. Close and to a lesser extent by other professionals dealing with him. This was a clear departure from his previous mental health history. Mr. Close acknowledged that *"for over 6 months he was never more than a day or two out with his medication.* "

189. On 19 December 1995 Mr. Alan Critchley, the senior probation officer, wrote to all the professionals concerned in the care and treatment of Mr. Donnelly setting out the need for a Mentally Disordered Offenders Panel meeting on 11 January 1996. The copy in the North East Essex Mental Health Services file has an endorsement from Dr. Euba which reads as follows: "*I will not attend. Mr. Critchley contacted and informed that Mr. Donnelly wants no further contact with psychiatric services.* "

190. The information which precipitated that entry by Dr. Euba can only have come about after Dr. Euba looked at the file note on Mr. Donnelly which would have contained the last letter from Mr. Close to Dr. Baloch dated 14 December 1995 where he had stated that "*he does not feel the need to accept any help from our service.* "

191. Dr. Euba's decision not to attend the panel was communicated to Mr. Critchley, who was not aware at that time of a great deal of information which became available at the panel meeting. He was, to that extent, poorly placed to assess the importance of a psychiatric input to the panel's deliberations. In any event he did not challenge Dr. Euba's decision and did not review the position on learning about the purchase of a combat knife.

COMMENT

192. Although Dr. Baloch believed that she had a conversation with Dr. Euba about the handling of Mr. Donnelly's case clearly that cannot have occurred otherwise Dr. Euba would not have made the comments on the letter of invitation that he did. If there had been such a conversation between Dr. Baloch and Dr. Euba expressing concern about Mr. Donnelly's treatment it is highly unlikely that Dr. Euba would have absented himself from the Mentally Disordered Offenders Panel Meeting.

193. By the end of December 1995 there was serious cause for concern in the care and supervision of Mr. Donnelly in the community. The concerns fell into three main categories:

(i). His failure to present for medication between 3 November and 23 December 1995. It was clearly stated, by Mr. Donnelly on several occasions, to different professionals, that he did not wish to take his medication, a fact underlined by his smashing of the ampoules.

(ii). The continuing concerns that Mr. Donnelly was having access to, and smoking cannabis regularly despite his statement that he had not smoked cannabis for several weeks.

(iii). The episodes of violence which continued to occur after 7 October 1995 when the target at that time was his mother's property. This was also accompanied by continuing evidence of paranoid ideation well documented by CHAC during conversations with Mr. Donnelly and picked up by the registrar Dr. Velasco when he saw him on 31 October 1995.

COMMENT

194. The significance of these concerns taken together is that the psychiatric services had failed to initiate any proactive strategy to deal with this new situation. Mr. Close the community psychiatric nurse whilst having previously dealt appropriately with Mr. Donnelly failed during this period to initiate any action which would have led to a reassessment of Mr. Donnelly. As has been discussed already several aspects of information failed to find their way to Dr. Baloch, who was still the

consultant psychiatrist responsible for Mr. Donnelly's care, prior to her leaving on holiday which she did on 1 January 1996.

195. Mr. Close checked with Mr. Clift that he was proposing a formalised arrangement for the continuation of Mr. Donnelly's medication by incorporating it into his probation order as a requirement for him to accept treatment. He also recorded having some conversation with the probation officer Jackie Hill who was preparing the probation report on Mr. Donnelly at that time. Mr. Close expressed the view that he did not see the need in December for any urgent action to assess Mr. Donnelly stating,

> *"I did not feel so at that stage because my records show that he denied any paranoid feelings and no psychotic features were detectable when seen on 1 December, and he was in the process of transferring his studies from the University to the Colchester Institute which he was finding more manageable."*

196. He went on to state that Mr. Donnelly did not want to attend,

> . *"..at Dr. Baloch's clinic, he did not want his injections, he did not want to see me, I felt all I could do was convey that to relevant people involved with his care which I did on 4 December...there did not seem to me to be any deterioration. I mean, I had nothing. When I could not have contact with Mícheál, I had no reports from anyone else to indicate that he had deteriorated."*

197. When questioned about the destruction by Mr. Donnelly of his flat Mr. Close expressed the view that,

> *"I cannot recall informing Dr. Baloch at that stage but there was a plan on that day (19 December) to have a Mentally Disordered Offenders Panel meeting."*

198. Mr. Close expressed the view that he had discussed with Dr. Marfleet the incident in relation to the flat but he was not sure about the incident relating to the breaking of the window at the CHAC accommodation. Mr. Close did acknowledge that if he felt that something was getting serious or was an emergency he would have arranged admission screening.

199. In summing up his view of Mr. Donnelly at that time Mr. Close stated *"I had no reason to believe he was unwell at that time, even though he was not seeing me. It was his mother who took him into The Lakes two days before Christmas."*

200. Dr. Donnelly on the occasions that she saw her son had formed the view that he was clearly not taking his medication and she could see that he was not taking it. She wished to take her son with her to Eire to a family wedding and would not travel with him unless he had received his depot medication.

COMMENT

201. It is of note that the only effective mechanism for ensuring that Mr. Donnelly complied with his medication came in the form of a presentation at The Lakes by his mother. It should not at this time have taken his mother's actions to have presented him at The Lakes for his assessment. Care in the community had effectively been abdicated at this point. His mother's motivation was that she wished to take him to Eire for the family wedding and was obviously aware that without taking his medication there was no hope that his behaviour would be tolerable whilst he was

there. Dr. Donnelly, although having some idea that he was not complying with his medication, would have been unaware of the extent to which he had been experiencing a deteriorating mental state over recent weeks and months.

202. Mr. Donnelly's departure to Eire was the subject of a message from Dr. Baloch to Mr. Close with a note that *" Mičhéal has gone to Eire with his mother for Christmas.* " The message relating to his mother stated that " *Mičhéal 's mother had taken him to The Lakes, demanding that he be given his depot injection, to which he had agreed.* "

(ii) The trip to Eire

203. The reports of the trip to Eire come essentially from Dr. Donnelly, in her evidence to the Inquiry, who described a difficult trip with her son and his brothers in the car from Colchester to Holyhead to catch the ferry. Dr. Donnelly gave a graphic account of a journey in freezing temperatures where she had to get out repeatedly to defrost the window with her son "*going on and on about how dangerous it was, how he was risking his life doing things like that.* " The family travelled just before Christmas Day and almost immediately after Mr. Donnelly had his depot injection at The Lakes. Apparently his behaviour seemed to settle for a while in Dublin possibly because as Dr. Donnelly stated "*he felt reassured, being surrounded by the family and things going on.* " It appeared that Dr. Donnelly was still wary about his state of mind although he appeared well contained and controlled and calm on the surface. Shortly after Christmas, however, she said that they had discovered he had purchased a combat knife.

204. Mr. Donnelly told his younger brother he had a knife and the brother immediately told Dr. Donnelly.

> "*I knew that it did not matter whether it was a combat knife or a kitchen knife...whatever it was going to be. That I knew he had gone out and bought a combat knife, I knew that was his way of thinking and what he was homing in on.*"

205. Dr. Donnelly described that he lived in a fantasy and delusional world, described such comments back to his childhood when she said he took an unrealistic and obsessive view with things military. She described him decorating his room with tanks and soldiers and guns marching up the walls, across the ceilings and down the other side.

206. A threat was made at the wedding a few days after Christmas. Mr. Donnelly had already bought a combat knife and brought it back to the house where it was discovered and removed by his younger brother. Whilst at the wedding Dr. Donnelly stated that in the course of the reception afterwards he threatened to knife one of his cousins. She described the scene where everybody was sitting quite politely concerned simply with the ceremony when her son asked his cousin out of the blue "*do you want to be knifed at a wedding?*"

207. Dr. Donnelly described that her cousin did not respond and her son, Mr. Donnelly, just smiled, she felt "*because the medication was beginning to take effect on him and he kept falling asleep.* " There were further concerns raised by Dr. Donnelly on their return from Dublin which she described as follows:

> "*His behaviour on the way back from Eire was really horrendous, because again, we came back and instead of the 6 degrees we had on the way over, it was foggy all the way down. So, we were driving back through this - Mičhéal kept falling asleep, then he would wake up. When you are driving through fog at night-time, things are*

quite hallucinatory, and Michéal kept waking up and kept thinking that things were going on, and the rest of it. This was really getting to him. So he got extremely agitated and insisted that we stop on a number of occasions, that everybody got out and walked around so that he could see that nothing had happened, we had not crashed, everything was going on quite all right; and Michéal would walk around, and then keep insisting that we were not driving all the way back, that we better find some place to stay, and he was going to pay for us to stay the night rather than keep on driving...He was getting very, very agitated with this fog. "

208. Apparently when Dr. Donnelly did not let him out at her house because she was not letting him in at that stage he became agitated and jumped out of the car at a roundabout and ran off. It was as a result of that that she got her son to come and change the number of the locks at the house.

COMMENT

209. It is clear that on the balance of the information later given by his mother concerning the trip to Eire Mr. Donnelly's mental health was anything but stable. There had been the return to the recurrent themes of paranoia, the purchase of combat knives and the issuing of threats of violence this time to a cousin at a wedding. All these were clear signposts of a deteriorating mental condition which had not been arrested by the depot injection given on 23 December at The Lakes.

(iii) Care and supervision in the community between 2 January 1996 and 10 January 1996

210. On 2 January 1996 the duty social worker of the Mental Health team, Ms. Sarah Spratling received a phone call from Dr. Donnelly expressing her concern about her son stating that he was now "*violent, threatening and aggressive*". She took down details that he had bought an combat knife which was taken from him by a member of the family. Dr. Donnelly had also stated that he is "*quite paranoid*" about the people he lives with. It was also noted that he had threatened a cousin in Eire.

211. The action taken by Ms. Spratling was that she tried to contact Mr. Close with a view to asking him to phone Dr. Donnelly the next afternoon i.e. 3 January 1996. She later contacted Mr. Close who agreed to telephone CHAC who apparently said that Mr. Donnelly was seen by a support worker at about 3pm on 2 January and appeared "*fine*". It was also noted that Mr. Close intended to visit Mr. Donnelly the next day at his accommodation at 211 Avon Way.

212. A note was made by Mr. Critchley, on 3 January 1996, to advise the court duty probation officer that Mr. Clift had rung to advise that over the New Year Mr. Donnelly had bought a combat knife. The entry stated "*please treat him with great caution.* "

COMMENT

213. Although it is right to say that the purchase of the combat knife and the incident in Eire was communicated quickly and efficiently by Mr. Close to both Mr. Clift and thereafter to the Probation Service as well as to CHAC this was not information that was communicated at this stage to Dr. Baloch or to the staff who took over Mr. Donnelly's care at The Lakes. There was a distinct difference at this point between the risk that the Probation Service assessed as being posed by Mr. Donnelly and the risk which the mental health service assessed that he posed to the community or himself at this time.

214. Mr. Close discussed the latest developments on 2 January 1996 with Ms. Ellie Scrivener the manager at CHAC who recorded that he "*sounded surprised by mother's concern; because Michéal had been talking to staff this afternoon and had appeared to be fine, calm and settled.*" Mr. Close made an arrangement to visit Michéal the next day and to liaise with his mother.

COMMENT

215. Mr. Close at this time maintained an appropriate level of contact with CHAC and moved quickly in order to see Mr. Donnelly for himself. It is of note that he had waited until this juncture to speak to Dr. Donnelly although until then he had been acceding to Mr. Donnelly's wishes not to have any contact with his mother.

216. On 3 January 1996 when Mr. Close attended to visit Mr. Donnelly no meeting took place. There was no response when he called, although it was felt that he was there but refusing to answer the door to Mr. Close, who by that time was associated with the giving of a depot injection. He left a message to say that he would see him either at his flat or at the Community Mental Health Team at Holmer Court if he preferred.

217. There then followed a discussion, at some length with Dr. Donnelly, who is recorded as stating that she did not want anything more to do with him and recounted his behaviour in Eire as having been "*unpleasant, obnoxious and sometimes threatening*". Mr. Close recorded the fact that he was paranoid about other people in the CHAC accommodation. Dr. Donnelly stated the view that he had "*manipulated his way into staying with her prior to Christmas*". She also expressed the view that he was reluctant to continue his medication and only had the last injection at The Lakes at her insistence prior to going to Eire. She also recounted his purchase of a combat knife in Eire and the removal of it by a family member.

218. In his entry for that day Mr. Close set out a plan which had two limbs to it: the first being his reappearance in Court on 10 January 1996 for sentencing, and the second the panel meeting which had already been arranged by Mr. Critchley for the day following that, 11 January, to discuss his "*future care and management*".

219. On 4 January 1996 Mr. Close recorded a phone call from Dr. Donnelly stating that:

> *" Michéal has just been to my house looking for belongings he left behind - he was unable to gain access because mother had had security digital lock changed. Mother states that she is concerned because he threatened to "burn the house down", and is also worried that he may have acquired another knife."*

220. The response of Mr. Close to this extremely serious piece of information, in the light of the earlier history, was that he advised Dr. Donnelly to contact the police immediately if she had any concerns regarding her safety. Mr. Close also contacted the staff at the CHAC accommodation and told them about Dr. Donnelly's concerns.

221. The CHAC accommodation notes on 2 January 1996 recorded the contacts by Mr. Close on 3 January in their log and detailed a verbal warning given to Mr. Donnelly for the damage to his flat which occurred before Christmas. On 4 January it was noted that he was "fine" and on 8 January 1996 it was noted that he was "*very well, rational, alert*" that he had acquired a sick note from Dr. Marfleet for a period of 13 weeks which was believed to be in relation to his college course.

222. On 8 January 1996 Mr. Donnelly was seen by the GP Dr. Marfleet, who did not notice anything unusual about his presentation which appears to have been echoed on the same day by the note by Mr. Close who states:

> *"mental state stable, talking calmly and rationally, no paranoid feelings or evidence of any psychotic features."*

He did however go on to note that:

> *"eyes appeared glazed and when questioned about cannabis admitted continued use on a casual basis. "*

223. Mr. Close also notes serious aspects of Mr. Donnelly's behaviour when he recorded:

> *"talked about explosive outbursts prior to Christmas when he broke up/smashed windows and belongings in his flat, and slashed the settee to bits with a kitchen knife. Says he was aggravated by the noise of a neighbour using the toilet at night."*

As to the relationship with his mother Mr. Close noted,

> *"relationship with mother very tense and was prone to rows/arguments whilst at a family wedding in Eire at Christmas. Mother wants no contact at present to which Mícheál says he agrees. "*

> *"Says that when he stopped medication he did find it harder to think clearly and make decisions and is willing to resume medication (next depot due in 4 days) but also wants to see Dr. Baloch to discuss dose and frequency."*

224. The information that was passed on by Dr. Donnelly following the family's return from Eire and also the information that was made available to Mr. Close by CHAC was not passed on to either Dr. Baloch or to Dr. Thu.

225. Once more it seems that Mr. Close's failure to recognise the connection between a deteriorating mental state and the aggressive behaviour led to him withholding vital information which could have led to Dr. Thu or Dr Euba deciding to reassess Mr. Donnelly by admitting him to The Lakes.

COMMENT

226. Despite being given his injection just prior to them leaving for Eire around Christmas time his mental state deteriorated fairly rapidly within a week or 10 days of the injection. Dr. Baloch's team should have been made aware of the fact that Mr. Donnelly was not now responding to the dosage of medication that he had been responding to previously. In September the previous out-patient assessment where Mr. Donnelly presented with clear symptoms of paranoia had resulted in his depot injection being increased to a three weekly instead of a four weekly cycle. It is possible that if the information which Dr. Donnelly had made available to Mr. Close had been passed on to Dr. Baloch's psychiatric team or to Dr. Thu in February they would have considered increasing his medication. Upon that information being received Dr. Thu would have had to consider admitting Mr. Donnelly to The Lakes for reassessment of his management.

227. It was clear that there was a lack of any effective risk assessment by Mr. Close to bring into account all the evidence that he was being presented with at this time. Mr Close had detailed information, given in the early days of January 1996, that Mr. Donnelly's mental health had deteriorated quite significantly. Despite appearing calm and rational on occasions he had clearly been lying when he had said that he had given up the use of cannabis. Indeed he appeared to have been under the influence of cannabis on 8th January 1996.

228. The incident where he destroyed his flat just prior to Christmas had a more serious connotation because it had nothing at all to do with the relationship with his mother. The explanation that it had simply been because a neighbour had used a toilet at night should have put Mr. Close on notice that this was not the behaviour of somebody who was *'well mentally'*.

229. The continued use of cannabis of itself was already an indication that his mental state was deteriorating as it seemed to go hand in hand with the belief that it enabled him to avoid side effects some of which were evidenced by his general presentation. The cannabis of itself reduced the effectiveness of his depot injections which was not assisted by any oral medication being taken.

COMMENT

230. This information, and the accumulation of it combining the incidents both before Christmas, over the holiday period in Eire, and the subsequent events since his return, and threats of violence to his mother and her property, ought to have led to a screening assessment for admission. The combination of threats, purchase of knives and destructive activity was more serious than had been evidenced in February to April 1995 and yet this man was still being maintained in the community in the hope that the court disposal on 10 January 1996 would significantly contribute to the management of his state of mental health.

231. The underlying, and quite serious error of judgment, was the assumption made by Mr. Close that his offending behaviour and the risk that Mr. Donnelly posed both to himself, and to others, was something that was capable of rational thought. It was assumed, that this was something that could be addressed by a probation order with a condition for treatment.

232. This view was expressed by Mr. Close in oral evidence when he stated:

> . "*..and I think it was hoped from the court sentence on 10 January that to incorporate treatment as a condition of his bail would be helpful in ensuring that this difficult man continued to receive medication in the community.* "

COMMENT

233. Mr. Close's view of Mr. Donnelly as a "difficult man" was an inappropriate way of describing Mr. Donnelly. Mr. Donnelly was difficult because he had a deteriorating mental health condition. There was a fundamental failure to acknowledge that his offending behaviour was directly linked to a deteriorating mental state. The failure to make that link, which had already been made by the Probation and mental health services in April 1995 was at the heart of the mental health services' inability to take any effective action at this time, in relation to the care and supervision of Mr. Donnelly in the community.

234. It was in this context therefore that when he appeared at court on 10 January 1996 Mr. Donnelly was sentenced to a period of 2 years probation with a requirement: "*that the defendant attends any courses as directed by probation and that he also receives treatment including injections as directed*".

235. The Court also took into account the breach of the conditional discharge relating to the April 1995 offence for criminal damage.

COMMENT

236. There is a well recognised guiding principle of mental health supervision and care in the community that past behaviour is the best indicator of future behaviour. This principle seems to have been forgotten by those most closely responsible for the care and supervision of Mr. Donnelly. The most serious aspects of Mr. Donnelly's behaviour were not communicated with any sense of urgency by Mr. Close to Dr. Baloch (who by this time was on holiday) and the psychiatric team at The Lakes responsible for the overall treatment of Mr. Donnelly. In the absence of any decision to present Mr. Donnelly for a screening assessment and the failure to pass on this information speedily there could be no proper risk assessment by a consultant psychiatrist at this time.

(iv) The Mentally Disordered Offenders Panel meeting on 11 January 1996 and the period up to 4 March 1996

237. The Mentally Disordered Offenders Panel Meeting was attended by Mr. I Clift, the Court Diversion Worker, Mr. Close, the CPN, Mr. Alan Ramsay, Ms. Ann Taylor and Mr. Alan Critchley for the Probation Service. Apologies were received from Dr. Baloch, Dr. Seewoonarain, and Ms. Ellie Scrivener of the CHAC Housing Accommodation. This meeting was a crucial meeting and the only real attempt during this period to adopt a full multi-disciplinary approach to discuss and assess the risk of Mr. Donnelly's condition. The notes of the meeting were as follows:

> "*AJC opened the meeting by thanking people for attending. Mr. Donnelly had been placed on probation with a condition that he receives injections. This is a unique condition and one that is difficult for the Probation Service to supervise. The Probation Service had not wanted the order to be made.*
>
> *IC. There is a full background report setting out the course of Mr. Donnelly's illness and offending.*
>
> ***ASSESSMENT OF RISK:*** *IC feels that if Mr. Donnelly is left untreated there is a risk of violence. His mother will be at risk as would someone who made a racist comment.*
>
> *Over the Christmas period he bought a knife in Eire.*
>
> *This was taken from him by a relative.*
>
> ***ACCOMMODATION:*** *Mr. Donnelly is living at 211 Avon Way. This is satisfactory and the staff are supportive. He has received a warning for damage caused to his flat.*

Mr. Close felt that Mr. Donnelly's offending is linked to his personality. His use of cannabis increases his paranoia. He felt that Mr. Donnelly's mother was at risk regardless of treatment. The intention is that he receives injections every 3 weeks. Donnelly feels that this is too much and he will be asking to have this reduced. Mr. Close wasn't sure what role a probation officer would have with the case. He felt that it would be reasonable to notify the Probation Officer if the injection was a week overdue.

Mr. Clift felt that whilst Mr. Close would be catering for the mental health issues there is a role for the Probation Officer to challenge offending on the basis that some of Donnelly's offending was "rational".

Ian Clift stressed that Michéal was co-operative towards authority figures.

Mick Close said that offending was likely to be against his mother who currently wants no further contact.

CONCLUSION

Mr. Alan Critchley to exempt Donnelly from national standards on the basis of his mental health and he does not need to be seen weekly.

Mr. Close to notify Ann Taylor after one week if Donnelly does not have his injection.

Mr. Close and Ann Taylor to have a joint meeting with Donnelly. "

The notes made by Mr. Close set out a 6 point plan as a result of the Mentally Disordered Offenders Panel Meeting.

(a) To continue to see him for monitoring of his mental state and to receive depot medication as recommended by Dr. Baloch.

(b) To arrange further out-patient review to see Dr. Baloch.

(c) Mr. Donnelly to be made aware that if he fails to have an injection and is overdue by one week then he is obliged to inform the probation office who will consider he has breached the Probation Order.

(d) A joint appointment with Mr. Close and Ann Taylor on the following week on 17 January.

(e) To continue with the drop in facility at the Oxford Road project.

(f) Continued support and assistance from care staff at his accommodation (CHAC).

COMMENT

238. The crucial omission from this Panel Meeting was the absence of any psychiatric input which would have been able to fully assess all the relevant information which had been passed by CHAC and by Dr. Donnelly to Mr. Close. It is questionable, however, whether or not all the relevant information was indeed before

the Mentally Disordered Offenders Panel Meeting on 11 January 1996. The other omission was that there was no worker from CHAC present, and therefore certain key players were missing from that panel meeting.

239. The plan, whilst on the face of it provided some safeguards to monitor Mr. Donnelly, did not address the fundamental problem that there was clear evidence of a deteriorating mental condition which ought to have been the subject of a full psychiatric assessment by the time the panel met on 11 January 1996. There appeared to be an absence of consensus in that the Probation Service, whilst willing to work under the auspices of the order, did not believe it was within their remit to treat Mr. Donnelly or to perform the tasks best suited to the Mental Health Services.

240. The minutes of the Mentally Disordered Offenders Panel Meeting were not circulated to anyone attending nor to any of the people on the list who had been asked to attend. The notes of the meeting remained on the probation file. This failure seriously undermined the various agencies' knowledge of the risk assessment that had been made at this meeting. Consequently those who did not attend had no information on the result of the Mentally Disordered Offenders Panel Meeting save for Dr. Baloch and Dr. Marfleet who received a partial account in a prompt letter from Mr. Close dated 15 January 1996.

241. The absence of a forensic psychiatrist or a consultant psychiatrist from the meeting was a serious handicap in the ability of the panel to conduct a full and detailed risk assessment.

242. There is no acknowledgement in the notes of Mr. Close's contribution to the meeting that the level of seriousness of Mr. Donnelly's behaviour had been noted. For instance the smashing of the flat did not include any details that he had ripped his settee to bits with a knife; nor does it include the account that he had threatened a family member with being stabbed at the wedding; nor does it include a significant threat in the light of future events e.g. the threat recorded on 4 January 1996 to burn down his mother's house. Even if the minutes of the Panel meeting had been circulated these factors represent crucial omissions from the recorded notes which ought to have been documented. An aggravating feature was that it appears to have been the first Mentally Disordered Offenders Panel Meeting attended by Mr. Close and therefore as part of a new practice the meeting carried all the uncertainties of poor attendance and an absence of clear direction. Similarly there was no mention of any paranoid delusions which were being evidenced both before and after Christmas by care workers at the CHAC accommodation and by his mother.

243. The agreement that there would be a delay of one week before contacting the Probation Service was the only safeguard against Mr. Donnelly's non-compliance with his medication. Crucially the decision had been left to allow this period of time to elapse before instigating any action, rather than to consider whether to utilise the powers available under the Mental Health Act 1983 for an assessment. Similarly, the panel failed to recognise that the Probation Service being notified of the failure to take medication was an unrealistic sanction as the matter could not be brought back before court within a 2 week period of the breach being notified. The breach process is cumbersome, and it was recognised by the Chair of the Court, Mrs. Stapleton, when giving evidence that it was highly unlikely that any further sanction would have been invoked for a breach, even if it had been brought back to court.

244. There was an appropriate identification of risk in that it was recognised that cannabis increased his paranoia and that offending was likely to be against his mother; it was also recognised that if Mr. Donnelly was left untreated there was a risk of violence and that his mother would be at risk, as would someone who made a racist comment. The identification of these risks did not, however, carry with it any effective safeguards. There was no recognition of the level of risk indicated by Mr. Donnelly's past behaviour and the recent signs of deterioration in his mental condition even whilst under medication.

245. There then followed a key letter written by Mr. Close dated 15 January 1996 to Dr. Baloch, and copied to Dr. Marfleet. The letter summarised appropriately the outcome of the criminal proceedings but contained an inaccurate summary of his mental state stating that *"he has remained well mentally, although there was one occasion prior to Christmas when he did extensive damage to his belongings and his flat."*

COMMENT

246. The message conveyed in the letter was that this was an act which was entirely rational. This was underlined with the indication that he was warned by staff at CHAC and that he did acknowledge, in response that type of behaviour would not be tolerated.

247. Although a report is given of his disturbed behaviour whilst in Eire it does not convey the level of seriousness and significantly omitted to mention the threat of stabbing his cousin at the wedding. Again a rational explanation for the possession of the combat knife is recorded by Mr. Close.

248. A summary of the decision of the Mentally Disordered Offenders Panel Meeting was set out and the plan for seeing Mr. Donnelly with the Probation Service and administering his depot injections was also set out in the letter.

COMMENT

249. The letter represented the only information that was sent by Mr. Close to the consultant psychiatrist and effectively, at that time, her team in her absence. The letter was fundamentally flawed in that it presented a managed picture of Mr. Donnelly's care omitting the facts that:-

(a) the staff at CHAC had expressed concerns over his deteriorating mental state and the state of his paranoia on various occasions between mid December and the date of the letter 15 January 1996

(b) the letter omitted to convey the mother's clear report that he had been *"violent, aggressive and paranoid"* whilst in Eire and on his return

(c) the significant threat reported by his mother in early January that he would, *"burn her house down"*

(d) the detailed account of the destruction to the flat where he had actually slashed his settee to bits with a knife

(e) the fact that his mother believed he had purchased another combat knife since his return from Eire

250. The failure to record the fact that Mr. Donnelly may still have been in possession of a combat knife was all the more alarming because this was information that had been passed appropriately by Mr. Close to Mr. Clift; who had conveyed it to Mr. Alan Critchley the Senior Probation Officer, who issued as a warning to staff, dated 3 January 1996 "*please treat him with great caution*".

251. This was a clear failure by Mr. Close to include a comprehensive picture of what had been happening to Mr. Donnelly, coupled with the absence of key elements that would have informed a risk assessment. The subsequent out-patient appointment which took place, attended with Dr. Thu, was critically lacking in the information necessary to make an informed decision in relation to Mr. Donnelly's care and treatment in the community. It would have been perfectly proper, upon the full picture having been made available, for the consultant psychiatrist covering Dr. Baloch's caseload to have requested the admission of Mr. Donnelly for assessment.

252. The first appointment between the Probation Service and Mr. Donnelly was cancelled as he stated that he had an exam, and the meeting was rescheduled with Mr. Close for 22 January 1996. At interview Mr. Donnelly said that he was studying for a degree in environmental biology at Colchester Institute. He complained further to Ms. Ann Taylor about the noise in his flat in Avon Way being too great and his wish to leave. He described his relationship with his mother; that he is "*currently buttering her up*", and "*perceives he is seen to be the bane of her life*". All the notes of the meetings with Ms. Ann Taylor on 22 January, 8 February, 14 February show that she was presented with no evidence that his mental state was deteriorating at that time.

253. It is recorded in the CHAC notes dated 15 January 1996, that Mr. Close had given an update to the care workers at his accommodation of the Mentally Disordered Offenders Panel meeting a few days earlier.

254. Mr. Donnelly returned to his concern about medication and the side effects in his conversation with Ms. Ann Taylor. He spoke of his meeting where he expected to see Dr. Baloch on 20 February 1996 and stated that he "*hoped for a reduction in dose*".

255. Mr. Donnelly did in fact keep his meeting with Dr. Thu at the out patient clinic on 20 February. Dr. Thu had met Mr. Donnelly several years before and recorded his case as one which she had discussed over the years with Dr. Baloch. She was clear in her evidence to the Inquiry in stating that as, she had not at that stage been provided with the full details of recent occurrences, paranoia or the incident of threatened violence in full detail, she was unable to raise those issues with Mr. Donnelly. Dr. Thu was of the opinion that if she had raised those issues directly with him she may have seen his presentation as being somewhat different and therefore formed a different view of his mental condition at that time.

256. In the absence of that further information from Mr. Close, and not having had sight of the minutes of the Mentally Disordered Offenders Panel Meeting on 11 January 1996, Dr. Thu recorded that he had now deferred his college course as he had felt tired after receiving his Depixol injection, but admitted that his injection had "*moderated*" his behaviour and that he was more predictable at that time. He also gave an account that he attended Oxford Road 2 or 3 times a week as well as doing voluntary work with a conservation group in Highwoods once a week. He asked Dr. Thu if she could reduce his medication back to every 4 weeks again. She advised him to stay on the same dose of Depixol for the time being and stated that he would be seen in Dr. Baloch's out-patient clinic in 4 weeks time.

257. In oral evidence she recalled a conversation with Mr. Close the next day on 21 February 1996 to convey to him the results of the examination. There is no record however, either in the clinical notes, or by Mr. Close of this conversation.

258. The clinical notes acknowledged that he was due to go to court again a few days later on 28 February 1996 to see whether the Probation Order with the condition of treatment was a lawful one. Dr. Thu did therefore have knowledge of his return to court and of the possible illegality of the Probation Order.

COMMENT

259. The illegality of the treatment requirement in the Probation Order probably affected Mr. Donnelly's compliance. It is difficult to ascertain when he gained this knowledge.

260. It is likely that his failure to take his medication after the last depot injection given on 23 February was influenced to an extent by his knowledge that the legality of the order was likely to be adjudicated upon on 28 February 1996 in any event.

261. The lapse of one week before the matter was reported to the Probation Service and the absence of any other action taken by the Mental Health Services failed to take account of the speed with which his mental health could deteriorate in the absence of medication. There was clear evidence to suggest that on his trip to Eire, only one week after being given his depot injection, his behaviour was beginning to deteriorate quite significantly. The mental health services ought to have anticipated the fact that this pattern would repeat itself.

262. On 28 February 1996 the Magistrates' Court took the decision to remove the illegal part of the Probation Order.

263. There is a note in the Probation Service records dated 29 February 1996 that a message had been left by Mr. Close (not received by Ms. Ann Taylor until 4 March) which stated that " *Mičhéal failed to attend for injection 23/2 no contact since - now one week overdue.* " Mr. Close had, in accordance with the agreement of the Mentally Disordered Offenders Panel Meeting on 11 January, informed the Probation Service of Mr. Donnelly's failure to comply with his depot injection. The entries from Mr. Close are consistent with the fact that he was aware that Mr. Donnelly had not attended his scheduled appointment to receive his depot injection on 23 February 1996. Mr. Close had clearly spelt out the consequences to Mr. Donnelly in terms of him informing the Probation Service one week later. There is also a record in Mr. Close's notes that he did just that on 1 March, which was a Friday afternoon.

COMMENT

264. There is a total absence in the risk assessment and the plan that was set out at the Mentally Disordered Offenders Panel Meeting of any proactive role being taken, led by the Mental Health Services, in the event of Mr. Donnelly's failure to comply with his medication. The Mental Health Services had set out, quite clearly, to rely upon notification to the Probation Service as the only sanction or safeguard in respect of Mr. Donnelly's behaviour. This serious error of judgment led directly to no further efforts being made by Mr. Close between 23 February 1996 and 1 March 1996 to attempt to locate Mr. Donnelly to administer his injection. Similarly there was no

message communicated to any of the other services to indicate that there would be a heightened increase in the risk of Mr. Donnelly's offending behaviour.

265. Any full and proper risk assessment placing Mr. Donnelly in a higher category would have automatically led, in these circumstances, to proactive steps being taken either to administer Mr. Donnelly's depot injection directly, or for that compliance to have been enforced under the powers available under the Mental Health Act 1983.

266. It is evident that even if the message had got through to Ms. Ann Taylor on the Friday afternoon there is absolutely no action she would have been able to have taken to have Mr. Donnelly brought back before the courts for non-compliance. By 28 February that part of the Probation Order had been found to be illegal and had been removed. The sanction envisaged in the event of non compliance with medical treatment was, by 28 February, a sanction which was unenforceable and which was known to be inoperable to Mr. Donnelly. This fact is a further failure in the difference of approach that then existed between the Mental Health Services and the Probation Service.

267. The Court had also been told at that time that Mr. Donnelly was complying with his medication; a fact that was clearly inaccurate on 28 February 1996. The court did not have a vital piece of information that it would have needed to have ordered any psychiatric assessment of Mr. Donnelly.

268. The basic failure in the care and supervision of Mr. Donnelly in the community was the belief held by Mr. Close that his medication would be controlled by the Probation Order and the Criminal Justice System, whilst unbeknown to him, there was no sanction available in terms of an enforceable Probation Order. Even if the condition of treatment had been a lawful one it could not have operated in time to have assisted Mr. Donnelly, nor should it have removed from the Mental Health Services their primary responsibility to ensure that they managed the risk that Mr. Donnelly posed not only to himself, but more directly to his mother who was at the highest risk, and generally to members of the community.

269. There were, however, several indications that his presentation up to 28 February 1996 was that he gave every appearance of being calm, lucid and "*normal*". This view was confirmed by the evidence of Mr. Burgess, a CHAC care worker who stated in evidence that in the immediate period before the arson he had been "*behaving the best ever that I have seen him behave*". In explanation he said he was not aggressive; his conversation would be more lucid and the topic of conversation would be more normal; *"he looked better; his colour was better; he was less paranoid"*. Mr. Burgess went on to say that he believed he saw him virtually the day before the incident. His view was:

> *"He was very well. Things seemed to be improving generally in his life, in terms of getting him to comply with the medication and all the rest of it."*

COMMENT

270. These observations are of some significance as they go some way to explaining the judgment exercised by Mr. Close and the lack of a sense of urgency in the overall supervision of Mr. Donnelly at this time. Mr. Close in particular, nearly always saw Mr. Donnelly when he was "*well mentally*" and this period would have been no exception to that. What one did not have at this point was a complete picture of Mr. Donnelly's presentation. A number of health care professionals who had a snapshot

view of Mr. Donnelly, relied far more upon that snapshot view of his mental condition than of taking into account firstly his past behaviour, secondly, the evidence of his very recent deteriorating condition and thirdly his propensity to deteriorate within a short space of time in the absence of medication.

Chapter 2

The criminal justice process, the probation service and the court diversion scheme

(i) Arrest, detention and charge

271. Mr. Donnelly was arrested at 4.10pm on 7 October 1995 after the police had been called to 46 Turner Road by Dr. Donnelly as a result of the criminal damage that he had caused to her vehicle and property. The arresting officer was a PC Edwards and the custody sergeant was a PS Watson. Mr. Donnelly was apparently lucid and calm upon his arrest and was able to tell the custody sergeant that Dr. Baloch, his psychiatrist had stated "*I am suffering from schizophrenia.* " He also stated that he was taking Largactil and Depixol, by way of medication. The custody sergeant made a call to a Dr. Macallan, as a result of which Mr. Donnelly was examined between 17.06 pm and 17.17 pm, when he was returned to his cell.

272. Dr. Macallan, the Forensic Medical Examiner (FME), certified that he was fit to be detained and interviewed. There is no note, either in the custody record, or in the doctor's notes of the examination, that the question of an appropriate adult was considered. During his interview with the FME, Mr. Donnelly admitted that he went to see his mother over a dispute about money and admitted putting paint stripper into the fishpond and smashing her car windows. The FME did not record any voices or hallucination noting that he

> "*seemed calm and rational now*". "*Speech unclear*". It was also noted that "*Mr. Donnelly does lack insight into his medical condition*".

COMMENT

273. There was an oversight by the FME who failed in his examination sheets to record the dose of medication that Mr. Donnelly was taking. Dr. Macallan in his evidence stated that he did not see it as his duty to liaise with psychiatric services in relation to his examination of Mr. Donnelly. The frequency of Mr. Donnelly's dosage was not recorded, nor was it recorded that he had received his last dosage some 2 weeks before the examination. Dr. Macallan accepted that his primary function was to consider the question of whether he was fit to be interviewed or not and facilitate the police in that regard. Dr. Macallan accepted that his examination was somewhat short and indeed from the custody record cannot have been longer than 11 minutes in total.

274. Whilst Dr. Macallan did record many of the details of Mr. Donnelly's presentation accurately there was an omission, to record appropriate details about the frequency and dosage of his medication. The examination in his cell appeared to be rather cursory in the time allotted given the fact that he was dealing at the time with a known schizophrenic. There does not appear to be anything to suggest that either the custody sergeant or the FME were aware of previous offending history relating to his mother.

275. The decision not to request an appropriate adult was made, it seems, on the basis of the calm and rational presentation of Mr. Donnelly at the time. The custody

sergeant's evidence was that essentially she was looking to the FME for guidance and was reassured by his view, as far as she recalls it, that an appropriate adult was not necessary. Accordingly one was not called.

276. Overall the arrest, detention and medical examination of Mr. Donnelly whilst in custody on 7 October 1995 was appropriate. The exercise of discretion to release Mr. Donnelly on bail does, however, stand in contrast with the decision not to grant police bail when the offences against his mother's property were committed earlier in that year, in February 1995.

277. Mr. Donnelly was bailed to appear at Colchester Magistrates' Court on 15 November 1995. It is doubtful whether at that point the Crown Prosecution Service's case file carried the information that Mr. Donnelly had a record as a mental health patient or as a mentally disordered offender.

(ii) The pre-sentence report, the defence solicitor and the court diversion scheme

278. By 15 November 1995, the care workers at the CHAC accommodation had arranged for Mr. Donnelly to be legally represented by Mr. Paul van Schaik, a sole practitioner locally based. Mr. van Schaik met with Mr. Donnelly and Ms. Carolyn Turrell at CHAC on 18 October 1995. At that meeting it was agreed that contact would be made with Mr. Clift, the Court Diversion Worker. He apparently suggested to Ms. Carolyn Turrell that he be involved. There was a brief discussion between Mr. van Schaik and Mr. Clift on 27 October but in essence it was agreed that Mr. Clift would provide a report, which was accepted, as Mr. van Schaik felt it would be useful to have this information on his client as a defence solicitor.

279. On 6 November, Mr. van Schaik spoke to Mr. Clift, as the latter was becoming concerned about the timescale for the preparation of his report. He was told subsequently by Mr. van Schaik that his report would not be needed for 15 November as the Court would require a pre-sentence report in the first instance. At the hearing on 15 November 1995 the court did not appear to have been aware that Mr. Donnelly was a mentally disordered offender, however a guilty plea was entered and a pre-sentence report ordered. There was a further brief discussion between Mr. van Schaik and Mr. Clift on 10 November and a meeting between the two on 17 November, where it was recorded by the solicitor that,

> "*engaged in attending upon Ian Clift and agreeing with him that we should not get a report from Dr. Baloch but that he should send a letter commenting on Mr. Donnelly's capacity to do community service and whether there is any point in him doing probation.* "

280. Mr. van Schaik wrote to Mr. Donnelly on 21 November 1995 explaining the reasons for his absence from the next court hearing on 30 December and informing him that his agent, Mr. Matthew Welch, would be covering for him that day. He also mentioned the fact that,

> "*I spoke to Ian Clift last week and he has agreed to prepare a report for the hearing on 30 December. He said that in his view it was better not to have a second report from Dr. Baloch and I agree with him.* "

281. On 22 November 1995, Mr. van Schaik wrote to Mr. Clift with reference to the report which was requested and that he had agreed to prepare for the hearing on Wednesday 30 December. The letter from Mr. van Schaik stated that "*I confirm that in particular I should be grateful if the report could deal with the usefulness or otherwise of a probation order and whether Mr. Donnelly is fit to do the community service. For what it is worth my own view is that Mr. Donnelly is receiving the help and support that he needs already and that a probation order would therefore simply be a waste of resources. I would have thought that Mr. Donnelly was unsuitable for community service but your comments would be most helpful.*"

282. There is then a file note dated 30 November 1995, following a phone conversation between Mr. van Schaik and Mr. Clift, when it is recorded,

> "*Engaged attending upon Ian Clift. Apparently Mr. Donnelly has stopped taking his medication. This means that he becomes psychotic. It is Ian's opinion therefore that the courts should make a probation order with the conditions that he comply with the directions of his doctors/medical advisers and use medication as required by them. I said that that sounded very sensible.*"

283. By 6 December 1995 Mr. van Schaik received Mr. Ian Clift's first report. The report prepared by Mr. Ian Clift dated 21 November 1995 was addressed in a letter to Mr. van Schaik and confirmed the instructions and the interaction between himself and Mr. van Schaik when it stated:

> "*Thank you for asking me to undertake the above. I saw the defendant at the Community Mental Health Centre, Colchester on 4 November 1995. I undertake this report having not seen any prosecution papers but on the basis of conversations with you on the telephone, and a letter of request.*"

284. Mr. Clift then goes on to detail in a comprehensive manner Mr. Donnelly's mental health and in his summary and conclusions states as follows:

> "*Clearly Mr. Donnelly is a man with long-standing serious mental health problems. In addition his problems are made worse by illicit drug use and his failing relationship he has with his mother. In addition to the assessments by Dr. Baloch and Mick Close, community psychiatric nurse, I find no overt signs of mental illness during my interview with him.*
>
> *Evidence suggests that there has been an improvement in his mental state this year. I accepted as clear that he was probably symptom free at the time of the offence. Mr. Donnelly is also clear that the damage to his mother's car was through a "fit of temper" and not because of the experience of delusional ideas or beliefs or hearing voices. Clearly, however, the past has shown that Mr. Donnelly was unwell at the time of the previous offences. I believe that this fact must be taken into consideration when passing sentence and having to take into that process previous offences from which he has been conditionally discharged from.*
>
> *It is clear from Mr. Donnelly that the impact on him of the relationship with his mother is something which will continue to bother him and as such requires attention and consideration. Unless he addresses the difficulty of making a clean break from his mother he is likely to have further unfortunate contact. He stated to me that he now realises the importance of this fact and will set about taking the*

necessary action. Since my initial interview with him I have received reports that he is unwilling to take medication and did not feel he requires injections. It is my view that should Mr. Donnelly not take his medication then there is a risk of serious offending behaviour. Mr. Close had made strenuous efforts to keep in contact with Mr. Donnelly in order to give these injections, resulting in him having to "track him down. " It is clear that a more formal arrangement is necessary to ensure the injections are able to be administered.

Suggestion

1. *It is my view that a Probation Order would be best suited to Mr. Donnelly. Furthermore it is my view that a condition of treatment to receive injections from Mick Close at Holmer Court as directed by him is also necessary. I have spoken to Dr. Baloch and she also gives her approval to this arrangement.*

2 *Further, with a Probation Order and Mick Close in developing a more independent lifestyle may assist in the reduction of the future potential for further offending. "*

285. There is a letter given by hand from Mr. van Schaik to his agent Matthew Welsh dated 12 December 1995, the day before Mr. Donnelly's hearing where he states:

"Ian Clift's report is very helpful. Hopefully I will have the opportunity to have a brief word with you before I have to disappear to the County Court. "

286. On 13 December 1995, Mr. Welsh took the view not to disclose Mr. Clift's report to the court and records what occurred at court in a letter to Mr. van Schaik, dated 14 December 1995 where he states:

"The court obviously were concerned about Mr. Donnelly's behaviour. Unfortunately he has not been taking his medication and in court was behaving strangely and badly. Consequently the Magistrates' decided that they could not sentence without further information and adjourned the case to 10 January 1996 at 10.30am in order to allow a psychiatric report to be prepared. They said they required this to give them more insight. They also asked about probation to make a reassessment. "

287. There then followed a record of a conversation between Mr. van Schaik and Matthew Welsh and a further conversation with Mr. Clift which recorded that "*he has spoken to Dr. Baloch who is going to be away for the next 7 weeks and I said that I would make an application next week for the report to be prepared by Ian Clift rather than by Dr. Baloch*". Prior to 10 January 1996 Mr. van Schaik recorded a further conversation with Ian Clift on 3 January 1996.

288. When shown the file notes and letters written by Mr. van Schaik, Mr. Ian Clift's response was as follows:-

Question: *"Do those two records i.e. 21/11/95 and 14/12/95 reflect an accurate summary, in terms of your recollection?*

Answer: *Absolutely not, no. I mean, that would be completely ridiculous to suggest. I cannot - I mean, I do not imagine, under any circumstances, I would have ever had that conversation with Mr. van Schaik. I just think that is - particularly bearing in mind the considerable amount of conversations I*

had with Dr. Baloch concerning the case around the time. I just do not know why that would have occurred at all."

COMMENT

289. There is clearly a conflict of evidence between the recorded notes made by Mr. van Schaik and the recollection of Mr. Clift. We have taken the view that at the time the records were made by Mr. van Schaik he would have had no motive to inaccurately record the information he was being given by Mr. Clift. The memoranda and notes are consistent, not only with each other, but with the letters that were written to Mr. Welsh and to Mr. Donnelly at that time. Whilst there is not necessarily a sinister connotation to the suggestion by Mr. Clift that the report from Dr. Baloch was not necessary, we take the view that the recording of Mr. van Schaik reflected the more accurate position. This account would also fall in line with the view expressed by all professionals at this time that Mr. Donnelly's case did not really warrant the intervention of a consultant psychiatrist and therefore there would be no need for Mr. Clift, Mr. Close or the other professionals involved to place Mr. Donnelly before a consultant psychiatrist or forensic psychiatrist for a mental health assessment. It would not, in their view have been necessary, given their risk assessment of him, to trouble Dr. Baloch with having to write a full psychiatric report at this time.

290. In oral evidence Mr. Clift stated "*I remember one occasion quite vividly, actually, in November when Mr. Donnelly had come to Holmer Court for an injection and I happened to see Mr. Donnelly there with Mick Close, at Holmer Court and I recall - yes, I recall that event. The reason I recall that was because I felt that Mr. Donnelly was very suspicious and very tense...I remember seeing him earlier than I had arranged to see him.*"

291. Mr. Clift, in his evidence, did recall one interview that he had with Mr. Donnelly which must have either been on the 3 or 4 November that "*I found no overt signs of mental illness during my interview with him.*"

COMMENT

292. The account of Mr. Donnelly's presentation given in oral evidence and the account given in the report prepared for Mr. van Schaik and the court is clearly different. It is quite likely that Mr. Clift did not fully set out in his report the observations that he made of Mr. Donnelly at this time. Whilst not a major discrepancy, it obviously adds to the Court's view that Mr. Donnelly was not a serious risk and that his mental health was being adequately controlled which was consistent with the views being expressed by Mr. Close at this time.

293. In his statement to the Inquiry Mr. Clift stated that:

"Before Dr. Baloch went on leave I spoke to her about my report. She agreed with my conclusions about Michéal's injections about my suggestion that a Probation Order with a condition of treatment was appropriate. Between 16 and 21 November 1995 I spoke to Dr. Baloch, as documented in the notes, who agreed with the conclusion that I proposed to put in my report, provided the Probation Service agreed with the suggestions for a Probation Order."

294. There is a note in Ian Clift's diary of which only two pages are now available stating that on 26 November "*spoke with Dr. Baloch agreed with injections with Probation Order would be a good idea, provided Probation agree*".

295. There is also a note of a conversation held again on 11 December 1995 which stated *"spoke to Dr. Baloch and said that Probation now unhappy. Dr. Baloch told me that we needed,*

> *"Carrot and stick" to ensure he received injection. Said she was very worried that he commit serious offence. Told me that case was adjourned and that she would be receiving request for a report from the Court. "*

COMMENT

296. Whatever the previous level of understanding between Mr. van Schaik and Mr. Clift, it was clear, as a result of the conversation with Dr. Baloch, that Mr. Clift anticipated a psychiatric report being prepared by Dr. Baloch or one of her colleagues. Clearly Dr. Baloch was appropriately concerned at this time on the basis of the information that she had received. The information provided by that time obviously did not include anything about the serious incidents which were to occur later when Mr. Donnelly trashed his flat, nor the trip to Eire, nor the subsequent events which were recounted by his mother in early January 1996.

297. Here again it is apparent though that the Mental Health Services appear at this stage to be relying upon the powers of the Criminal Justice Service to attain that degree of control in terms of compliance with medication which ought to have been the responsibility of the Mental Health Services.

298. Dr. Baloch agreed in general terms with the record of conversations made by Mr. Clift when giving her oral evidence. It is fair to say therefore that she agreed with the conclusions made in his pre-sentence report which essentially remained unchanged when they were presented in a slightly amended fashion at the final court hearing on 10 January 1996.

COMMENT

299. In spite of the seriousness of Dr. Baloch's concerns as to the possibility of Mr. Donnelly committing a serious offence she left on vacation for 7 weeks without having made any file note as to her concerns about Mr. Donnelly's propensity for violence and therefore failed to attempt any risk assessment in any proactive way in relation to his care. There was an expectation that the request for a report would be initiated during the criminal justice process. His care and supervision should have been managed by the Mental Health Services rather than by the Court.

300. Although Dr. Baloch expressed the view that she would have briefed her staff on the case before leaving, it is apparent from Dr. Euba's written note on the letter sent by Mr. Critchley dated 19 December 1995 that no such briefing was given. If Dr. Euba had received such a briefing then as the senior registrar, he would probably have attended the Mentally Disordered Offenders Panel Meeting on 11 January 1996. If he had been properly briefed by Dr. Baloch he would not have made the entry that he did on that correspondence. It is however fair to say that Dr. Baloch's concerns were not raised to the level necessary to trigger an assessment primarily because only an incomplete picture was painted by Mr. Close in his letter of 11th December 1995. Even if Dr. Euba had been briefed the subsequent events including the trashing of his flat, the threats to his mother and the details of the trip to Eire were not adequately communicated by Mr. Close to the psychiatric services.

(iii) The probation service

301. On 15 November 1995 there was not a Probation Officer in court when the case was adjourned and when the request for a Pre-Sentence Report (PSR) was allocated, and no connection was made with the earlier PSR in April 1995. The Probation Service's own record of the court process includes a note indicating that Mr. Donnelly was known to both Mr. Clift and Dr. Baloch. This appears to have been overlooked when the case was allocated.

COMMENT

302. It was clearly unsatisfactory that a report should have been allocated without a proper check having been made of the record of the Probation Service's previous involvement with Mr. Donnelly. It is important that there is a clear management responsibility for allocation decisions and for checking that the systems are in place to identify previous service involvement in the case.

303. The failure, at allocation, to connect the case with the previous PSR was, however, of little significance in the Probation Service's handling of the case, as it quickly became apparent that Mr. Donnelly was suffering from a mental illness.

304. The case was allocated to a trainee, Ms. Hill, although she worked under the close supervision of an experienced Probation Officer, Mr. Barford, appointed as a practice teacher and the case was discussed in detail with the Local Community Supervision Team.

COMMENT

305. It is likely that the attention the case received was increased by the fact that the PSR was undertaken by a trainee. Certainly the trainee, Ms. Hill, in her evidence at the Inquiry showed that she was capable of making a good assessment of Mr. Donnelly. Her observation of Mr. Donnelly, as conveyed in her evidence at the Inquiry, was impressive.

306. Ms. Hill saw Mr. Donnelly on two occasions. She found it impossible to discuss the offence or his relationship with his mother without him becoming agitated. She commented in evidence that,

> *"He was bizarre, he made me feel uncomfortable. To bring his mother in the conversation, I pursued that route, I would be looking for an escape route rather quickly... He did not realise that his behaviour was offending."*

307. Ms. Hill gave a graphic account of his presentation during those two interviews which occurred some time between 15 November 1995 and 13 December 1995. She commented that:

> *"He was fidgety, he talked about people watching him a lot. I can remember on one of the interviews he said there was somebody outside waiting for him. He spoke about people always after him all the time...the bizarre behaviour was around his persecution complex he appeared to have."*

308. Ms. Hill recalled that because of her concerns about Mr. Donnelly she had contact with his Community Health Worker, Mr. Close. She stated:

> *"If he did not take the medication, he would have these persecution complexes and voice hallucinations, and preferred to live (as he called it) than to be a zombie. So,*

that alerted me to the fact that there was a problem around his medication, which I liaised with Mick Close about."

309. In addition Ms. Hill met with Mr. Clift to discuss the case and was aware of Mr. Clift's view that a Probation Order with a requirement of psychiatric treatment was the most appropriate disposal. This was not a course of action that was welcomed by the Probation Service locally. It was considered that there was nothing that Probation supervision could add to what could be provided by the Mental Health Services and that challenging his offending behaviour with a view to changing him, the core business of probation, would have been impracticable. There was also doubt whether it was possible to use a requirement of Probation Order to enforce the taking of medication. Mr. Barford, the Probation Officer supervising Ms. Hill, demonstrated in his evidence to the Inquiry that there was resentment among Probation Officers about having to supervise Probation Orders recommended by Mental Health professionals where it was not clear what the Probation Officer could contribute in their liaison, when even making contact with the Mental Health Services was difficult.

310. Ms. Hill picked up in the pre-sentence report dated 11 December 1995 that there was clear antagonism against taking any further medication. She commented in the PSR that "*Mr. Donnelly tells me that he no longer wishes to continue with his medication and did not keep his last appointment on 24 November 1995.*" Ms. Hill made a cogent argument against the imposition of a Probation Order stating,

> "*It is our opinion (Supervision Team) that there is already a great deal of support in existence for Mr. Donnelly. He has 24 hour support from CHAC and a high level of support from the Mental Health Services. This would suggest that a further layer of supervision, such as would be provided by a Probation Order is not required. In my view it could exacerbate his persecutory delusions and is unlikely to affect his offending behaviour. Furthermore, Mr. Donnelly informs me that he would not agree to any conditions that would require him to have medication for the reasons outlined earlier in the report. With regard to this it should be noted that under the Mental Health Act sufficient powers exist to compel a patient to receive medication if an assessment of risk is established.* "

311. As a result of that reasoning the PSR did not recommend the making of a Probation Order but asked the Court to consider a further conditional discharge as an option.

COMMENT

312. Although there had been a meeting with Mr. Clift it appeared that there had been no expectation that it might be possible to negotiate an agreement with the Mental Health Services about what advice might be offered to the Court. There was an assumption of the inevitability that the Probation Service would be "*dumped*" on. Mr. Barford's oral evidence indicated that the Probation Service expected that a Probation Order with a condition of treatment would be made in any event, following a further adjournment for the necessary psychiatric report.

313. While the PSR was a thoroughly competent piece of work in collecting information and arriving at an understanding of the offence, the failure to engage more positively with the difference of opinion with Mr. Clift was regrettable. Criticism cannot be levelled at Ms. Hill, who as a trainee, properly deferred to her supervisors and the views of the Community Supervision Team.

314. The failure, however, was two-fold. Firstly, Mr. Clift failed to negotiate an agreement with the Probation Service that took into account its assessment of Mr. Donnelly's needs and of the degree of assistance the Probation Service could actually afford. Secondly, the Probation Service failed through Mr. Barford to take a more assertive line with Mr. Clift and to express those views more forcefully if necessary directly to the consultant psychiatrist responsible for Mr. Donnelly's care.

315. One of the anomalies of the criminal justice process was the decision by Mr. Welsh not to disclose the report by Mr. Clift which was available to the court on 13th December. Although this was made for reasons of sound professional judgement it had the effect that at the adjourned hearing of 10th January 1996 the Court believed that it was receiving for the first time a new and comprehensive psychiatric report which in effect was virtually the same report that was at court on 13th December. Only one amendment had been made since that date by Mr. Clift.

316. As was expected, the case was adjourned to 10 January 1996 for a report from Dr. Baloch. The court papers indicated the Bench had in mind a Probation Order with a requirement for psychiatric treatment. Ms. Hill was on leave from 18 December to 10 January and it was clear in her evidence to the Inquiry that she considered that her responsibility for the case had ended when the PSR was completed.

COMMENT

317. The Probation Service should, however, have taken steps to contact the psychiatrist who it was expected would prepare the report, not least to ensure that the psychiatrist had a copy of the PSR and was aware of the views of the service about the inappropriateness of the Probation Order.

318. Mr. Barford should have identified the need to follow this through and have made sure that it was done. The Probation Service should have been more proactive in attempting to make contact with a psychiatrist, however disillusioned officers were about past attempts to liaise with psychiatrists.

319. On 19 December 1995 Alan Critchley, the Senior Probation Officer, recognising that it was probable that the Court would make a Probation Order, called a meeting of the MDO Panel for 11 January, the day after the court was expected to sentence Mr. Donnelly.

COMMENT

320. The decision to call the Panel meeting was a responsible one and recognised the importance of a co-ordinated approach to the supervision of Mr. Donnelly if the Probation Order was made. It would, however, have been a great deal more helpful if the Panel had been convened before the adjourned Court date. If this had happened the Court would have had the benefit of advice based on all those involved pooling their knowledge, and ideally reaching an agreement about what mechanisms could best reduce the risk of re-offending. Information, provided by Mr. Close, which was only made available to the Probation Service at the Panel meeting, after the Court had sentenced, was crucial to a risk assessment. The value of calling the Panel before sentence was correctly identified by Ms. Ann Taylor in her statement to the Inquiry.

321. The Court report which was then re-dated 5 January 1996 by Mr. Clift only contained one sentence in addition to the factual statements and opinions which had been prepared and available to the Court but not produced on 21 November 1995. The single

piece of information given to the court on 10 January 1996 in addition to that which they would have had some 6 weeks earlier was the sentence:

> *"In addition I have also received reports that he has purchased knives in recent times over the Christmas period."*

COMMENT

322. This additional information contained only a fraction of what had occurred between 15 November 1995 and 10 January 1996. The court was not given any information that Mr. Donnelly had wrecked his flat, slashing the settee to bits with a knife, and had not only bought a combat knife in Eire but had threatened to stab a cousin at the wedding. Neither did this Court report make any mention of the fact that he had been suffering from paranoid delusions whilst in Eire only a few days after receiving his depot injection at The Lakes on 23 December 1995. Most significantly, the Court report detailed none of the threats expressed to his mother, nor did it contain any mention of his threat to burn her house down. Even the suggestion that he had purchased another knife, a fact that was communicated by Mr. Clift to the Probation Service on 3 January was not mentioned in his report. In essence, given the close proximity and the working relationship between Mr. Clift and Mr. Close these were significant omissions from the information provided in the Court Report. The events of the weeks prior to 10 January 1996 ought to have demonstrated very clearly to Mr. Clift that his recommendation of a Probation Order as a means of controlling Mr. Donnelly's behaviour was completely unrealistic and that his case cried out for the intervention of the Mental Health Service in order to assess properly the risks that Mr. Donnelly posed.

323. Mr. Clift ought to have taken far more notice than he did of the view expressed by the Probation Service as to the practicality of the Probation Order as a means of compliance. Even without the probation view his own experience as the court diversion worker ought to have alerted him to the fact that, in effect, the Probation Order with a condition of treatment amounted to nothing more than a bluff as far as Mr. Donnelly was concerned.

324 This question was dealt with by Mrs. Pauline Stapleton, the Chair of the Bench which sentenced Mr. Donnelly, in her evidence to the Inquiry.

Question: *"The process to get him back to court, what was your expectation?...how quickly did you see that process being able to occur? Say, for instance, that 7 days had passed then the probation are informed how quickly did you see that matter being brought back to court?*

Answer: *Within a fortnight, being realistic.*

Question: *Can I stay on that, because when we look at the time scales, whether or not the 7 days is wise, the process of returning to court does take, as you say, in fact, a fortnight would be doing very well; by then, of course, he had been a long time off medication.*

Answer: *Right.*

Question: *I wonder how much any one really thought through whether this was a degree of bluff and what would happen if he actually did become non-compliant?*

Answer: *Yes, you are right. I mean, this is the whole dilemma for everybody, is it not?*

Question: *...did you see this as a real effective tool to do that or is it more of a sort of, well, see if this works?*

Answer: *No, neither; probably what you said. It was probably more of a bluff."*

325 Mrs. Stapleton was clear in stating that in her own mind the primary safeguards as to Mr. Donnelly's care would be provided by the Mental Health Services rather than by the Court itself. This was in direct contradiction to what the Mental Health Services believed. They had the opposite view i.e. that the Probation Service and the Court would be the mechanism of controlling Mr. Donnelly in the community.

COMMENT

326. It has been stated repeatedly in the Mental Health Guidelines and Circular that the Criminal Justice process is not a substitute for the Mental Health Act 1983 but simply meant to complement it. It was entirely inappropriate to have abdicated the responsibility of the Mental Health Services in relation to the care of Mr. Donnelly. There was a completely unrealistic expectation that a phone call late on a Friday afternoon would somehow reduce the risk of Mr. Donnelly re-offending and thereby ensure his compliance with medication. The failure to utilise the powers available under the Mental Health Act 1983 fell into two distinct periods: the first being when he failed between 24 November and 23 December 1995 and the second in the days between 23 February 1996 and 4 March 1994.

(iv) Risk Assessment

COMMENT

327. The most glaring omission in the care and supervision of Mr. Donnelly in the community was the absence of any detailed psychiatric assessment between his mother's presentation of him at The Lakes on 22 September 1995 and the offence occurring on 4 March 1996. During this period there is ample evidence of his deteriorating mental state, his failure to take medication, his continued use of cannabis and his violent and aggressive behaviour, some of it clearly unrelated to his relationship with his mother.

328. The decision as to whether such an assessment was necessary was made in the first instance by Mr. Close. That was a judgement that he was not qualified to make on the basis of the evidence that had been presented before him. As a community psychiatric nurse his primary responsibility was to have obtained a second opinion of his own limited assessment of Mr. Donnelly's mental health. Clearly Mr. Close was presented with a whole array of evidence from a variety of sources which suggested Mr. Donnelly's mental health was deteriorating. He chose to see that as a personality problem and in effect not to make any link between his offending behaviour, his aggressive and violent outbursts and his mental health.

329. The failure to make this link was in direct contradiction to the view taken by the Mental Health professionals and the Criminal Justice system in the February to April assessments that had been carried out when Mr. Donnelly was bailed from Court to The Lakes and eventually discharged on 27 March 1995.

330. The psychiatric clinicians may not have faced great difficulty in diagnosing his condition when they were dealing with Mr. Donnelly at this time. Ms. Hill, his probation worker, the care workers at CHAC and Dr. Donnelly, had all picked up evidence of clear psychosis.

331. The circumstances in which a patient whose mental health is thought to be deteriorating may be detained under section 2 or section 3 of the Mental Health Act 1983; the 1983 Act requires a patient to be actually suffering from a mental illness at the time of the diagnosis which are used to support an application for admission...the Act is not couched in terms of "futurity", which will allow a patient to be admitted simply on the grounds that his or her past medical history suggests that he or she will relapse in the future.

332. The key occurrences where a mental health assessment could and indeed should have been obtained were:

(i) The offence relating to Dr. Donnelly's property on 7 October 1995;

(ii) The trashing of Mr. Donnelly's flat including the slashing of the settee with a knife on 20 September 1995;

(iii) The report from Eire made by Dr. Donnelly and in particular the threats of violence uttered to her against her property e.g. to burn it down, reported to Mr. Close on 4 January 1996.

333. The risk assessment at the Mentally Disordered Offenders Panel Meeting was a flawed process from the outset. There were a number of reasons for this:

i. The Panel Meeting ought to have pre-dated the sentencing exercise on 10 January 1996 rather than post-dated it.

ii. There ought to have been some central coordination to have ensured a consultant or forensic psychiatric input.

iii. The decision to make a full risk assessment ought to have been adjourned until such a professional input could have been obtained.

iv. The decision by Dr. Euba not to attend significantly undermined the Panel Meeting and its effectiveness.

v. The continued view and treatment of Mr. Donnelly as a low risk priority to be monitored predominantly by the Probation Service continued to exist in spite of the wording of the Panel minutes themselves.

vi. The minutes of the Panel Meeting were not circulated to the various professionals.

vii. There were no care workers from CHAC who were invited to attend who possessed some of the best information and insight into Mr. Donnelly's presentation during this period.

334. Save for the Panel Meeting, the Court report prepared by Mr. Clift, dated 25 November 1995 (updated by one single sentence referring to the carrying of combat knives, on 5 January 1996), was the only attempt at risk assessment that was conducted by the Mental Health professionals or the Criminal Justice system.

335. Supervision was of a very cursory nature as it was quite clear that Mr. Donnelly in January and February 1996, although taking his medication, refused to have any proper interaction with Mr. Close and therefore was inaccessible to be gauged for the risk that he posed. Mr. Close did not appear to have a close relationship with Mr. Donnelly and this was further compounded by his being seen as simply the medication policeman, which by then he was.

336. The whole scenario in Eire, if it had been presented from any other source, such as a care worker, ought to have resulted in Mr. Donnelly being presented for a psychiatric assessment. The Inquiry was left with a strong impression that because the source of the information was Dr. Donnelly and that because both Mr. Close and Mr. Clift felt that there was a dysfunctional relationship underlying this antagonism, which had a logical and rational cause, no such assessment was set in motion.

337. Dr. Donnelly, when she reported the threats to burn down her house, was told by Mr. Close, that she should call the police if she felt herself to be in danger. That advice, whilst obviously sensible, did not reflect the professional approach one would expect of the Mental Health Services receiving such information. It was a foreseeable consequence that, in the absence of medication, and within the space of as many weeks, Mr. Donnelly would carry out the threat he had uttered against his mother's house, with the tragic consequences that ensued. Clearly no one at the Mentally Disordered Offenders Panel meeting thought this of great significance because it was not a threat which was recorded in the notes of that meeting.

338. A number of professionals including the care workers at CHAC, Dr. Baloch and indeed those present at the Mentally Disordered Offenders Panel meeting had all foreseen the likelihood of serious offending behaviour in the light of Mr. Donnelly not complying with his medication. The similar views expressed over a period of weeks by a number of professionals in relation to his care made the failure to act more quickly all the more surprising in the circumstances.

COMMENT

339. There was ample evidence between February 1995 and March 1996 that his presentation included:

(a) delusional deviation;
(b) persecutory delusions, often hinging around racial persecution;
(c) fascination with combat issues/knives;
(d) identifying with Knight Templars;
(e) poor state of care, dress, etc;
(f) refusal to acknowledge mental illness and therefore he expressed no need to take medication;
(g) the use of cannabis to cover the side effects of medication;

(h) extreme anger when discussing his mother or in interactions with his mother;
(i) aggressive behaviour linked to previous issues acted out on property belonging to his mother;
(j) aggressive and violent behaviour completely unrelated to his mother but sparked by irrational responses to ordinary everyday events.

340. The major flaw in Mr. Close's reasoning was the continued separation of Mr. Donnelly's mental illness from his offending behaviour and thereby the perception that his relationship with his mother was part of a rational thought process. In the letter of 16 October 1995 Mr. Close states:

> *"Apart from some mild paranoid ideation at times he remains well mentally and the wild episodes do seem to be as a consequence of the poor relationship with his mother, rather than to any deterioration in his mental state."*

341. Once that opinion had been formed it was almost inevitable that Mr. Donnelly would be seen as less of a risk to either his mother, himself or to others in the community.

342. The use of cannabis, whilst acknowledged on several occasions by Mr. Close, and other mental health professionals does not seem to have been addressed in any purposeful way but simply to have been recorded.

343. The joint Health/Social Services Circular dated HC(23) states at paragraph 14:

> *"It is necessary to have effective arrangements both for monitoring what the agreed services are, indeed provided, and for keeping in contact with a patient and drawing attention to changes in his or her condition..."*

344. Paragraph 16 states: *"the particular responsibility of the key worker is to remain in sufficient contact with the patient, to advise his professional colleagues of changes in circumstances which might require review and modification of the care programme."*

COMMENT

345. It was not apparent that the care and supervision offered to Mr. Donnelly met the requirements as set out in these circulars. Indeed, by contrast Mr. Close met less frequently with Mr. Donnelly after the Court disposal of 10 January 1996 as opposed to the period leading up to it. The reverse should have been the case on the evidence of his deteriorating mental state.

(v) The court diversion scheme

346. Home Office Circular 66/90 was recommended by the NHS Management Executive to Regional and District Managers (EL/90/168). In making the recommendation the Director of Operations stated:

> *"Government policy is that, wherever possible, mentally disordered people should receive care and treatment from health and social services authorities rather than be cared for within the criminal justice system...these powers should be used to their fullest possible extent."*

347. The purpose of the Circular was to provide clear guidance to the establishment of good working practices and liaison between the criminal justice agencies, courts, health and social services. Mr. Donnelly's case demonstrates what can go wrong when this liaison breaks down.

348. The Crown Prosecution Service, for instance, received no information from the police of the fact that Mr. Donnelly was a mentally disordered offender. A number of guidance papers addressed the various needs within this area. In 1992 the Department of Health published the White Paper, "*Health of the Nation*" which stated:

> "*Mentally disordered people who commit offences are a particularly vulnerable group. There is a risk that if their health and social care needs are not recognised and met, then they slip into a vicious circle of imprisonment, re-offending and deteriorating mental health*[2]."

349. Some progress was made in that in August 1994, the Essex Mentally Disordered Offenders Steering Group was formed. This was the group that was to attempt to implement Home Office Circular 66/90 and the recommendations of the Reed Report. The Essex Mentally Disordered Offenders Steering Group consisted of representatives of North Essex Health Authority; South Essex Health Authority; Essex Police; Essex Social Services and Essex Probation Service. Although the Steering Group began to consider how to implement the Court Diversion scheme and to co-ordinate the strategies of each particular agency, particularly in relation to the psychiatric assessment of offenders, this was still not fully operational as Mr. Donnelly's case illustrates. The theory was for the diversion scheme to come into operation as soon as the police had their attention drawn to an offender suspected of suffering from mental disorder.

350. There are over 100 Court Diversion schemes of various types established in England and Wales. There is, however, no consistent model as the Reed Report envisaged "*we believe that no firm view should be taken nationally about preferred models, at least until the range of different schemes and outcomes for patients have been properly evaluated.*" After the Essex-wide planning conference on 2 December 1994, funding was made available by North Essex Health Authority to begin the development of the Court Diversion Scheme.

351. On 1 January 1995, Mr. Clift, the community mental health nurse, was appointed by North East Essex Mental Health Services (NHS) Trust to be the first diversion worker in a Court Diversion Scheme serving three Magistrates' courts, Clacton, Colchester and Harwich. At the time that Mr. Donnelly's needs arose Mr. Clift was working on his own and according to his own evidence had even formulated his own job description.

352. The report of the Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford identified several main problems which were apparent in their much more detailed examination and evaluation of the scheme in operation.

353. Those concerns are set out fully in Part 4 under "*Policy and Management Issues*" Chapter 3 paragraph 1374 to 1380. The main problems identified with the scheme as it was in 1995 were that:

(i) Mr. Clift operated on a limited basis Monday to Friday 9am to 5pm;
(ii) His time was spread too thinly with too many agencies and courts;
(iii) There were limited resources for interviewing and assessment of clients;

(iv) He did not have direct access to the forensic psychiatric services at Runwell Hospital;

(v) Although identified by himself in his job description as covering the assessment of mentally disordered offenders within police stations in North East Essex, during 1995 he was only able to attend a police station on 5 occasions in the first year of operation.

COMMENT

354. It is quite apparent that the ideal arrangements for a court diversion scheme were unachievable in North East Essex during 1995 in terms of the early diversion of mentally disordered offenders from the criminal justice process whilst at the police station. Indeed Mr. Donnelly was missed until the care workers at CHAC sought to address the issues and engaged the solicitor who then began the liaison with Mr. Clift.

355. The absence of effective access to the forensic psychiatric services was clearly a drawback in Mr. Donnelly's case as well Although it is fair to say that Mr. Clift had the opportunity if he had wished to use it to have a far fuller assessment conducted by Dr. Baloch over and above conversations in passing. Such informal contact appeared to have characterised his interaction with the psychiatric services in relation to Mr. Donnelly.

356. It was evident from the oral testimony of Mrs. Stapleton, the Chair of the Bench, that she was unaware of any training that had occurred in terms of mentally disordered offenders and the local Bench. Subsequently, and coincidentally there was a training session on Mental Health, open to all members of the Colchester bench in January 1996. Although it is our understanding that some training has now been embarked upon this must be regularly updated with refresher courses so that not only Chairs but the whole of the lay bench have a full and proper appreciation of the complexities and needs of mentally disordered offenders when they appear before them.

357. The role of the Court Clerk was of some importance in that the imposition of an illegal sentence was primarily the responsibility of the court clerk, Ms. Julia Baker, who had the conduct of the proceedings on 10 January 1996.

358. In his evidence it was clear that Mr. van Schaik only saw his responsibility towards Mr. Donnelly as being to obtain the lightest possible sentence, with as little intrusion as possible into his client's life. Whilst this may be appropriate for most defendants, for mentally disordered offenders there needs to be a different approach and emphasis. Mr. van Schaik believed it appropriate simply to be the voice of his client complying with his normal duty as a legal representative and not to inform the court if he knew something to be clearly misleading or incorrect.

359. There is a duty upon all solicitors, as officers of the Court, not to mislead the Court. Clearly, this can at times conflict with instructions that are given by clients. In answering questions to the Inquiry panel it was apparent that Mr. van Schaik had no knowledge of the propensity for schizophrenics to commit suicide, which is known to be as high as 10%. He was quite clear in his evidence to the Inquiry that if he had known that propensity his actions as Mr. Donnelly's legal representative would have been quite different.

360. Home Office Circular 12/95 stated expressly that,

"legal representatives in the defence of mentally disordered suspects have an important role to play in the implementation of effective inter-agency arrangements in helping to ensure that the treatment and care needs of mentally disordered people are met. Where possible, legal representatives should be involved in local schemes."

361. It is our opinion that Mr. van Schaik's representation of his client's interests fell short of what one would have expected for a vulnerable client, known to have a serious mental health problem.

(vi) Race, Ethnicity and Culture

362. Throughout the interaction of Mr. Donnelly with the Mental Health Services there are continued references to him as "coloured" which is a regrettable and offensive term of phrase for people of African Caribbean origin whether mixed race or not. The inappropriate use of terminology is a feature which persisted both in the documentation and in the oral evidence provided to the Inquiry. Whilst unintentional it did not give the impression that the Mental Health Services were aware of the implications of a service which failed to address the racial, and to a lesser extent cultural needs of Mr. Donnelly.

363. A consistent error was made in recording Mr. Donnelly's ethnic origin as he is inaccurately recorded as being "*Dark European*" in the custody record. The custody record depends on a subjective view of ethnic appearance which could be inaccurate and misleading.

364. Dr. Macallan, the FME recorded Mr. Donnelly's presentation on 7th October 1995 but described his appearance in the following terms:

> *"He might have had a very dark suntan or he may have had parents with coloured skin. He certainly was not a Negro and he was not definitely - and he was not Asian in appearance, but his skin was dark. He may have been Mediterranean extraction."*

365. By contrast the Probation Service demonstrated a clearer understanding of the dynamics of race and ethnicity as they affected Mr. Donnelly's case. For example, Ms. Taylor made efforts to spell and pronounce " *Mičhéal* " as "*M'hal.* " Similarly, Ms. Hill during her two interviews was able to raise the issue whilst dealing with some psychotic symptoms that she noted. In oral evidence she stated,

> *"I mean, one of the particular things with Mr. Donnelly was his racial persecution. He would talk about that. That, again, would... his demeanour would change and he would become quite agitated... he talked about his Irish links and his relatives; and he was very... I can remember him almost wanting to put that to one side, and claiming, I think his father's. "*

366. Mr. Donnelly was also clear in identifying that race was an issue for him as he stated during his interviews with Ms. Hill. She related in evidence that "*he was very clear...because of course we have monitoring forms, and stuff like that, I think there was a whole list of race that he gave me to go down. "*

367. By contrast, in oral evidence Mr. Close had been asked about Mr. Donnelly's racial identity as follows:

"*Question:* *Just in relation to his ethnicity, did that actually affect your interaction with him in any way?*

Answer: *I do not believe it did. Does that mean that race is an issue or...*

Question: *Do you think this is an issue?*

Answer: *I do not think it is an issue.*"

COMMENT

368. Whilst Dr. Macallan did not intend to cause any offence, his use of language reflected the poor recognition of ethnicity and the need to record in appropriate terminology an individual's ethnic or racial origin. There ought to be sufficient awareness of the need to record ethnicity both in the Essex Police Service and in the Medical Services, given the guidance issued by the Department of Health. This is particularly relevant due to the different attributes and susceptibilities to illness linked to ethnicity.

369. There are two levels at which race and ethnicity were a factor in Mr. Donnelly's engagement with both the criminal justice system and the mental health services. On one level it is clearly necessary to record an individual's ethnic origin accurately. This is also important in terms of using appropriate terminology so as not to cause offence. It is clear that in oral evidence Dr. Baloch, Dr. Macallan and Dr. Marfleet reflected the inappropriate use of terminology evidenced from both police documents and from the records of the Mental Health Services. By contrast, Ms. Hill was able in only two interviews to go to the next level whereby to have any professional understanding of Mr. Donnelly it was necessary to identify the importance of race and ethnicity as far as he was concerned.

370. In order to assess whether those comments were part of the persecutory complex or were exacerbated by his mental state one would need to recognise race and ethnicity as an issue in the first place. It is clear that only the Probation Service appear to have recognised race and ethnicity as an issue as far as Mr. Donnelly was concerned. Mr. Close demonstrably failed to deal with race as an issue where it was clearly apparent over the years that was a concern for Mr. Donnelly and therefore ought to have been for those dealing with his professional care. A colour blind approach to mental health must be inherently wrong. An approach which fails to deal with the proper care, treatment and supervision of ethnic minorities in the community must be inappropriate in a multi-racial society.

Chapter 3

Housing and support services for the mentally ill

371. The identification of supportive accommodation ought to have provided a comprehensive support network for Mr. Donnelly following his discharge from hospital on 27 March 1995. The CHAC accommodation and care workers did provide an appropriate and caring environment.

372. Initially when Mr. Donnelly was placed he did not have his own self-contained flat and the shared accommodation at Greenstead proved problematical within a short space of time. The Inquiry identified through Mr. Clive Burgess that although there had been a proper screening assessment of Mr. Donnelly before admission to the CHAC accommodation his case file was spread in several different areas and was therefore not easily accessible to any particular care worker. This appears to have been a particular management policy decision at the time which is no longer the current practice.

COMMENT

373. Although the right to individual privacy is a consideration for mentally disordered offenders this must take account of the need to access the relevant information in relation to their psychiatric care and supervision within the community.

374. It is clear that care workers at the CHAC accommodation ought to have had comprehensive information on each tenant so they can be aware of what symptoms or signs to note in their log book of incidents. On the whole the log book was appropriately kept and sufficiently well informed to enable anyone accessing the information to make some valued judgement on the overall presentation of Mr. Donnelly. We were satisfied that there was an appropriate level of care and support provided by the workers.

375. We are also satisfied that the care workers maintained an appropriate level of contact with the psychiatric services through the community psychiatric nurse Mr. Close. The only drawback to this contact was their inability on occasions to recognise which information ought to be conveyed to Mr. Close and the apparent failure by Mr. Close to advise them of the type of information he required.

376. There ought to be the opportunity for direct access to psychiatric services in the event that the community psychiatric nurse cannot be contacted or there is an out of hours emergency. Information as to the presentation of a patient in residence in supported accommodation ought to be conveyed directly both to the care co-ordinator on a regular basis to ensure that a proper multi-agency approach is applied.

377. Care workers from the supported housing accommodation should attend at the Mentally Disordered Offenders Panel meetings given the knowledge that they would have about a client's overall presentation.

378. The Oxford Road Unit - The discharge plan, although setting out that there would be a programme of activities at Oxford Road, did not specify clearly which sort

of activities would most benefit Mr. Donnelly. Whilst we were satisfied that the Oxford Road Unit firstly through Ms. Barker and then through Ms. Johnson did attempt to facilitate a discussion and a planned set of activities with Mr. Donnelly, this was, not clearly apparent from the documentation.

379. Overall both the Oxford Road Unit and the CHAC accommodation did provide an appropriate level of supportive accommodation and activities for Mr. Donnelly. Given the shortage of supported accommodation, identified by the Christopher Edwards and Richard Linford Inquiry, in the North Essex area, they were a resource he was fortunate to be referred to.

380. Whilst the workers at Oxford Road obviously had a very good and detailed knowledge of Mr. Donnelly some of their concerns were not passed on to the psychiatric services. This contributed to the failure to paint a comprehensive picture of Mr. Donnelly's mental health needs being presented to the psychiatric services in sufficient time to take action.

PART III

POLICY AND MANAGEMENT ISSUES

Chapter 1

The interface between the Mental Health Act 1983 and the criminal justice system

381. The main theme identified in the course of the Inquiry was the absence of agreement and clarity of purpose between the two main groups of agencies responsible for the care and supervision of Mr. Donnelly between September 1995 and March 1996. The failure to have clear areas of responsibility and to liaise appropriately between these two agencies was the crucial factor which led to a different response to the care and supervision of Mr. Donnelly during this period compared to that which had worked more successfully in the period from February to April 1995.

382. The guidance from the Home Office as to the role of the mental health services and the criminal justice system is well documented.

383. Home Office Circular 66/90 sets out quite clearly the background to this relationship. In recognition that government policy is quite clear that where possible mentally disordered offenders should receive care and treatment from the Health & Social Services certain basic requirements were set out.

384. In the Circular dated 3 September 1990 it was stated quite clearly that:

> *"The government recognises that this policy can be effective only if the Courts and Criminal Justice Agencies have access to Health and Social Services. This requires consultation and co-operation, and this Circular aims to provide guidance on the establishment of a satisfactory working relationship between courts, criminal justice agencies and Health and Social Services."*

385. The Circular did however state quite clearly that at the outset the Crown Prosecution Service ought to consider the issue of whether it is in the public interest to proceed with a prosecution. The guidance noted in paragraph 6 states:

> *"It will be important to distinguish between those forms of mental disorder which are made worse by the institution of criminal proceedings and those forms of mental disorder which, by reason of the institution of criminal proceedings where the service is satisfied that the probable effect upon a person's mental health outweighs the interest of justice in a particular case, it will consider discontinuing the proceedings. Where the form of mental disorder is present without there being any indication that proceedings will have an adverse effect, the Crown Prosecutor will take account of the public interest in attempting to ensure that the offence will not be repeated as well as having regard to the welfare of the person in question. "*

386. There was also a duty set out in paragraph 4 (iii) upon the police as the guidance stated if the suspect is able to meet the requirements for a caution to be administered, he might be cautioned. If the criteria for the caution are not met, the police should consider whether any action need be taken against the suspect. In some cases the public interest

might be met by diverting mentally disordered persons from the criminal justice system and finding alternatives to prosecution, such as admission to hospital under sections 2 or 3 or to guardianship under section 7 of the 1983 Act or informal support in the community by Social Services Departments.

COMMENT

387. It would appear that in Mr. Donnelly's case the police did not give any consideration as to whether it was necessary to proceed with the charges against Mr. Donnelly. The file which was sent to the Crown Prosecution Service by the police did not flag up the fact that he had a history of mental illness and therefore was unlikely in the circumstances to have considered the question of whether it was in the public interest to proceed with the prosecution.

388. Mr. Donnelly would not have been eligible for a caution and on balance it may have been felt that because of the continuing use of violence against his mother's property that it was an appropriate decision to charge him on this occasion. Notwithstanding these considerations nothing that the Inquiry panel heard by way of written or oral evidence demonstrated that the Crown Prosecution Service considered this question according to the guidance referred to.

389. Paragraph 20 specifically provided for the situation identified in Mr. Donnelly's case where it was felt that a probation order with a condition of treatment would be appropriate. In identifying this as a possible remedy the specific guidance was issued stating that,

> "*there should be liaison between the probation officer, the author of the medical report and the offender's lawyer about an appropriate recommendation to the Court.* "

COMMENT

390. It was clear in Mr. Donnelly's case that there was not an effective liaison between the agencies and Mr. Donnelly's solicitors. The most obvious failure which fails to take into account the guidance set out above was the absence of an effective liaison between the probation service, Mr. Donnelly's solicitor and the author of the medical report. If there had been this effective liaison it would have been picked up that there was in fact no medical report prepared by a practitioner approved under Section 12 Mental Health Act before the Court.

391. Paragraph 22 of the Circular clarifies this fundamental requirement when it states "*the effectiveness of probation orders with a condition of treatment depends on close cooperation, understanding and communication between the probation service and local psychiatric services, and is aided by the presence at local level of psychiatric staff with an interest in forensic psychiatry. It would be helpful for each probation area to draw up its own code of practice for probation officers undertaking supervision of a mentally disordered offender, defining lines of responsibility and accountability (e.g. clarifying the boundaries between a responsible medical officer and a probation officer, especially where both are carrying statutory responsibilities).*"

COMMENT

392. It is precisely this type of structured liaison which was lacking in Mr. Donnelly's case. The disagreement between the probation service recommendation and Mr. Clift's view that a condition of medical treatment under a probation order

was required was left unresolved and this clearly flies in the face of the good practice and guidance foreseen as necessary in this Home Office Circular dating from 66/90.

393. The Circular concluded that:

> *"Where a prosecution is necessary it is important to find suitable non-penal disposal wherever appropriate and the police, courts, and the probation service are asked to work together with their local health and social services to make effective use of the provisions of the Mental Health Act 1983 and other services which exist to help the mentally disordered. "*

394. It is correct to say that although a non-custodial disposal was found for Mr. Donnelly the Courts were faced with a recommendation which was wholly unrealistic as an effective safeguard for the supervision, care and treatment of Mr. Donnelly in the community. Not only was an inappropriate decision reached but the decision was made on a court report which no one at the material time recognised as being legally inappropriate for the recommendation it was purporting to make.

395. In the summary of the conclusion at paragraph 26(ii) it was stated that,

> *"the attention of court clerks is drawn, in particular, to the desirability of establishing arrangements and cooperation with the probation service and the local health and social services authority, for speedy access to professional advice to the court to assist it in its decision making;"*

COMMENT

396. The interface between the criminal justice system and the mental health services did not accord with the guidance set out in this Home Office Circular 66/90 and it fell far short in the material respects of the liaison and cooperation that one could reasonably expect to have been in operation between these agencies. The failure of the Magistrates' Court to take effective responsibility for the procurement of the psychiatric report and the confusion about its existence in any event was one of the major contributing factors to the inappropriate sentence which was passed on Mr. Donnelly on 10 January 1996. The subsequent reliance upon the criminal justice process via the probation service to regulate Mr. Donnelly's depot medication was a failure not only of the mental health services but of the criminal justice system itself to recognise how ineffective a remedy that was.

397. In 1992, the Department of Health published a White Paper; Health of the Nation, which stated:

> *"Mentally disordered people who commit offence are a particularly vulnerable group. There is a risk that if their health and social care needs are not recognised and met, then they slip into a vicious circle of imprisonment, reoffending, and deteriorating mental health. "*

COMMENT

398. Although he had not been imprisoned before in the United Kingdom, Mr. Donnelly's offence against his mother had involved an element of the *"revolving door"* process. Mr. Donnelly re-entered the criminal justice process at more or less the same point he had left it in April 1995.

RECOMMENDATIONS

(i) Police and Crown Prosecution Service

1. WE RECOMMEND *that the decision not to call an appropriate adult at a police station, where there is evidence of mental illness past or present, ought to be recorded in the custody record and the reasons for that decision being made ought also to be recorded as a matter of good practice. Any such discussion with the forensic medical examiner ought to be recorded and his or her support or otherwise for the presence of an appropriate adult ought to be recorded.*

2. WE RECOMMEND *that any police papers which are sent to the Crown Prosecution Service relating to a person known to be suffering from a mental illness or with a previous history of mental illness, must be recorded specifically in the documentation filed with the Crown Prosecution Service.*

3. WE RECOMMEND *that the custody record front sheet ought to have a section where it can be clearly recorded if it is known that a suspect/person charged has ever been diagnosed as suffering from a mental illness.*

4. WE RECOMMEND *that the forensic medical examiner should make a note of his examination and forward a copy to the General Practitioner for onward transmission to the psychiatrist who is treating a mentally disordered offender.*

5. WE RECOMMEND *that Essex Police Force ought to have an accurate system of recording ethnicity which is relevant to the Commission for Racial Equality and Home Office guidelines. Such a system ought also to request clarification from the individuals being monitored in the light of any uncertainty.*

(ii) The Probation Service and Mental Health Service

6. WE RECOMMEND *that a court duty probation officer should ensure that when a defendant is known to be mentally disordered or suspected of suffering from a mental illness that fact should be clearly identified in the request for the pre-sentence report.*

7. WE RECOMMEND *that the case records maintained by the Probation Service on an individual should all be kept together. Similarly, all relevant information should be provided to the manager responsible for allocation prior to that decision being made.*

8. WE RECOMMEND *that the Essex Probation Service and the Essex Mental Health Trust should formulate a protocol in the event that there is disagreement as between the recommendation made by the Probation Service to the Court in the Pre Sentence Report and the recommended treatment and care provided for by the mental health services.*

9. WE RECOMMEND *that the implementation of a multi-agency care programme approach should be given effect by local protocols to agree the policies and practices in relation to the use and operation of probation orders (with or without conditions of treatment) for mentally disordered offenders.*

10. **WE RECOMMEND** *that where a pre-sentence report has been presented and the case has been adjourned for a psychiatric report, the probation officer who prepared the pre-sentence report and the psychiatrist should discuss the case as a matter of routine. We also recommend that the author of the pre-sentence report should take responsibility for updating the report in the event of any further developments coming to the notice of the probation service.*

11. **WE RECOMMEND** *that the care coordinator, designated under the care programme approach should be the primary person responsible for ensuring that the notices and minutes of the Mentally Disordered Offenders Panel meeting are properly circulated. It must also be the care co-ordinator's responsibility that in the event of non-attendance of a consultant psychiatrist or forensic psychiatrist that such an expert view is taken in writing as soon as practicable or the Mentally Disordered Offenders Panel meeting adjourned until they are able to attend.*

12. **WE RECOMMEND** *that a local protocol should be agreed and thereafter monitored between the relevant agencies, health trusts, the probation service, the police, Magistrates' court service, the Crown Prosecution Service, social services. Such protocol should cover all the issues of a multi-agency approach in a case of an Mentally Disordered Offenders being supervised in the community.*

13. **WE RECOMMEND** *that the local protocol must be extended to the court diversion scheme to ensure an appropriate level of liaison and the application of the multi-agency approach between health trusts, social services, Magistrates' court services, Crown Prosecution Service, probation service, police as well as local defence solicitors.*

14. **WE RECOMMEND** *that all the relevant agencies adopting the multi-agency approach and liaising in this manner should co-ordinate their training and risk assessment.*

15. **WE RECOMMEND** *a system being introduced to ensure that, as soon as a Mentally Disordered Offender comes into contact with the police, or enters the criminal justice system, that fact be made known by the Police or Crown Prosecution Service to the community mental health team and the General Practitioner, as well as to the court diversion worker. When that information becomes known the court diversion worker would be the central person responsible for making sure all the relevant information is provided to the court. There would be close liaison with the care co-ordinator.*

16. **WE RECOMMEND** *that wherever possible the court diversion worker, or his agent responsible for the Mentally Disordered Offender concerned, attends court to ensure that the court can access the fullest level of information possible about the mentally disordered offender appearing before them. Whilst the court diversion worker's presence is not necessary at the various adjournment stages it is essential if the court seeks to make a disposal or a sentencing determination on a given date.*

17. **WE RECOMMEND** *that the court duty probation officer ought not to give information to the court e.g. that a Mentally Disordered Offender is currently taking medication unless satisfied that this has been verified at first hand with the community psychiatric nurse and/or psychiatrist responsible for the administration of depot medication. Information from the defence solicitor and/or the defendant himself should not be relied upon in this respect.*

18. **WE RECOMMEND** *that, where a mentally disordered offender is brought back to court for the purposes of amending, deleting, discharging or in any way altering the sentence imposed previously, the supervising probation officer should make a formal report to the court updating them on the situation.*

19. **WE RECOMMEND** *that where it is felt necessary to deviate from probation service national standards the reasons for doing so should be clearly stated and the extent to which they are not to be complied with should be set out.*

20. **WE RECOMMEND** *that in the case of all part-time staff who are supervising mentally disordered offenders in the community there must be a backup staff member appointed.*

21. **WE RECOMMEND** *that within the multi-agency approach there must be mutually consistent systems of assessment of risk to the mentally disordered offender, him or herself, the community, or any significant individual likely to be targeted. Such a system must adopt mutually consistent assessments covering the propensity for violence to people and property, threats uttered, previous offending behaviour, and the likely threshold at which the risk assessment/dangerousness is likely to enter a higher risk category.*

22. **WE CONCUR WITH THE RECOMMENDATION** *of the Christopher Edwards and Richard Linford Inquiry that, in order to provide a comprehensive and early diversion facility, the court diversion scheme needs to be properly resourced and certainly extended by additional funding to enable a 24 hour, 7 days a week service to be provided.*

23. **WE RECOMMEND** *that there be a full and proper training programme designed to ensure that Magistrates' court clerks are fully conversant with the needs of mentally disordered offenders both with the Mental Health Act 1983 and with the sentencing provisions applicable to them. We also recommend that wherever possible if there is uncertainty about the legal provisions then the matter should be adjourned or put back so that proper and detailed enquiries can be made.*

Chapter 2

Risk assessment, care and supervision in the community

399. Health Service Guidelines HSG(94)5 introduced supervision registers for mentally ill people from 1 April 1994. The provision and establishment of supervision registers was designed to identify those people with a severe mental illness who may be a significant risk to themselves or to others. The requirement built upon the guidance set out at HC(90)23/LWASL(90)11 on the introduction of the Care Programme Approach. Guidance focused on the first stage development of the comprehensive mental health information system as set out in the Health of the Nation. This required all mental health provider units to have effective information systems in place by 1995.

400. There had been a slow and inadequate implementation of the Care Programme Approach in North Essex between 1990 and 1994. See paras 1563 - 1588 of the Christopher Edwards and Richard Linford Inquiry.

401. The system of key workers was not operating effectively. The CPA policy did not adequately set out the responsibilities and remit of the care co-ordinator. There was no clear emphasis placed on the specific duties of the care co-ordinator which was to maintain regular contact with the patient. This liaison was essential in order for the care co-ordinator to advise professional colleagues of changes in circumstances which might require a review and a modification of the individual care programme. Guidance within the Care Programme Approach policy was minimal.

402. A 10-point plan had been announced by the Secretary of State in August 1993 to improve community care for mentally ill people containing commitments to introduce special supervision registers for patients who were most at risk and who needed most support. The purpose of the supervision registers was set out as being:

> *"Identifying all individuals who enter the care of the NHS provider unit known to be at significant risk or potentially at significant risk of committing serious violence or suicide or of serious self neglect as a result of severe and enduring mental illness is a key element in:*
>
> *a) Providing a care plan aimed to reduce the risk and ensuring that the patient's care needs are reviewed regularly and that contact by a key worker is maintained;*
>
> *b) Providing a point of reference for relevant and authorised health and social services staff to enquire whether individuals under the Care Programme Approach are at risk;*
>
> *c) Planning for the facilities and resources to meet the needs of this group of patients; and*
>
> *d) Identifying those patients who should receive the highest priority for care and active follow up."*

The categories for inclusion were set out in paragraph 9 which stated,

"At the time of inclusion on the register and at each subsequent review at which the patient is left on the register, patients should be assigned to one or more of the following three categories. Assignment to more than one single category should be for specific reasons:

a) Significant risk of suicide.

b) Significant risk of serious violence to others.

c) Significant risk of severe self neglect."

The circular went on to suggest that,

> *"Where the risk of committing serious violence, suicide or self neglect is considered to be continued on specific events (e.g. seeking to take medication, or loss of a supportive relationship or home) the identifying warning signs should be recorded in line with current best practice."*

403. The Care Programme Approach was only adopted as a detailed policy in April 1997. At no stage was Mr. Donnelly considered for inclusion on the supervision register for mentally ill people as would have been appropriate under the guidance set out in HSG(94)5 annex A. The primary responsibility for the failure to implement the Care Programme Approach lay on the health side. North Essex Health Authority was under a duty to monitor its contract with all the NHS Trusts in North Essex in order to ensure that the requirements of the care programme approach were being delivered.

404. The risk assessment that was carried out by Dr Baloch and which was re-confirmed at the Mentally Disordered Offenders Panel meeting was appropriate. The management of Mr. Donnelly however was not. The risk factors that were clearly identified were that of a man who suffered from a serious chronic mental illness such as paranoia which led to him becoming aggressive and violent particularly against his mother. It was recognised that on an appropriate level of medication his mental illness was brought under control and he did in fact get better. This is the way that he was managed until mid-1995. Both Mr. Clift and Mr. Close chose to manage him through a probation order and via the criminal justice system with support from the mental health services.

405. Mr. Clift's line manager at the time, Ms. Deanna Carey, was in post until she left the employ of the North East Essex Mental Health NHS Trust in November 1996. Although there appeared to be regular meetings to discuss Mr. Clift's casework it does not appear that the intervention of Ms. Carey altered Mr. Clift's assessment in any material respect. It has been impossible to analyse the extent of the supervision in the absence of supervision notes and the subsequent loss by Mr. Clift of his diary records for the period.

406. Similarly there are no supervision notes available to show the extent or content of any discussions between Mr. Close and his immediate line manager Mr. Peter Flack. Consequently the extent of Mr. Close's clinical supervision remains unclear. In any event neither Mr. Close nor Mr. Clift placed any great emphasis on receiving guidance from management in relation to the various decisions highlighted in this report.

RECOMMENDATIONS

24. **WE RECOMMEND** *that care co-ordinators be issued with guidance as to their duties and responsibilities outlining clearly their central role in ensuring the management of individual care plans.*

25. **WE RECOMMEND** *that all local agencies should monitor their implementation of the Care Programme Approach to ensure that the joint policy is fully implemented. Any progress reports on the joint action plan should be issued to ensure that all parties, and the public at large are satisfied that the inadequacies identified in the joint report have been removed.*

26. **WE RECOMMEND** *that General Practitioners should be accessed by care co-ordinators to ensure that the information that they have and their knowledge of the patient is accessed on a regular basis notwithstanding busy General Practitioners schedules and their busy workload. It is essential that General Practitioners are involved in the decision making process by care co-ordinators.*

27. **WE RECOMMEND** *that court diversion workers must maintain properly detailed notes of their work relating to mentally disordered offenders. Where possible such notes should be kept accessible to other professionals. It should be the responsibility of line management to record and maintain proper records of supervision and advice given to staff under the Court Diversion Scheme.*

28. **WE RECOMMEND** *that Community Psychiatric Nurses should receive regular clinical and management supervision of their case work, regardless of their seniority. Such supervision notes should be maintained as part of the overall management responsibility.*

Chapter 3

Housing and support services for the mentally ill

407. The provision of appropriate housing for Mr. Donnelly was initiated by the Mental Health Services, working with the CHAC accommodation to provide adequately for Mr. Donnelly's needs.

408. Earlier attempts had proved largely unsuccessful as either Mr. Donnelly or his mother had viewed that as inappropriate. Once the recommendation came from Dr. Baloch matters proceeded quite quickly. The assessment by Mr. Flack, Mr. Close's manager was conducted expeditiously to enable Mr. Donnelly to move in March from the Lakes, where he had been since February.

409. The evidence given by the care worker at CHAC, Mr. Burgess, suggested a caring service offering a good level of support. There was the strong suggestion that they were heavily reliant on the advice from Mr. Close and felt unable to initiate a mental health assessment for Mr. Donnelly. The information supplied to Mr. Close was on one occasion met with a response that there was nothing he could do if Mr. Donnelly continued to smoke cannabis.

COMMENT

410. The underlying message given by Mr. Close to the workers at CHAC was that Mr. Donnelly was a low risk with his anti-social behaviour having a rational explanation. This led inevitably to the CHAC staff being unable to see the necessity of communicating the fullest picture of Mr. Donnelly's presentation.

411. The care workers at CHAC could, if they had been provided with a clear picture of Mr. Donnelly's mental health, acted as an early warning system for his deteriorating mental health. Instead they failed to be informed as to the risk that he posed, particularly as they did not have the risk assessment provided by the Mentally Disordered Offenders Panel meeting.

412. The Oxford Road Unit provided a useful level of support for Mr. Donnelly for approximately nine years and was arguably in possession of a lot of comparative information about how he presented whilst normal and whilst deteriorating. The destruction of the ampoules on two occasions was picked up by the key worker at Oxford Road but not accessed elsewhere by mental health professionals until sometime later.

413. There was an appropriate level of activities provided for Mr. Donnelly although it may have been more constructive if these could have been used, where appropriate, as indicators of his mental health generally.

COMMENT

414. The Oxford Road Unit could have provided an important source of information for Mr. Close, in spite of Mr. Donnelly's irregular use which tended to fluctuate depending on his attendance at the various courses. An important part of the jigsaw was missing as they were not invited to the Panel meeting, nor did they receive

the subsequent minutes and had only a partial view as to the risk assessment conducted on Mr. Donnelly.

RECOMMENDATIONS

29. **WE RECOMMEND** *that supported accommodation for mental health patients ought to have a full and centralised filing system and their psychiatric and social needs be made accessible to all relevant care staff.*

30. **WE RECOMMEND** *that the supported housing sector should have direct access, to the psychiatric services if they are concerned about a resident's/client's behaviour. They ought, in appropriate circumstances, to be able to initiate a mental health assessment without waiting for the Community Psychiatric Nurse or General Practitioner to take the first step.*

31. **WE RECOMMEND** *that the presence of care/project workers at the Mentally Disordered Offenders Panel meeting should be given a high priority, and in their absence there should be a full written report available via the care co-ordinator. In any event, a summary of file notes on any medium to high risk patient should be forwarded on a monthly basis to the care co-ordinator for transmission on to the General Practitioner and psychiatrist for evaluation.*

32. **WE RECOMMEND** *an information pro forma be designed and supplied by the Mental Health Services upon commencement of residence/project attendance with regular updates supplied thereafter. Such a pro forma should make clear what symptoms to be alerted for in order that mental health professionals have a full picture of the patient's/client's presentation.*

33. **WE RECOMMEND** *that a clear set of activities are formulated in consultation with the Mental Health services, and then monitored as to their suitability for clients using the Oxford Road Unit.*

34. **WE RECOMMEND** *a closer level of co-operation between the Oxford Road Unit and the other agencies involved particularly through the care co-ordinator appointed under the Care Programme Approach.*

Chapter 4

The Care Programme Approach in North Essex

415. There have been many administrative and organisational changes during the 1990's promoted by central government to achieve a major change of emphasis in mental health policy to ensure that care in the community was taking place. A number of government circulars and guidance to develop these principles occurred together with the recommendations of a number of reports of independent inquiries in mental health homicides. It is clear that central government was concerned with the service delivery of care in the community both for the mentally ill and those who had the responsibility for their care. The then Minister of Health in August 1995 wrote to the Chairmen of National Health Service Trusts and Health Authorities stating:

> *"It is clear that much remains to be done by health and local authorities working together to implement the Care Programme Approach fully."*

416. In Essex these deficiencies were picked up, and a lack of consistency and an absence of clarity of purpose in the development of health strategy and development and community care planning overall was recognised. There tended to be a reactive and inconsistent approach throughout Essex at this time. These deficiencies were recognised by the District Auditor's Review of Mental Health Services 1994/5 and by the North Thames Regional Office Review of DHA's Performance on Mental Health, November 1995.

417. The circumstances leading up to the homicide on March 4, demonstrated quite clearly that there was inadequate co-ordination between the various agencies involved in the care and supervision of Mr. Donnelly in the community. Whilst the Mentally Disordered Offenders Panel and the court diversion schemes of themselves were designed to improve inter-agency working and partnerships, the reality and practice were somewhat different.

418. There was on many occasions a lack of a clear lead given by the key worker. In this case that role was primarily held by Mr. Close but was never clearly defined. The co-ordination and exchange of information was unacceptable. It is correct to say that a number of advances have been made in the North East Essex area as a result of the tragedy not only from the homicide committed by Mr. Donnelly, but from the recommendations and concerns raised in the Christopher Edwards and Richard Linford Inquiry. The main changes that have been implemented are:

a) Care Programme Approach policies and procedures have been updated and have become fully operational from April 1997.

b) Care Programme Approach review meetings are being monitored increasingly by computerised systems with clinical teams being advised concerning the need to include carers on a formal basis in reviews.

c) A new policy on health records was issued in January 1998 recognising the need for Care Programme Approach care co-ordinators to record a

chronology of events of all patients who exhibit a medium to high risk of harm to others.

d) The Mentally Disordered Offenders Panel Meetings have been incorporated into Care Programme Approach policy by the Mentally Disordered Offenders Steering Group with the agreement of the Probation Service.

e) Further guidance was issued in October 1997 concerning patients who are known risks who fail to keep appointments or who are not at home when the Care Programme Approach care co-ordinator called, to ensure that contact is made with a patient as part of an assertive outreach programme and actively consider calling an emergency review to re-evaluate the care programme approach.

419. There is no community forensic service provision in North East Essex which is a serious factor undermining the efficiency of the implementation of the care programme approach in that part of the county. If such provision had existed it is possible that there could have been an input by a forensic psychiatrist to the Mentally Disordered Offenders Panel meeting on 11 January 1996 or that there could have been liaison between Mr. Close and such a source of expert advice.

420. Similarly, the court diversion scheme lacked access to a forensic psychiatric service which again reduced the effectiveness of the scheme.

RECOMMENDATIONS

35. WE RECOMMEND ***that a community forensic service be established in North Essex in line with the recommendations of the Christopher Edwards and Richard Linford Inquiry.***

36. WE RECOMMEND ***that a specialist post be created for a forensic psychiatrist to be available in North Essex. The responsibilities of this post should include support for:***

(i) The court diversion scheme.

(ii) Forensic medical examiners attending police stations.

(iii) Care co-ordinators seeking advice.

(iv) Probation officers seeking expert advice.

(v) Supported accommodation staff requesting expert advice.

Chapter 5

Multi-disciplinary partnerships

421. A feature of the Mr. Donnelly case was that there were some underlying difficulties between the multi-agency approach involving the police, the Magistrates' court service, the probation service and the mental health services. Whilst problems will often occur when different agencies work with each other, bringing together their different cultures, practices and individuals, it is unfortunate if those differences hamper the effectiveness of a multi-disciplinary approach to the care and supervision of the Mentally Disordered Offenders in the community.

422. The underlying problem identified in this case was that the probation service experienced some frustration with a mental health service which had, not for the first time, recommended a probation order with a condition of treatment without it being agreed with the probation service itself. The court diversion scheme, which had only been running for some months at that time, had to consider Mr. Donnelly's case, while lacking adequate supervision and guidance as to his mental health needs. It was a feature of Mr. Clift's work that he had himself effectively written his own job description and was overstretched and over committed for the task he was requested to do.

423. The manner in which the Court requested the report was in our view inappropriate. There was no follow up either by Mr. Clift or the probation service.

424. The other significant problem was the operation of the adversarial system whereby the defence solicitor attempts to obtain the least interventionist sentence for his client while the court requires the fullest possible information in order to make a sentencing determination. These roles, whilst they are not meant to conflict, obviously did so in Mr. Donnelly's case. Mr. van Schaik was not aware of the dangers of self harm posed by Mr. Donnelly's deteriorating mental condition. It was clear from his oral evidence that if he had been aware of those risks, he would have been less willing to have acted simply on Mr. Donnelly's instruction but would have considered the wider picture. It is likely in those circumstances he would have been more proactive in contacting the probation service and may well have engaged Dr. Baloch or a forensic psychiatrist directly instead of placing his reliance upon Mr. Clift's report.

425. The role of the Crown Prosecution Service and the police was, to all intents and purposes, a background one having omitted to make an early reference to the court diversion scheme or, it appears, to have considered whether it would have been in the public interest to have pursued a prosecution against Mr. Donnelly.

426. The probation service, however, did put aside its reservations about the effectiveness of the probation order as it tried to supervise Mr. Donnelly in the community. Notwithstanding that professionalism, a more proactive role ought to have been adopted in challenging the view of Mr. Clift that a probation order with a requirement for treatment was, in the circumstance, an appropriate recommendation to make with regards to Mr. Donnelly.

427. There is an acknowledgement by the probation service and the mental health service of the inadequacy of the effective joint planning and joint working that was applicable to the care of Mr. Donnelly.

428. Since 4 March, 1996 the relevant agencies have made significant efforts to work more efficiently together. For example the following have been set in place:

a) A county mental health strategy group has been established which includes representatives from Trusts that provide mental health services in Essex.

b) A multi-agency approach in the field of mentally disordered offenders has developed since 1994 through the Essex Mentally Disordered Offenders Steering Group.

c) The internal review conducted by the probation service and by the mental health service have both made recommendations with action plans. These have been taken forward together with the recommendations of the Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford which are currently being implemented as part of a joint action plan.

429. The new mental health strategy announced by the Government in the week of 14 December, 1998, and due to be published in March 1999, will require implementation at a local level to make best use of the additional resources that will be available from central government. Notwithstanding this additional targeting of resources there are inherent difficulties in different organisations effectively working together. The development of an effective multi-agency approach has to take account of the realities of separate funding, management and leadership; different information and technology systems; different recording systems and the different accountability of individuals. To overcome these obstacles a co-ordinated and committed approach will be required by the agencies working together.

RECOMMENDATIONS

37. WE RECOMMEND ***that the recommendations of the Christopher Edwards and Richard Linford Inquiry are consolidated with the recommendations from this Inquiry to prevent duplication and to ensure that best practice is achieved across the county.***

38. WE RECOMMEND ***that Care Programme Approach care co-ordinators are responsible for co-ordinating the support provided by all other agencies having an input into the care and supervision of mentally disordered offenders such as housing, probation, the court diversion scheme, work project and accommodation care workers.***

39. WE RECOMMEND ***that Care Programme Approach care co-ordinators have the primary responsibility to ensure that all essential information is passed not only to those directly involved with the care and treatment of a patient but that such information passes speedily to a consultant psychiatrist or forensic psychiatrist responsible for the care of the patient.***

40. WE RECOMMEND ***that the Care Programme Approach review meetings are held regularly, involving both the patient as well as significant carers. In the event that those meetings cannot be attended by an agency or representative a written report updating the meeting on a patient's progress must be submitted.***

41. WE RECOMMEND *that a formal risk assessment is conducted on a multi-agency basis involving a consultant psychiatrist or forensic psychiatrist. Such assessment must be an informed decision based on a full exchange of information and where possible on an agreed set of criteria between the different agencies.*

42. WE RECOMMEND *that all patients who have been designated as a medium to high risk category of harm to others should have a chronology of events compiled by the Care Programme Approach care co-ordinator. This chronology should be shared at the earliest opportunity with all those agencies and individuals involved in the care, treatment and supervision of the patient in the community.*

43. *WE RECOMMEND that the Mentally Disordered Offenders Panel meetings should be formally incorporated into the Care Programme Approach policy and be treated as reviews. In every case where there is a medium to high risk of harm to others the mental health trust should provide the lead role in overall co-ordination through the care co-ordinator.*

44. WE RECOMMEND *that the responsible medical officer (RM0) should always attend such reviews/panel meetings or in his/her absence the meeting should be provided with a full update. If any major decisions are to be made about the care, treatment or supervision of the patient then the RMO must be in attendance and the meeting adjourned, if necessary, for that to take place.*

45. WE RECOMMEND *that the court diversion scheme should offer consultant psychiatric/forensic psychiatric sessions as part of the service to provide medical support to mentally disordered offenders.*

46. WE RECOMMEND *that there should be a comprehensive community forensic service made available in North East Essex.*

47. WE RECOMMEND *that the magistrates' court service should ensure that psychiatric reports are only requested from Section 12 approved doctors where a recommendation is being considered for a condition of treatment as part of a probation order, and arrange that advance copies are provided to the court diversion service and the probation service.*

48. WE RECOMMEND *that where referral to an anger management course or other such course is being considered this should be discussed with the psychiatrist responsible for the overall treatment and supervision of the patient in the community. The primary responsibility for referral should rest with the care co-ordinator. Where mentally disordered offenders who present a medium to high risk fail to attend for appointment or are not at home when a General Practitioner calls, the Care Programme Approach care co-ordinator should be alerted immediately. Failure to take depot medication and to attend for out-patient appointments should fall into a similar category, in order to provide an effective mechanism for monitoring the care and supervision of the patient in the community. When such failures occur a co-ordinator should ensure that:*

(1) contact is made with the patient;

(2) consideration is given to calling an emergency review to re-evaluate the care programme; and

(3) the consultant psychiatrist responsible for the care and supervision of the patient in the community is notified immediately.

PART IV (a)

AN ASSESSMENT OF THE INTERNAL REVIEW OF THE ESSEX PROBATION SERVICE

Part IV(a)

An assessment of the internal review of the Essex Probation Service

430. Mr. Alex Bamber, Group Manager of North East Essex Probation Services carried out an internal review having read all the papers in the case and interviewed most of the witnesses seen by the Inquiry.

431. The report, whilst consisting of a comprehensive chronology of events and containing a good appreciation of the facts, was somewhat difficult to follow with an over concentration, in our view, on distancing the Probation Service from some overall responsibility in terms of the eventual outcome of the homicide of 4 March 1996.

432. Whilst it is accepted that the analysis of the suitability of a probation order was comprehensively dealt with there was, however, a failure to identify the need for the Probation Service to be more proactive in liaising with the psychiatric services prior to 10 January 1996.

433. The internal review appears to have made the assumption that following the submission of Ms. Hill's report at court on 13 December 1995 the matter then passed to the Court administration itself. The review did not address itself to the continuing responsibilities of the probation service following the remand for a psychiatric report.

434. Neither did the internal review identify clearly the responsibility of the practice supervisor and the senior probation officer to more assertively review and negotiate an appropriate recommendation in Mr. Clift's report.

435. The review identified satisfactorily the limitations of a Probation Order when used to try and attempt to control the medication of a mentally disordered offender in these circumstances. It also highlighted appropriately the inability of a Probation Order to provide a speedy enough response when there was a refusal to take medication.

436. The review failed to address the issue of why the Probation Service, upon receipt of information from Mr. Clift about the possession of a combat knife, did not identify a role for itself to update the court prior to the adjourned hearing on 10 January 1996. Ms. Hill had clearly identified a high level of instability and it was not sufficient that the probation service took no further interest in what happened between 13 December 1995 and 10 January 1996. The paucity of information provided to the court of what had occurred between these dates must also have been the responsibility of the Probation Service. This fact was not considered by the internal review. Given the warning that was communicated to the Probation Service by Mr. Clift on 3 January 1996 that ought to have triggered a more proactive response by the Probation Service than is identified in the internal review.

437. The internal review assumed that there was no causal link between a failure to take medication on 23 February 1996 and the offence which occurred on 4 March. This assumption appears to be based upon the fact that Mr. Donnelly's original medication was containing his mental health condition. The report fails to address Mr. Donnelly's use of cannabis in this respect, which together with his deteriorating mental condition, meant that he was not being contained by the dosage of medication he had been on. His mental health could and had already deteriorated quite significantly only a short time after he had been

given his depot injection on 23 December 1995. Therefore one could assume that the medication in early March 1996, being a week overdue, could well have made a difference to his overall presentation and psychotic symptoms if he had been presented for an assessment to a consultant or forensic psychiatrist.

438. The internal review appears to accept without question that a request for a psychiatric report had been made by the Colchester Magistrates' Court. Our view is that this is over optimistic given the confused nature of the form that we looked at. The form used by the Magistrates' Court purportedly requested a psychiatric report, but did not identify Dr. Baloch, and was designed for a completely different purpose and had no follow up by the administrative staff.

439. The conclusion in Mr. Bamber's report therefore that there was some failure within the Trust in our view is misplaced and if anything there would appear to have been a failure in the Magistrates' Court administration itself. There is no other record that we had found of correspondence failing to reach Dr. Baloch or correspondence from her failing to reach the GP or anyone else. In our Inquiry we had produced to us however other pro forma and individual letters requesting psychiatric reports sent from the Colchester Magistrates' Court to Dr. Baloch which evidence that quite a different system had applied in 1994.

COMMENT

440. The internal review takes the view that the absence of any newly prepared reports on 28 February 1996 seemed "*remarkable*". We do not take the same view given the fact that a Mentally Disordered Offenders Panel Meeting had decided that Mr. Donnelly, although presented as a high risk, was not actually regarded as such in reality by any of the services at that time. Those involved in the court process were really only concerned to know that an illegal requirement and a technicality was removed. There was no active consideration given to preparing a full psychiatric report, not least of all because Mr. Donnelly's solicitor Mr. van Schaik was of the view that the less intrusive any court order the better it was for his client.

441. The Inquiry panel was of the view that the recommendations of the internal probation review were an adequate reflection of such an inquiry with the more limited resources and time span that was available. We would however suggest that any internal review ought to be discussed with a second manager to allow the opportunity for ideas to be tested and to ensure that the review represents a consensus after discussion between two senior managers.

PART IV (b)

AN ASSESSMENT OF THE INTERNAL REVIEW OF THE MENTAL HEALTH SERVICES

Part IV (b)

An assessment of the internal review of the Mental Health Services

442. Whilst the remit of the review was quite clearly appropriate and it took account of the Probation Service's internal review, it is not clear what methodology was used and whether any carers or professionals involved in the supervision, care and treatment of Mr. Donnelly were actually independently interviewed as part of this process. If they were not then it appears that the internal review of one service relied upon the internal review of the probation service to formulate much of its review. This in our opinion cannot be appropriate if one is to take an independent assessment of the provision of health care in this regard.

443. The Panel does not take the view as expressed in the early part of the review, that Mr. Donnelly had a tenuous link with the Oxford Road Unit. Indeed it was clear from the evidence both oral and written that although his contact was at times intermittent, he developed good personal relationships with both Ms. Barker and later with Ms. Johnson who were the key workers at the Oxford Road Unit.

444. There are also some simplistic conclusions which in our view are not made on the basis of any constructive analysis or interpretation of the facts that were known. For instance the review takes the view that the absence of medication and Mr. Donnelly's avoidance of Mr. Close on 23 February 1996 would not have made any difference to what happened on 4 March 1996. This fails to recognise that Mr. Donnelly's condition was not being contained by the current level of medication, nor did it deal with the fact that the mental health services, who were wholly reliant at that time upon the probation service for the control mechanism for his taking his medication, had in effect abdicated responsibility for his care and assessment. The mental health services review fails to identify that the Oxford Road Unit, the CHAC accommodation care workers and Dr. Donnelly all referred information to Mr. Close. However, important information was not passed on to the psychiatric services or acted upon in order to utilise the Mental Health Act 1983 to present Mr. Donnelly for a mental health assessment.

COMMENT

445. It is our view that this internal review tended to rely upon a general criticism and avoided dealing with the more obvious irregularity in his care, treatment and supervision in the community.

446. It is acknowledged that there was no Care Programme Approach care co-ordinator. The probation service review had picked up the clear disparity between a high level of supervision and monitoring of Mr. Donnelly by Mr. Close prior to 23 December 1995 with his lack of contact with Mr. Donnelly following the making of the Probation Order on 10 January 1996. The mental health services review does not comment on this.

447. The review fails to pick up on the fact that the Mentally Disordered Offenders Panel Meeting, whilst allowing for the fact that Mr. Close would notify the probation service within 7 days of the failure by Mr. Donnelly to comply with his medication, made no assumption that this would remove the responsibility for the community psychiatric nurse to take any other action in the event of either non-compliance or of a noted deterioration in his mental health.

448. The internal review did, however, note appropriately that some of the relevant information, such as the threat to burn down his mother's house, was not communicated by Mr. Close to the consultant psychiatrist or the locum working in her place. Similarly, there was an appropriate reference to the failure to invite the Oxford Road Unit key worker to attend the Mentally Disordered Offenders Panel meeting on 11 January 1996.

449. The Inquiry disagrees however with the internal review's view that the failure to communicate with Dr. Donnelly was "*aggravated by Mićhéal's mother's inconsistent behaviour towards her son*". This in our view is no excuse for the failure to utilise the information that she clearly gave prior to the Mentally Disordered Offenders Panel meeting. Dr. Donnelly's reaction, in our view, is entirely consistent with that of a loving parent who nevertheless was suffering great stress herself due very largely to having to care for a mentally disordered son, whom she clearly loved. It is hardly surprising that there was a considerable degree of ambivalence and antagonism in the relationship, some of it clearly linked to his mental illness.

450. The review did however pick up appropriately in its conclusion, the main theme, the gaps in practice and the absence of a full forensic history. There was however a failure to highlight the fact that there was a significant degree of failure to exchange vital information by mental health professionals and errors of judgement compounded by the absence of consistency in the exchange of information relating to the care and treatment of Mr. Donnelly.

PART V

CONCLUSIONS

Part V

Conclusions

451. The key question which one has to ask in this Inquiry is whether or not any action or omission could have occurred to prevent the tragic death of Mr. Matthew Bowyer. We have not been able to find any such explanation in the tragic sequence of events which occurred leading up to the death of Matthew Bowyer and the arson attack on Dr. Donnelly's house on 4 March 1996.

452. What we have been able to deduce is that there were predictable and foreseeable consequences likely to result from the failure of Mr. Donnelly to take medication. The associated risks were exacerbated by the decision to rely almost exclusively upon a probation order as a mechanism for controlling Mr. Donnelly's depot medication. The contrast between his care, treatment, and supervision which was appropriately dealt with from February to April 1995 stands in stark contrast to the differences of opinion, confusion and the lack of clarity which were applied to the management of his case by the various agencies involved from September 1995 to March 1996.

453. Although there were instances of good practice and no single agency or individual could have been said to have acted out of any wrongful motivation, the absence of a consistent exchange of relevant information handicapped the decision making process and the exercise of discretion whether by the psychiatric services, the courts or by those care workers closest to him.

PART VI

SUMMARY OF RECOMMENDATIONS

Part VI

Summary of Recommendations

PART III POLICY & MANAGEMENT ISSUES

Chapter 1 (pages 72-77)
The interface between the Mental Health Act 1983 and the criminal justice system

(i) Police and Crown Prosecution Service

1. WE RECOMMEND *that the decision not to call an appropriate adult at a police station, where there is evidence of mental illness past or present, ought to be recorded in the custody record and the reasons for that decision being made ought also to be recorded as a matter of good practice. Any such discussion with the forensic medical examiner ought to be recorded and his or her support or otherwise for the presence of an appropriate adult ought to be recorded.*

2. WE RECOMMEND *that any police papers which are sent to the Crown Prosecution Service relating to a person known to be suffering from a mental illness or with a previous history of mental illness, must be recorded specifically in the documentation filed with the Crown Prosecution Service.*

3. WE RECOMMEND *that the custody record front sheet ought to have a section where it can be clearly recorded if it is known that a suspect/person charged has ever been diagnosed as suffering from a mental illness.*

4. WE RECOMMEND *that the forensic medical examiner should make a note of his examination and forward a copy to the General Practitioner for onward transmission to the psychiatrist who is treating a mentally disordered offender.*

5. WE RECOMMEND *that Essex Police Force ought to have an accurate system of recording ethnicity which is relevant to the Commission for Racial Equality and Home Office guidelines. Such a system ought also to request clarification from the individuals being monitored in the light of any uncertainty.*

(ii) The Probation Service and Mental Health Service

6. WE RECOMMEND *that a court duty probation officer should ensure that when a defendant is known to be mentally disordered or suspected of suffering from a mental illness that fact should be clearly identified in the request for the pre-sentence report.*

7. WE RECOMMEND *that the case records maintained by the Probation Service on an individual should all be kept together. Similarly, all relevant information should be provided to the manager responsible for allocation prior to that decision being made.*

8. WE RECOMMEND *that the Essex Probation Service and the North East Essex Mental Health NHS Trust should formulate a protocol in the event that there is disagreement as between the recommendation made by the Probation Service to the Court*

in the Pre Sentence Report and the recommended treatment and care provided for by the mental health services.

9. WE RECOMMEND *that the implementation of a multi-agency care programme approach should be given effect by local protocols to agree the policies and practices in relation to the use and operation of probation orders (with or without conditions of treatment) for mentally disordered offenders.*

10. WE RECOMMEND *that where a pre-sentence report has been presented and the case has been adjourned for a psychiatric report, the probation officer who prepared the pre-sentence report and the psychiatrist should discuss the case as a matter of routine. We also recommend that the author of the pre-sentence report should take responsibility for updating the report in the event of any further developments coming to the notice of the probation service.*

11. WE RECOMMEND *that the care coordinator, designated under the care programme approach should be the primary person responsible for ensuring that the notices and minutes of the Mentally Disordered Offenders Panel meeting are properly circulated. It must also be the care co-ordinator's responsibility that in the event of non-attendance of a consultant psychiatrist or forensic psychiatrist that such an expert view is taken in writing as soon as practicable or the Mentally Disordered Offenders Panel meeting adjourned until they are able to attend.*

12. WE RECOMMEND *that a local protocol should be agreed and thereafter monitored between the relevant agencies, health trusts, the probation service, the police, Magistrates' court service, the Crown Prosecution Service, social services. Such protocol should cover all the issues of a multi-agency approach in a case of an Mentally Disordered Offenders being supervised in the community.*

13. WE RECOMMEND *that the local protocol must be extended to the court diversion scheme to ensure an appropriate level of liaison and the application of the multi-agency approach between health trusts, social services, Magistrates' court services, Crown Prosecution Service, probation service, police, as well as local defence solicitors.*

14. WE RECOMMEND *that all the relevant agencies adopting the multi-agency approach and liaising in this manner should co-ordinate their training and risk assessment.*

15. WE RECOMMEND *a system being introduced to ensure that, as soon as a Mentally Disordered Offender comes into contact with the police, or enters the criminal justice system, that fact be made known by the Police or Crown Prosecution Service to the community mental health team and the General Practitioner, as well as to the court diversion worker. When that information becomes known the court diversion worker would be the central person responsible for making sure all the relevant information is provided to the court. There would be close liaison with the care co-ordinator.*

16. WE RECOMMEND *that wherever possible the court diversion worker, or his agent responsible for the Mentally Disordered Offender concerned, attends court to ensure that the court can access the fullest level of information possible about the mentally disordered offender appearing before them. Whilst the court diversion worker's presence is not necessary at the various adjournment stages it is essential if the court seeks to make a disposal or a sentencing determination on a given date.*

17. WE RECOMMEND *that the court duty probation officer ought not to give information to the court e.g. that a Mentally Disordered Offender is currently taking medication unless satisfied that this has been verified at first hand with the community psychiatric nurse and/or psychiatrist responsible for the administration of depot medication. Information from the defence solicitor and/or the defendant himself should not be relied upon in this respect.*

18. WE RECOMMEND *that, where a mentally disordered offender is brought back to court for the purposes of amending, deleting, discharging or in any way altering the sentence imposed previously, the supervising probation officer should make a formal report to the court updating them on the situation.*

19. WE RECOMMEND *that where it is felt necessary to deviate from probation service national standards the reasons for doing so should be clearly stated and the extent to which they are not to be complied with should be set out.*

20. WE RECOMMEND *that in the case of all part-time staff who are supervising mentally disordered offenders in the community there must be a backup staff member appointed.*

21. WE RECOMMEND *that within the multi-agency approach there must be mutually consistent systems of assessment of risk to the mentally disordered offender, him or herself, the community, or any significant individual likely to be targeted. Such a system must adopt mutually consistent assessments covering the propensity for violence to people and property, threats uttered, previous offending behaviour, and the likely threshold at which the risk assessment/dangerousness is likely to enter a higher risk category.*

22. WE CONCUR WITH THE RECOMMENDATION *of the Christopher Edwards and Richard Linford Inquiry that, in order to provide a comprehensive and early diversion facility, the court diversion scheme needs to be properly resourced and certainly extended by additional funding to enable a 24 hour, 7 days a week service to be provided.*

23. WE RECOMMEND *that there be a full and proper training programme designed to ensure that Magistrates' court clerks are fully conversant with the needs of mentally disordered offenders both with the Mental Health Act 1983 and with the sentencing provisions applicable to them. We also recommend that wherever possible if there is uncertainty about the legal provisions then the matter should be adjourned or put back so that proper and detailed enquiries can be made.*

Chapter 2 (pages 78-80)
Risk assessment, care and supervision in the community

24. WE RECOMMEND *that care co-ordinators be issued with guidance as to their duties and responsibilities outlining clearly their central role in ensuring the management of individual care plans.*

25. WE RECOMMEND *that all local agencies should monitor their implementation of the Care Programme Approach to ensure that the joint policy is fully implemented. Any progress reports on the joint action plan should be issued to ensure that all parties, and the public at large are satisfied that the inadequacies identified in the joint report have been removed.*

26. WE RECOMMEND *that General Practitioners should be accessed by care co-ordinators to ensure that the information that they have and their knowledge of the patient is accessed on a regular basis notwithstanding busy General Practitioners schedules and their busy workload. It is essential that General Practitioners are involved in the decision making process by care co-ordinators.*

27. WE RECOMMEND *that court diversion workers must maintain properly detailed notes of their work relating to mentally disordered offenders. Where possible such notes should be kept accessible to other professionals. It should be the responsibility of line management to record and maintain proper records of supervision and advice given to staff under the Court Diversion Scheme.*

28. WE RECOMMEND *that Community Psychiatric Nurses should receive regular clinical and management supervision of their case work, regardless of their seniority. Such supervision notes should be maintained as part of the overall management responsibility.*

Chapter 3 (pages 81-82)
Housing and support services for the mentally ill

29. WE RECOMMEND *that supported accommodation for mental health patients ought to have a full and centralised filing system and their psychiatric and social needs be made accessible to all relevant care staff.*

30. WE RECOMMEND *that the supported housing sector should have direct access, to the psychiatric services if they are concerned about a resident's/client's behaviour. They ought, in appropriate circumstances, to be able to initiate a mental health assessment without waiting for the Community Psychiatric Nurse or General Practitioner to take the first step.*

31. WE RECOMMEND *that the presence of care/project workers at the Mentally Disordered Offenders Panel meeting should be given a high priority, and in their absence there should be a full written report available via the care co-ordinator. In any event, a summary of file notes on any medium to high risk patient should be forwarded on a monthly basis to the care co-ordinator for transmission on to the General Practitioner and psychiatrist for evaluation.*

32. WE RECOMMEND *an information pro forma be designed and supplied by the Mental Health Services upon commencement of residence/project attendance with regular updates supplied thereafter. Such a pro forma should make clear what symptoms to be alerted for in order that mental health professionals have a full picture of the patient's/client's presentation.*

33. WE RECOMMEND *that a clear set of activities are formulated in consultation with the Mental Health services, and then monitored as to their suitability for clients using the Oxford Road Unit.*

34. WE RECOMMEND *a closer level of co-operation between the Oxford Road Unit and the other agencies involved particularly through the care co-ordinator appointed under the Care Programme Approach.*

Chapter 4 (pages 83-84)
The care programme approach in North Essex

35. WE RECOMMEND *that a community forensic service be established in North Essex in line with the recommendations of the Christopher Edwards and Richard Linford Inquiry.*

36. WE RECOMMEND *that a specialist post be created for a forensic psychiatrist to be available in North Essex. The responsibilities of this post should include support for:*

(i) The court diversion scheme.

(ii) Forensic medical examiners attending police stations.

(iii) Care co-ordinators seeking advice.

(iv) Probation officers seeking expert advice.

(v) Supported accommodation staff requesting expert advice.

Chapter 5 (pages 85-88)
Multi-disciplinary partnerships

37. WE RECOMMEND *that the recommendations of the Christopher Edwards and Richard Linford Inquiry are consolidated with the recommendations from this Inquiry to prevent duplication and to ensure that best practice is achieved across the county.*

38. WE RECOMMEND *that Care Programme Approach care co-ordinators are responsible for co-ordinating the support provided by all other agencies having an input into the care and supervision of mentally disordered offenders such as housing, probation, the court diversion scheme, work project and accommodation care workers.*

39. WE RECOMMEND *that Care Programme Approach care co-ordinators have the primary responsibility to ensure that all essential information is passed not only to those directly involved with the care and treatment of a patient but that such information passes speedily to a consultant psychiatrist or forensic psychiatrist responsible for the care of the patient.*

40. WE RECOMMEND *that the Care Programme Approach review meetings are held regularly, involving both the patient as well as significant carers. In the event that those meetings cannot be attended by an agency or representative a written report updating the meeting on a patient's progress must be submitted.*

41. WE RECOMMEND *that a formal risk assessment is conducted on a multi-agency basis involving a consultant psychiatrist or forensic psychiatrist. Such assessment must be an informed decision based on a full exchange of information and where possible on an agreed set of criteria between the different agencies.*

42. WE RECOMMEND *that all patients who have been designated as a medium to high risk category of harm to others should have a chronology of events compiled by the Care Programme Approach care co-ordinator. This chronology should be shared at the earliest opportunity with all those agencies and individuals involved in the care and treatment and supervision of the patient in the community.*

43. *WE RECOMMEND that the Mentally Disordered Offenders Panel meetings should be formally incorporated into the Care Programme Approach policy and be treated as reviews. In every case where there is a medium to high risk of harm to others the mental health trust should provide the lead role in overall co-ordination through the care co-ordinator.*

44. WE RECOMMEND *that the responsible medical officer (RMO) should always attend such reviews/panel meetings or in his/her absence the meeting should be provided with a full update. If any major decisions are to be made about the care, treatment or supervision of the patient then the RMO must be in attendance and the meeting adjourned, if necessary, for that to take place.*

45. WE RECOMMEND *that the court diversion scheme should offer consultant psychiatric/forensic psychiatric sessions as part of the service to provide medical support to mentally disordered offenders.*

46. WE RECOMMEND *that there should be a comprehensive community forensic service made available in North East Essex.*

47. WE RECOMMEND *that the magistrates' court service should ensure that psychiatric reports are only requested from Section 12 approved doctors where a recommendation is being considered for a condition of treatment as part of a probation order, and arrange that advance copies are provided to the court diversion service and the probation service.*

48. WE RECOMMEND *that where referral to an anger management course or other such course is being considered this should be discussed with the psychiatrist responsible for the overall treatment and supervision of the patient in the community. The primary responsibility for referral should rest with the care co-ordinator. Where mentally disordered offenders who present a medium to high risk fail to attend for appointment or are not at home when a General Practitioner calls, the Care Programme Approach care co-ordinator should be alerted immediately. Failure to take depot medication and to attend for out-patient appointments should fall into a similar category, in order to provide an effective mechanism for monitoring the care and supervision of the patient in the community. When such failures occur a co-ordinator should ensure that:*

(1) contact is made with the patient;

(2) consideration is given to calling an emergency review to re-evaluate the care programme; and

(3) the consultant psychiatrist responsible for the care and supervision of the patient in the community is notified immediately.