Report of the Inquiry into the Care and Treatment of **Naresh Bavabhai**

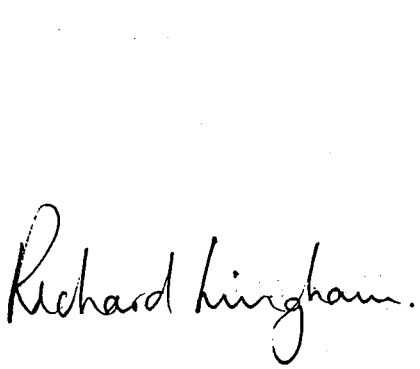
A report commissioned by
Wigan & Bolton Health Authority

September 1998

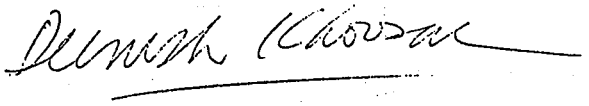
PREFACE

We were commissioned in November 1997 by Wigan & Bolton Health Authority to undertake this Inquiry.

We now present our report, having followed the Terms of Reference which were specified to us in December 1997 and the Procedure which was subsequently adopted and issued to all witnesses and their representatives.



RICHARD LINGHAM
DSS DipMH
Chairman



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September 1998

ACKNOWLEDGEMENTS

Our sincere thanks are due to the following people.

Mrs A Barkley, who has carried out her diverse responsibilities as Clerk to the Inquiry with considerable diligence and administrative skill.

Ms G Downham, Barrister at Law, whose wise judgement and breadth of understanding have always been evident in her role as Legal Advisor to the Inquiry.

Mr I Trussler and colleagues from Harry Counsell and Company, for their rapid and efficient transcription services.

Mrs M Rowe at Word Up DTP, for painstaking and accurate work in word processing, editing and printing this report.

All of the witnesses of fact, for their frankness and ready participation in a process which has often been personally demanding and at times inevitably stressful.

The legal, trades union and other professional representatives of witnesses, for their constructive contributions.

Dr A Kahn, who appeared as an expert witness, for his thorough preparation of evidence and clear responses to our questions.

Finally, but most particularly, we would like to thank Mrs S Bavabhai and members of her family, for their patient participation and for providing invaluable information.

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CHAPTER I

1.0. INTRODUCTION

1.0.1. On 14 July 1997 at Manchester Crown Court Naresh Bavabhai pleaded guilty to and was convicted of the manslaughter of Kenneth Horrocks on 18 November 1996. He was sentenced to a term of 11 years imprisonment.

1.0.2. Naresh Bavabhai was sentenced on the same day in connection with a burglary from Kenneth Horrocks' home in September 1996, along with one charge of theft and another of attempted theft between September and November 1996, all concerning the victim's property. Sentences of two years on each of these three offences were ordered to run concurrently with each other but consecutively with that for the manslaughter. His total sentence was to imprisonment for 13 years.

1.0.3. Naresh Bavabhai had been first arrested on 20 November 1996 on charges of burglary and deception. He admitted to those charges at Bolton Magistrates' Court on 21 November 1996 and was remanded in police custody. On 25 November 1996 he was remanded on bail for two weeks, to reside at Chattaway Nursing Home, Manchester whilst his home was sealed by police pending the completion of their inquiries. He was again arrested at the nursing home on 28 November 1996, and charged with the murder of Kenneth Horrocks. On 29 November 1996 he was remanded in custody to Her Majesty's Prison (HMP), Manchester.

1.0.4. He remained there on remand until his trial and returned there from Manchester Crown Court until he was transferred to HMP Full Sutton, near York on 26 August 1997, where he remained after sentence and during this Inquiry until his transfer to HMP Garth in the Summer of 1998.

1.0.5. At the time of the killing Naresh Bavabhai was aged 27 years and Kenneth Horrocks was aged 68 years. Both had been receiving treatment and care from local mental health services for a number of years. They lived in the same housing complex in Bolton and had attended the same day centre, but were not close associates.

1.0.6. On 20 November 1996, there had been an informal and untaped conversation between Naresh Bavabhai and a police officer on the subject of killing Kenneth Horrocks at which there was no solicitor or social worker present. Naresh Bavabhai was formally interviewed in connection with the charge of murder on 28 November 1996. His solicitor was in attendance on that occasion as was his social worker acting in the role of appropriate adult.

1.0.7. Until the day of his conviction Naresh Bavabhai maintained a plea of not guilty to murder. His manslaughter plea was accepted by the Crown Prosecution Service on the basis that there had been no intention to kill or cause grievous bodily harm. The judge, in sentencing, took account of that absence of intention and Naresh Bavabhai's long-standing psychiatric problems. [A full account of Counsels' submissions and of the Judge's sentencing comments is reproduced at Chapter IV of this report.]

1.0.8. There was no plea on the grounds of diminished responsibility. No psychiatric reports were ordered specifically to assist sentencing, nor was a probation pre-sentence report requested by the defence or ordered by the Court.

1.0.9. One psychiatric report was available to the Judge. That had been prepared three weeks earlier on behalf of the defence when Naresh Bavabhai was denying responsibility for the death of Kenneth Horrocks. Defence counsel, in reference to that report said: 'the report if I may say so is reassuring in this respect, that it is not suggested that his psychiatric problems played any part in this offence or these offences'. Addiction to amphetamine was described as the driving force behind the offences of dishonesty. Panic, it was submitted on his behalf, had followed Naresh Bavabhai's entry into Kenneth Horrocks' home for the purpose of theft and resulted in the killing. There has been no appeal against either conviction or sentence.

1.0.10. The author of the above psychiatric report gave evidence to the Inquiry indicating his surprise that there had been no further psychiatric report ordered to consider the alternative sentencing option of a hospital order. Similar surprise was reported to the Inquiry by the Probation Service, the Prison Medical Officer and the Consultant Psychiatrist responsible for Naresh Bavabhai's care over the previous seven years.

1.0.11. The Inquiry has had access to witness statements taken by the Police and has been able to obtain a transcript of court proceedings on the day of sentence [the

text of which is reproduced at Chapter IV]. Submissions from the prosecution based on those witness statements reveal Naresh Bavabhai's involvement in Bolton's drug-culture in the weeks prior to the killing. Both defence and prosecution counsel described an unusually elaborate plan of deception leading up to the burglary and the death of Kenneth Horrocks. In the words of defence counsel it was characterised by both "sophistication and extraordinary naivety".

1.0.12. Naresh Bavabhai was the first witness to give evidence to the Inquiry. By special arrangement, he was seen at HMP Full Sutton on 31 March 1998. He told the Inquiry Team under affirmation that he was prompted to kill Kenneth Horrocks by voices telling him to do so, 'because Kenneth Horrocks had some money', and he added 'and they seemed to justify it'. He also said that the voices were the same as those which had told him to take drugs and to kill anybody who came to his flat. He described concealing this at the time of trial because he understood that it would be in his interests for sentencing purposes not to be viewed as mentally ill.

1.0.13. Comment. The above background, and in particular Naresh Bavabhai's evidence, given at the start of the Inquiry's hearings, has necessarily influenced the course of the Inquiry's investigations. However, it is not within the remit of the Inquiry (see Appendix A) to explore the legal process and no comment is made in this report upon matters which do not specifically relate to the care and treatment of Naresh Bavabhai.

1.0.14. The Inquiry Team has considered it appropriate to address the question of whether Naresh Bavabhai suffered mental illness which was acute immediately prior to the killing, whether mental illness may have actively contributed to the killing itself, and whether there is any action which could reasonably have been taken to prevent the tragic death of Kenneth Horrocks.

1.1. HEALTH AND SOCIAL SERVICES INVOLVEMENT

1.1.1. From March 1989 until the time of his remand to HMP Manchester on 29 November 1996, Naresh Bavabhai had been receiving mental health care and treatment from Bolton Hospitals NHS Trust. He had been admitted to hospital on six occasions, all admissions being to Ward K2 of the Royal Bolton Hospital. His first admission was informally on 5 March 1989. Whilst in hospital he was detained briefly under Section 5(2) of the Mental Health Act 1983 on 6 March but returned to informal status, and was discharged on 16 March 1989. His second admission, which was also informal, followed closely on the first, being from 2 to 24 April 1989. Naresh Bavabhai's

third admission was on 17 May 1990, under Section 2 of the Mental Health Act 1983, and he was discharged from both section and hospital on 30 May 1990. The fourth admission on 17 October 1990 was informal, but he was then held under Section 5(2) of the Mental Health Act 1983 and detained under Section 3 of the Act on 19 October 1990. He became an informal patient on 27 December 1990 and was discharged on 31 December 1990. His fifth admission was as an informal patient between 4 February 1993 and 22 February 1993. The sixth and final admission was informally on 4 October 1996 and he was discharged on 4 November 1996 to day hospital.

1.1.2. Day-patient care was provided by the NHS Trust at Rivington Day Hospital, also sited within the Royal Bolton Hospital, adjacently to Ward K2. Naresh Bavabhai attended there both as an in-patient and between admissions from 1989 to 1991. Following referral by his consultant psychiatrist, he attended from 16 April to 4 September 1996 and after the last hospital discharge from 4 November 1996 until his arrest.

1.1.3. From 1989 until the time of his arrest, Naresh Bavabhai also attended Royal Bolton Hospital for outpatient treatment by his consultant psychiatrist and other doctors. From September 1990 he received an outpatient depot injection service at the hospital's John McKay Clinic, his last injection being on 4 October 1996. Community Psychiatric Nursing support was provided to Naresh Bavabhai from September 1990 until January 1992, from April to September 1991 and from 4 April 1996 until the time of his arrest. Following a referral by his consultant psychiatrist in April 1996, Naresh Bavabhai was assessed by the consultant psychiatrist from the NHS Trust's Substance Misuse Service on 4 July and 6 November 1996.

1.1.4. Following referral during his sixth hospital admission, he was seen between 5 and 16 October 1996 by nurses and a doctor from the Bolton Community Healthcare Trust's Community Drugs Team.

1.1.5. A social work service was provided to Naresh Bavabhai by Bolton Social Services Department from March 1989, his case remaining open with the Department until 1995. He was referred by the consultant psychiatrist to the social worker again in March 1996 but declined the service offered. In August 1996 he was referred again and had contact with the social worker from then until after he was remanded in custody. Naresh Bavabhai's mother and family received a separate support service from a Gujerati speaking social worker employed by the Social Services Department from 30 September to 12 November 1996.

1.1.6. By a letter dated 4 October 1996, members of Naresh Bavabhai's family made a formal complaint to the Director of Social Services in connection with their concerns regarding the levels of support he had been given by the involved agencies. A response was sent to them on 24 October 1996 by the Social Services Department's Principal Officer for Mental Health.

1.2. INVOLVEMENT OF OTHER SERVICES

1.2.1. Naresh Bavabhai had attended St. George's Day Centre, an independently run centre registered as a charity managed from the Community Health Council and funded by grant aid. He was referred in May 1989 and last attended in September 1996. The victim of the killing, Kenneth Horrocks, attended the same Day Centre from April 1992 until his death.

1.2.2. Between 1 March 1993 and his arrest on the charge of murder, Naresh Bavabhai resided in Warden Assisted accommodation owned and managed by Bolton Housing Department. A resident warden employed by the Housing Department lived on site, but he declined her supportive contact. Kenneth Horrocks lived in the same housing complex from February 1992 until his death.

1.2.3. A Gujerati–speaking link worker was made available from 1989 onwards for Naresh Bavabhai's mother when she attended review meetings at the hospital or day hospital.

1.2.4. Naresh Bavabhai received counselling concerning substance misuse from a trained voluntary counsellor based at St. George's Day Centre. He was referred by the Day Centre in January 1996 and attended until around September 1996. During this period he also attended Narcotics Anonymous with his counsellor on two occasions.

1.2.5. Whilst in custody and since sentence Naresh Bavabhai has received psychiatric care from the Prison Medical Service, spending time in the hospital wings of HMP Manchester, HMP Full Sutton and HMP Garth.

1.2.6. After the killing Naresh Bavabhai was seen by the Greater Manchester Probation Service who have continued to offer a support service since that date. They were not asked to prepare a pre-sentence report.

1.2.7. Prior to conviction a psychiatric report was commissioned by Naresh Bavabhai's lawyers and prepared in June 1997 by an independent Consultant Forensic Psychiatrist. That report was made available to the Judge prior to sentence.

1.3. INTERNAL INVESTIGATIONS

1.3.1. Following the death of Kenneth Horrocks, the Chief Executive of Bolton Hospitals NHS Trust and the Director of Social Services for Bolton Metropolitan Borough Council both initiated immediate internal investigations under the requirements of National Health Services Executive Circular HSG (94)27. This Inquiry has received and reviewed the resulting reports, which were quickly prepared and distributed on a 'need to know' basis.

1.3.2. The Inquiry team has also seen the family's letter, the response and other correspondence relating to the complaint on Naresh Bavabhai's behalf referred to in 1.1.6.

1.3.3. Comment. The detailed chronology and statements prepared by the Trust's staff appear to satisfy the requirements of an immediate investigation under paragraph 33 of circular HSG (94)27. The Social Service's report takes the form of a briefing note and chronology, which, together with the response to the complaint, also give a clear account of the department's involvement in Naresh Bavabhai's care.

1.4. INDEPENDENT INQUIRY

1.4.1. Following discussions between Wigan and Bolton Health Authority and the National Health Service Executive in the Summer of 1997, a decision was made between the Health Authority and Bolton Metropolitan Borough Council to set up a steering group to guide the establishment of an Independent Inquiry under the terms of paragraphs 34 and 36 of circular HSG (94)27.

1.4.2. A potential Chair for the Inquiry was identified in October 1997 and approaches were also made to an experienced consultant psychiatrist who was fluent in Gujerati and working in another NHS Region. The Chair met with the steering group in November 1997 when draft Terms of Reference and Procedure were agreed. They are reproduced at Appendices A and B. At that meeting it was also agreed that the Inquiry should have the benefit of an independent legal advisor.

1.4.3. Naresh Bavabhai and members of his family were kept informed of the setting-up procedure and Naresh Bavabhai's consent to the release of his records was obtained. After this a public announcement was made.

1.4.4. The original records were soon submitted by the agencies for copying and numbering by the Clerk to the Inquiry. It then became apparent that the records from Social Services were incomplete. In fact, apart from those dating from August 1996, his social work records were entirely missing. His social worker has since compiled a record of his contacts with Naresh Bavabhai and his family from 1990 to 1996 by reference to his diaries, supervision records and his memory. We have particularly examined the correspondence section of health records to discover any reports or letters from the social worker to doctors and nurses. The few notes we have found are generally consistent with the account that the social worker has reconstructed.

1.4.5. The records were reviewed by the Chair and Medical Member, so that by the end of January 1998 witnesses were identified and requested to prepare their evidence for hearings which commenced on 31 March 1998 at HMP Full Sutton and then at Bolton. The hearing of verbal evidence was delayed by the illness of a principal witness, but was completed on 7 May 1998. The evidence of an expert witness Dr A Kahn was heard on 26 May 1998.

1.4.6. With the exception of the Social Services' records referred to in 1.4.4., the records presented to the Inquiry have been complete. To our knowledge, no document has been withheld from us by any party. We have closely studied and compared the case records from each agency and we have as far as possible considered their inter-relationship with the operational policies, procedures and reports provided to us by the agencies.

1.4.7. Without exception, witnesses have co-operated fully with the Inquiry both at hearings and in response to any requests for further information. We are notably indebted to the witnesses from Naresh Bavabhai's family for the courteous and constructive way in which they have given evidence on a subject which self-evidently remains a cause of distress to them to the present day.

1.4.8. The verbal evidence of witnesses was quickly and expertly transcribed so that it could be sent to them within a day of their appearance at a hearing for the correction of any transcriptional errors. A number of witnesses have taken the opportunity to add additional comments which have been of assistance to the Inquiry.

1.4.9. Comment. The inter-agency steering group made deliberate decisions: to appoint a two-person team to conduct the Inquiry; to provide assistance from an experienced health services administrator as Clerk; that independent legal advice should be available as required, but particularly during hearings and if criticisms were to be disclosed to individuals under item 3 of the Procedure adopted by the Inquiry. The Inquiry team is able to report that it has worked well together and can state that the evidence in all its forms has been considered with appropriate thoroughness.

CHAPTER II

2.0. THE LIFE OF NARESH BAVABHAI UP TO APRIL 1996

2.1. GENERAL ISSUES

2.1.1. It is necessary for the members of an Inquiry into the treatment and care of a person suffering from mental illness to establish the details of his personal history in order to:

- familiarise the inquirers with the person and the background to his situation and circumstances;
- identify predisposing factors and events which may have influenced his behaviour and the course of his illness;
- establish the extent to which those responsible for providing treatment and care have taken account of those factors and events in forming their judgements, determining their actions and providing advice to other people involved in that treatment and care.

2.1.2. The members of an inquiry team are in a somewhat similar situation to those whose actions they are reviewing, in that their understanding of the patient's history is not an end in itself, but can play a very important part in understanding the person's situation and circumstances at the time as well as after the event.

2.2. AVAILABLE RECORDS

2.2.1. Although the health services records of Naresh Bavabhai contain many references to his background and circumstances, the Inquiry has been unable to find a social history written in terms which were subsequently shared by the professionals involved in his care and treatment from March 1989 onwards. The task of completing a social background report often falls to the junior doctor 'clerking' at the time of a hospital admission or may be requested when a social worker or nurse is involved. In the case of Naresh Bavabhai the historical notes completed by the admitting senior hospital doctor on 4 March 1989 were incomplete and further details were mainly picked up by the Consultant Psychiatrist, Dr K Mahadevan, during that admission and subsequent re-admission which ended with his discharge in June 1989. It should be noted that Dr Mahadevan recorded on 6 March 1989 'unable to gain history' and that

other professionals have recorded similar difficulties in obtaining personal information from Naresh Bavabhai. The 'clerking' notes for his admission in May 1990 were more comprehensive, but from then until 1995 the references to his background and current social circumstances appear randomly in the notes, most often in Dr Mahadevan's hand.

2.2.2. More comprehensive details of his history appear in the assessment completed on 7 July 1996 by Dr W. Dougal, Consultant Psychiatrist in substance misuse.

2.2.3. Nursing records relating to his admissions as an in patient and day hospital patient from 1989 to 1995 contain almost no details of Naresh Bavabhai's social history and circumstances. Some references do however appear in the assessments and running records, completed by his Community Psychiatric Nurse during January 1991. A fuller statement is included in the assessment completed by the Associate Community Psychiatric Nurse, Mr I Chisnell, on 6 September 1996.

2.2.4. Those social work records which are available (see 1.4.4) do not contain a social history apart from the details provided to support a housing application in 1996. Mr I Smith, the Senior Social Worker who had most contact with Naresh Bavabhai and his family cannot recall a request for social history information. None can be found in the correspondence section of the medical and nursing notes, again suggesting that such was not requested by health service colleagues.

2.2.5. It has therefore proved necessary for the members of the Inquiry to piece together the history of Naresh Bavabhai, from his medical and nursing records up to the time of the killing, from the few reports completed before his appearance in Court and whilst in prison. We have also received details from members of his family which illuminate episodes in his past which were not clear from those records.

2.2.6. We have noted that prison records still contain very little historical information apart from some brief notes included in Dr P Snowden's report for the defence dated 26 June 1997, and in the initial notes completed by Dr P Collins as consultant psychiatrist at HMP Full Sutton on 12 September 1997. When we interviewed Naresh Bavabhai at HMP Full Sutton on 31 March 1998, the medical staff were still waiting for his records from Bolton Hospitals NHS Trust.

2.2.7. COMMENT The Inquiry has found it essential to define Naresh Bavabhai's personal circumstances in the years up to the killing, in order to form a picture of his social contacts and the extent of his dependency on the support of his family. We have had to assemble much of his history from his contemporary records, and from the evidence of witnesses. We have found, however, that some of them had little knowledge of historical details or continued to carry misapprehensions, notably in relation to Naresh Bavabhai's domestic circumstances and social life.

2.2.8. A number of witnesses have given very important information which was available and which was causing them concern before the killing. Members of his family have cast a new light on Naresh Bavabhai's behaviour and his dependency which we have not otherwise found in his care and treatment records or to be reflected in management plans.

2.2.9. The Inquiry was concerned to find that the Prison Service had yet to receive a copy of Naresh Bavabhai's psychiatric records and that the absence of accurate historical information persists to the present day. In the course of discussion with the doctor and consultant psychiatrist in charge of Naresh Bavabhai's current treatment in prison the Inquiry panel found that these matters were germane to his present health and well being but were not known to his doctors.

2.2.10. It is hoped that the Inquiry's report may be of some assistance in filling remaining information gaps. However, the panel members are mindful that comprehensive psychiatric investigations were not undertaken before or after sentence and they consider it essential that a full detailed history should now be completed, using all appropriate sources of information.

2.3. PERSONAL HISTORY

2.3.1. **Parents.** Naresh Bavabhai was born in Bolton on 15 January 1969 to parents who had married in India and moved to England in 1959. They settled in Bolton where his father, who had been a carpenter in India, found employment in the textile industry. He is said by his children to have worked extremely long hours to support his family at home and in India until his retirement in 1988 following a leg injury. He was followed to England by his wife and two eldest children in 1962. The parents separated in 1989 after years of considerable marital discord and they subsequently divorced in difficult circumstances. Both parents are alive and Naresh Bavabhai resumed contact

with his father in 1995, having previously had a poor relationship with him. His relationship with his mother has always been close and he remained dependent on her care since becoming ill. Naresh Bavabhai describes her as a good woman and loving mother.

2.3.2. **Siblings.** Naresh Bavabhai is the third youngest of eleven children, comprising six brothers and four sisters. Only the two eldest learned to speak Gujerati, but the parents have never fully mastered English and communication in the family has been in pidgin Gujerati from children to parents and pidgin English in response. Five of the siblings have academic attainments which led to careers in the professions and commerce away from their home area. The others live and work in the Bolton locality. One of them has suffered from a stress disorder which has required treatment and one brother has been to prison for theft. With one exception the children have tended to adopt English ways of living, and three of them, including Naresh Bavabhai have adopted Christianity. They feel this has resulted in some criticism of the parents by other members of the local Asian community, and a degree of alienation for the family.

2.3.3. **Emotional development.** The pressures on the children from living in crowded circumstances in a house which was small, in poor repair and sparsely equipped were increased by the problem of their father's employment. He worked long night shifts and spent most of the day at home sleeping. The children were then expected to remain silent or to speak in whispers, and they feared his anger and violence if disturbed. Naresh Bavabhai is thought to have particularly borne the brunt of this aggression. In 1989 he described his mother as being 'quite a strong person who took a lot from his father and got on with her housework'. At that time he described himself as having been 'self-conscious about being poor and coloured' and of being 'very emotional and easily hurt'. In 1996 he again recalled a rather troubled childhood and said that his parents separated because of his father's violence, particularly to his wife and also to himself, as perhaps the most troublesome of all the siblings.

2.3.4. **Physical Development and Health.** His birth was normal, as were his milestones. He was never separated from his mother and denies any episodes of serious abuse during his childhood years apart from the physical chastisement from his father. He describes himself as having been a healthy child. He has never suffered a head injury or serious physical illness.

2.3.5. **Education and Employment.** He did well at school up to the age of ten and won a scholarship to Bolton School, the local public school, which he declined in favour of attending a grammar school. He was academically successful in the first

and second year but felt he did not fit in, 'that there were no local kids there, my background was poor and I was affected by the problems with my mum and dad'. He then started mixing with pupils who absconded and used solvents and he rejected education in the fourth year. After a period in Detention Centre he attended a Youth Training Scheme and his secondary education ended without any academic qualifications. He learned carpentry and joinery at college and is said to have gained a City and Guilds Certificate, but apart from casual employment in landscape gardening and in woodwork had not held a regular job up to the time of his illness in 1989, and has been incapable of work since then.

2.3.6. **Offending.** Naresh Bavabhai began to get into trouble with the Police in his early teens and in his fourteenth year was convicted of breaking and entering a dwelling house, for money to buy clothes and alcohol. He was sent to Detention Centre and is believed to have been there for three months. After this, although he is said to have had convictions for attempted burglary, he was never sent to prison or placed on probation. He and members of his family feel that the Detention Centre placement for a first offence reflected prejudice to him as an Asian person because those convicted with him received shorter sentences. The stigma of offending and then of mental illness are felt by the family to have been damaging to the reputation of the family within the Asian community.

2.3.7. **Substance Abuse.** Medical notes on his first admission in March 1989 record that he 'was once stopped for glue sniffing' and during the fourth admission in December 1990 'admits he has been smoking marijuana heavily'. By October 1992 it was noted 'not smoking cannabis now' and in February 1993 that he had 'recently taken cannabis' and 'but only occasionally'. In October 1995 he was referred to the Community Drugs Team by the Department of Genito-Urinary Medicine regarding his amphetamine use. It was then noted that his first use of amphetamines had been in 1993. In December 1995 he was noted to have stopped cannabis use. Amphetamine abuse was noted by Dr Mahadevan on 24 April 1996 and led to the assessment by Ms Smith from the Community Drugs Team and then by Dr W Dougal, consultant psychiatrist in substance misuse on 5 July 1996. She then noted a pattern of abuse dating back to 1983 when Naresh Bavabhai was 14. He said he had then used cannabis occasionally to help him relax, and from 16 to 19 had used alcohol when he could not afford cannabis. He had tried LSD and magic mushrooms, each on four occasions in his 20's and oral amphetamines at times, but without effect. He commenced injecting amphetamines in September 1995 and enjoyed the 'rush'. When Dr Dougal saw him again on 1 November 1996 there had been a marked escalation in his drug use.

In July 1996 he expressed a fear that his mother would throw him out if his amphetamine abuse increased. One of his brothers believed she had only learned of the amphetamine abuse early in 1996 but that she had been aware of cannabis use when he was much younger. Another brother felt that, like himself, she had been unaware of all forms of substance abuse until 1996.

2.3.8. **Personality and Relationships.** The admitting doctor on 4 March 1989 noted Naresh Bavabhai's pre-morbid personality, as reported by his sister, to have been 'a sensitive, quiet, serious person – but at times can be quite friendly; no close friends; no girlfriends'. Subsequent records tend to confirm that description, as does the evidence of those witnesses to the Inquiry who have known him well, and those opinions are consistent with his own comments referred to under Emotional Development (2.3.2).

2.3.9. His brothers say that Naresh Bavabhai found it difficult to make friendships with girls and to become a part of society. The admitting doctor on 17 May 1990 noted a tattoo on his arm 'Deb', who apparently was a girlfriend, but he did not wish to talk about it. Thereafter some records mention a girlfriend but it is unclear whether this was again to the same person or to a woman with two children who his mother said he used to visit. His Community Psychiatric Nurse on 9 September 1996 noted that he was 'spending time with his girlfriend x 3 a week'. Other references to a girlfriend in October/ November 1996 may relate to a woman member of the drug subculture in which he had become involved.

2.3.10. It appears from all records and accounts that he has never been a regular partner in a cohabitation and the extent of his sexual experience is unreported. One of the brothers also remembered Naresh some time after 1993 asking him questions about 'how to make relationships with the same sex and the opposite sex'. This had included 'the friends he had made by going in and out of hospital, knowing that he needed to break away from those friends because they were having a negative influence upon him. Naresh sometimes used to go to their flat and sometimes they used to visit Naresh at my mum's home. Some of them were into drugs and they were influencing Naresh to take these drugs and pay for the drugs. It obviously led eventually to Naresh injecting drugs himself.'

2.3.11. The witness statements prepared for the Court proceedings in 1997 show that in October/November 1996 Naresh Bavabhai was involved closely in the drug subculture in Bolton and that he identified with a group of fellow drug users. One brother described to the Inquiry Naresh Bavabhai's mixed feelings about those

associates: 'This is the irony of it: he desperately wanted to make friends of them. Some of them no doubt would be nice, honest, genuine people.' He added that Naresh wanted their friendship 'because it was his only contact outside of the family environment where nobody else would judge him for what he had done'. Another brother referred to pressures from those friends before the killing regarding money.

2.3.12. A major point of social contact from 1990 onwards was St. George's Day Centre, whose staff saw him always as 'a very, very charming young man: he was popular... everyone seemed to like him'. However, medical notes in May 1990 record 'he feels people at the day centre are getting at him'. One of his brothers, who went twice with him there, felt he could not really communicate with the other attenders who were much older.

2.3.13. **Religion.** In 1989, prior to the emergence of his mental illness, Naresh Bavabhai had been encouraged by one of his sisters to join her Church, which was a Christian sect in Farnworth with tenets based on Plymouth Brethren beliefs. His brother, who has also been involved with a similar Church, considered that it was 'very close, very tight,' that it limited the choice of girls which whom adherents could have contact and that it placed women in a subservient role in comparison to male Church members. He believed that the experience 'helped to confuse him and has been oppressive'. The admitting doctor on 17 May 1990 made several references to recent religious activity, noted his sister's account that he had recently had a vision, had seen the Devil talking to him and that he would not 'talk to his mother because she is evil i.e. Hindu'. There are few detailed notes of his further involvement with the Church, but Naresh Bavabhai still regards himself as a Christian and refers to some continuing contacts with his Church up to the time of the killing.

2.3.14. **Domestic circumstances.** Naresh Bavabhai left home at the age of 15 and aged 17 was living alone in a ninth floor flat in Rogerstead, Bolton. However, he always retained a bed in his mother's house and depended on her for support especially with feeding, laundry and budgeting. When he first became ill his brothers found that he had 'trashed' the flat, broken mirrors and covered the walls with religious graffiti. On discharge from hospital he returned to his mother's home and later gave up the flat, but on being allocated the sheltered flat in Cromford Close, Bolton, in March 1993, still retained his room with her, and remained almost totally dependent on her for daily feeding, laundry and help when short of money. His family say that he was 'always hopeless with money' but they consider that to some degree his continuing dependency on his mother reflected normal cultural expectations, even bearing in mind the extent of Naresh Bavabhai's disabilities resulting from schizophrenia.

2.3.15. The warden of Cromford Close considered that after the first few months of 1993 he seemed not to be living in his flat and she assumed he had gone. She thought that he had reappeared at the flat during the Summer of 1996, when she also noted that he would approach it from over the boundary wall and that his associates would often call, usually at night. He had opted not to have her supportive services, but she spoke to him in passing every few weeks, noting in the latter months that he appeared unstable.

2.4. COMMENT

2.4.1. According to the details found in Naresh Bavabhai's records and from his and his brothers' descriptions, it appears that theirs was an untypical Asian family in a number of respects: a. it is uncommon for marital discord to culminate in divorce in this age group; b. the children's grasp of their parents' language appears to have been limited, to the extent that their capacity to communicate may have restricted mutual understanding; c. with one exception the children did not adopt their parents' culture of origin, to the point that they have experienced rejection by the Hindu community; d. three of the children embraced a Christian sect.

2.4.2. Naresh Bavabhai's early years appear unremarkable, given the restrictions and pressures of home life. The effects of parental disharmony and his fear of his father recur in all his accounts of his childhood to the present, although they had been able to resume contacts with each other from 1995 onwards. The siblings appear in the main to have succeeded in life, although one brother has a criminal record and a sister has received treatment for mental health problems.

2.4.3. The award of a public school scholarship at age 10 suggests a high level of intelligence and a significant record of educational attainment at primary school. Rejection of education at age 14 appears to be related to involvement with a group of school refusers and may have been associated with his first substance abuse.

2.4.4. The reasons for his placement in a Detention Centre for a first offence at age 14/15 do not appear in the records and, apart from Mr Smith's enquiry to one of Mr Bavabhai's brothers in October 1996, seem to have remained uninvestigated to date.

2.4.5. At the time when he set up his own home, he began to establish increasingly isolated patterns of behaviour which coincided with the concealment of his more frequent use of cannabis and alcohol. Although he remained close to his mother and dependent on her for practical support, she saw the signs of his first breakdown after he had damaged his flat and his belongings there.

2.4.6. There followed an increasing separation of his personal life from his family life and from the image he projected in his role as a user of services. This may have been a coping mechanism to reconcile the various, and at time divergent, expectations which others had of him and which he had of himself. It could also be seen as his way of managing his situation through the engagement of his largely intact intellectual powers, rather than as a manifestation of the disease process.

2.4.7. Nevertheless, Naresh Bavabhai has been quite severely disabled by the escalating consequences of his adolescent delinquency, substance abuse and psychiatric illness. His educational attainments fall far short of his potential, so that he is not qualified to earn a living and has been unable to secure employment. He is poorly equipped to care for himself or to manage his personal and domestic finances. He lacks the social skills and confidence to make and maintain close personal relationships. He has found it difficult to guard himself from exploitation, lacks judgement in his choice of acquaintances, and he is inclined to over-invest his trust in them, to his own disadvantage.

CHAPTER III

3.0. THE STORY FROM MARCH 1989 TO THE PRESENT

3.1. CIRCUMSTANCES PRIOR TO REFERRAL BY GENERAL PRACTITIONER

3.1.1. Mrs Bavabhai was concerned about Naresh Bavabhai one evening in March 1989 when he came home from work as, instead of having his evening meal immediately, he went up to his room and did not come down. Mrs Bavabhai found him on the sill of an open window. His brother Navin Bavabhai managed to bring him back into the room. The general practitioner who was called, prescribed oral medication and ensured that he had calmed down before leaving. A few days later he became aggressive, began shouting and was rushing about, so the general practitioner was called again. He administered Sparine 50 mg by injection and sent him to the Medical Admissions Unit at Bolton General Hospital for admission.

3 1.2 On 4 March 1989 Naresh Bavabhai was assessed by the duty psychiatrist following the referral. He was interviewed together with his sister, Sumi Bavabhai. Naresh Bavabhai was unwilling to talk. Sumi Bavabhai said he had been shouting, running up and down the stairs, making threatening gestures and becoming aggressive. She believed that he was under considerable stress, having converted from Hinduism to Christianity, and he said he was due to be baptised that day. He was considered to be suffering either from a stress reaction or early stages of a psychotic illness. Sumi Bavabhai wanted to take him home and accordingly chlorpromazine (an anti-psychotic and major tranquilliser) was prescribed. She was advised to bring him back if necessary.

3.1.3. Comment There is no record of these events in Naresh Bavabhai's notes with his general practitioner, but appropriate action appears to have been taken when concerns were raised by the family.

3.1.4. This was Naresh Bavabhai's first contact with the psychiatric services. The assessment made took into account the information that was made available at the time. An agreed management plan was determined with fail-safe measures in place.

3.2. FIRST ADMISSION FROM 5-16 MARCH 1989

3.2.1. Naresh Bavabhai returned to hospital on 5 March 1989 because he had again been trying to climb out of windows. He was found to be agitated and restless with grandiose thoughts, quoting the Bible and his emotions were labile. He was admitted to K2 Ward.

3.2.2. Naresh Bavabhai was seen for the first time by his consultant psychiatrist, Dr K. Mahadevan, on 6 March 1989. He was found to be thought disordered and paranoid. Naresh Bavabhai was not willing to stay in hospital, so Dr Mahadevan placed him on Section 5(2) of the Mental Health Act 1983 at 10 a.m. that day. An application for Section 2 was made at the same time, but this was not pursued as he then agreed to remain in hospital.

3.2.3. During this admission his sister Sumi, his brother Navin and his mother Mrs Bavabhai were interviewed. They described how he had looked perplexed and was muttering strangely 'like he had a lot of sentences in his head, but could only get a few out'. He was clasping their hands and crying, then suddenly stood up, extending his arms and saying 'this is what it is like for me all the time'. He had smashed a mirror in his flat, which he claimed was broken by the Devil. Dr Mahadevan was informed that Naresh Bavabhai had been in Borstal as a teenager and had been sniffing glue and abusing cannabis and alcohol.

3.2.4. On 8 March 1989 Dr Mahadevan noted that Naresh Bavabhai was 'feeling a lot better. When I first came in I thought everyone was against me, but I know now you are trying to help me.' He said he had started a new job as part of Employment Training the previous week and had problems fitting in. Also he had a noisy neighbour. He now said he had broken the mirror by accident and that he was no longer bothered about baptism. The next day Dr Mahadevan noted the nurses' reports that he had been quite settled and showed no paranoid ideas. He was seen with his sister and mother, but there was nothing to add to existing notes. Dr Mahadevan agreed that he could have leave at the weekend and queried the possibility of discharge to his family home.

3.2.5. The consultant's next review on 13 March 1989 noted that Naresh Bavabhai remained well and that he wished to start a college course after Easter. He also noted 'sister seems apprehensive' and he agreed leave until Thursday. On 16 March 1989 Dr Mahadevan recorded that the leave had been successful, 'although the sister is a little apprehensive'. He was discharged on 16 March1989 with a follow-up appointment in six weeks.

3.2.6. Comment The first admission appears to have progressed satisfactorily with appropriate treatment being made available. The family provided a considerable amount of background information which was taken into account in the treatment programme. Though a history of substance abuse had been obtained, the role of this in his first presentation to psychiatric services was not explored.

3.3. BETWEEN HIS FIRST AND SECOND ADMISSION

3.3.1. Naresh Bavabhai was seen urgently at his request on 22 March 1989 by Dr Mahadevan, when he complained of feeling anxious again and believing that people were watching him. He wanted to move home because his neighbours were spying on him. He agreed to a trial of Sulpiride (an antipsychotic) and Dr Mahadevan arranged to see him again in two weeks.

3.3.2. Comment Dr Mahadevan acted appropriately in bringing forward the planned appointment.

3.4. SECOND ADMISSION FROM 1-24 APRIL 1989

3.4.1. Naresh Bavabhai's general practitioner referred him to hospital again suggesting that he should be admitted. The referral note said ' He did well on his medication but has stopped it now. He is refusing to take it and has relapsed back into an aggressive schizophrenia with agitation and expressions of suicide'. The admitting doctor on 1 April 1989 noted bizarre behaviour, agitation, poor appetite and sleep and being convinced that non-Christians were conspiring against him. On 3 April 1989 Dr Mahadevan noted that he complained of rigidity with his trial medication and that he had discontinued this after three days, saying that this was on his sister Sumi's advice. He remained rather agitated and suspicious in manner but denied specific paranoid ideas.

3.4.2. Sumi Bavabhai phoned Dr Mahadevan on 7 April 1989, concerned that her brother was being discharged prematurely and was assured that he was being allowed out on a few hours leave each day. She agreed to attend the next review on the ward, which took place on 13 April 1989. The nursing report then described him as quite settled and the plan agreed was for weekend leave and referral to the day hospital. A social worker Mrs P Cairns, having reported on the very unsatisfactory nature of his present flat, agreed to contact Homeless Families regarding accommodation. On 19 April 1989 Dr Mahadevan also wrote to Dr Astil, the Acting Medical Officer for

Environmental Health, about accommodation. Naresh Bavabhai was discharged from ward K2 on 24 April 1989 with plans to attend as an out-patient, restart college, attend the day hospital, continue with his medication and to start attendance at the St. George's Day Centre in Bolton.

3.4.3. Comment Dr Mahadevan involved family members in the treatment plan and agreed a comprehensive and manageable plan for that time.

3.5. BETWEEN HIS SECOND AND THIRD ADMISSIONS

3.5.1. Naresh Bavabhai first attended the Day Hospital on 26 April 1989. He also recommenced attendance at college each Monday and his regular appointments at the outpatient clinic. He attended St George's Day Centre twice per week from 25 May 1989, continued at the Day Hospital three days per week and was in regular contact with his family whilst he was awaiting new housing accommodation.

3.5.2. Dr Mahadevan reviewed him at the day hospital each week, noting that he stayed consistently well. He was apprehensive when on 7 June 1989 it was suggested that he may be discharged. This took place on 21 June 1989, after which he was to continue attending St George's Day Centre and at out-patients' every four weeks. The consultant's notes thereafter indicate that Naresh Bavabhai remained well, so that by November 1989 his appointments were reduced to four-monthly.

3.5.3. At review on 27 March 1990, Dr Mahadven noted that he was attending the Day Centre and due to join a Job Club as he had not been able to find a job so far. He had given up his flat and was living with his mother, the parents having separated.

3.5.4. Comment A package of care was made available which, though meeting Naresh Bavabhai's immediate needs appears to be somewhat disjointed as there was minimal communication between the different agencies.

3.6. HIS THIRD ADMISSION BETWEEN 17-30 MAY 1990

3.6.1. On 17 May 1990 Dr Mahadevan recorded 'message from relation; Naresh is very paranoid again'. He noted that an urgent Community Psychiatric Nurse visit was indicated, but in fact Naresh Bavabhai was brought to the ward that day by his sister and two brothers. He told the admitting doctor that he had been feeling people had

been criticising the word of God. 'You realise you can't be perfect. Only the Lord Jesus can be.' His sister reported that 'when he was admitted last year... he managed to convince people he was OK. He was back to his normal self until a month before'. He also believed that people at the day centre were getting at him.

3.6.2. At review on 21 May 1990, Dr Mahadevan recorded the relapse of paranoid schizophrenia. Naresh Bavabhai confirmed that he had discontinued his medication two or three months previously. The added stress of looking for a job had contributed to his relapse. He was now much more settled, but complained of feeling sleepy. He denied that people at the day centre were getting at him 'I was confused, I thought I was going through life as Jesus.... But I don't think that now'. At review on 24 May 1990 the consultant noted that he was very well, with no paranoid ideas, and that his brother thought he was well.

3.6.3. The doctor on duty on 29 May 1990 noted that he had returned with his brother and sister on the night of 26 May 1990, having become 'very confused after argument at home'. The Doctor added 'anxious state on night of 26/5 not documented'. He was complying with medication, had settled again on the ward showed no obsessive thoughts, phobias or paranoia. The doctor confirmed that he should be discharged on 30 May 1990 on oral chlorpromazine, to attend St. George's Day Centre and an out-patient appointment in two week's time.

3.6.4. Comment The notes of this admission by the admitting doctor, Dr Mahadevan and the discharging doctor are very comprehensive. They show that information was sought from family members as well as the patient. Since this was the second admission prompted by non-compliance, other steps could have been considered to improve compliance before Naresh Bavabhai was discharged.

3.7. BETWEEN HIS THIRD AND FOURTH ADMISSION

3.7.1. His first outpatient appointment was on 12 June 1990, when he said that he felt well and spoke of taking a post as an aircraft cleaner at Heathrow. His next appointment was in six weeks, but on 18 June 1990 when he called at the ward to visit a young female staff nurse he appeared confused and hesitant and it became clear that he had not been taking his medication regularly. He was seen at outpatients the next day and seemed improved. The doctor noted 'continue meds'.

3.7.2. On 17 September 1990, Mr A Walker, a training manager, called Dr Mahadevan to inform him that Naresh Bavabhai was laughing inappropriately, was vacant in his manner and had been regarded as being unwell enough to be taken off his job working with machinery in a joinery.

3.7.3. Dr Mahadevan received a phone call from Sumi Bavabhai on 18 September 1990 to say that Naresh Bavabhai had been wandering, talking to himself, saying silly things and not taking his medication regularly. Naresh Bavabhai was not willing to consider an increase in chlorpromazine or to attend the Day Hospital. Mr W Byrne, a Community Psychiatric Nurse (CPN) was asked to monitor the situation.

3.7.4. The CPN called at his home on 20 September 1990 and was informed by Mrs Bavabhai that her son was at college. When the CPN called the next day, Naresh Bavabhai was rather suspicious, claimed to be taking his medication, showed no signs of psychosis and spoke rationally of his hopes to get a job in the near future. He was rather disturbed as to why his sister was concerned about him. He told Mr Byrne that he went out on a regular basis with friends and said that he mixed well. The CPN then phoned the sister on 24 September 1990 and she rang him on 1 October 1990 to say that her brother had been behaving strangely over the weekend. After discussion with Dr Mahadevan on 3 October 1990, the CPN visited at home that day, when Naresh Bavabhai was again out. He spoke to his sister and asked if Naresh Bavabhai could ring him. On the same day Dr Mahadevan contacted housing services regarding accommodation needs.

3.7.5. On 15 October 1990 Mr Byrne visited Naresh Bavabhai at home in response to a request from his sister. He noted 'Very apathetic and withdrawn. ? Auditory hallucinations. Negativistic. Nil conversation.' The CPN discussed this with the GP, Dr Singh. An appointment was made with Dr Mahadevan which Naresh Bavabhai said he would keep and the CPN phoned his sister to request her to accompany him.

3.7.6. Naresh Bavabhai was seen in the outpatient clinic on 16 October 1990 by Dr Mahadevan with his family. They described him as 'very hostile and aggressive, standing eye to eye in front of sibs for up to 20 minutes'. He was withdrawn, with bouts of aggression, laughing inappropriately and playing loud music at inappropriate hours. Dr Mahadevan noted: 'Seen. Mute. Looks angry. Nods when asked if he will be admitted. Opinion, relapse paranoid schizophrenia. Admit, S5 [section 5 Mental Health Act 1983] if he attempts to leave, Close obs'.

3.7.7. Comment Although the behaviour as described by his brother and sister on 26 May 1990 suggested that Naresh Bavabhai's mental health was, fragile he was discharged three days later and, despite the episode on 18 June 1990, seems to have remained quite well at home until mid-September 1990. Both his employment supervisor and his family then reported a deterioration. Support and supervision was appropriately intensified, but by 16 October 1990 he was ill enough to justify admission and subsequent detention.

3.7.8. He appears again to have become acutely ill after failing to take his medication, but equally he could respond rapidly when, as on 18/19 June he resumed taking it. There is no suggestion in the notes that such a rapid fluctuation may have been influenced by substance abuse.

3.8. FOURTH ADMISSION BETWEEN 16 OCTOBER AND 31 DECEMBER 1990

3.8.1. On 16 October 1990 Naresh Bavabhai was readmitted informally to ward K2 because of his deteriorating mental state. He was unwilling to stay and was held on Section 5(2) of the Mental Health Act 1983 that afternoon, which was converted to a Section 3 on 19 October 1990 because of his changeable behaviour aggression, hostility and reluctance to stay in hospital and to take prescribed medication. The application was completed by Mr Ian Smith, an Approved Social Worker employed by Bolton Social Services. His interviews with Naresh Bavabhai, his mother and sister were his first contacts with them.

3.8.2. Because Naresh Bavabhai was not very compliant with oral medication, Dr Mahadevan commenced him on long acting injections of Depixol (an antipsychotic preparation) on 22 October 1990.

3.8.3. By 25 October 1990, Dr Mahadevan noted at review that Naresh Bavabhai was 'much more settled ('tho occasionally rather abrupt). Anxious to go home'. The plan was to phone the family to see if they were happy about a day's leave, then overnight weekend leave. On 28 October 1990 he had to be returned to hospital by the police because he refused to return voluntarily, and his family reported that he had been very hostile at home. Later that day he was observed to be staring in a very hostile manner, refusing to speak and he tried to leave the ward. By the next day he was much more articulate and refused to believe he had deteriorated over the weekend. He was very irritable and wanting to go on further leave.

3.8.4. At review on 1 November 1990 the ward doctor noted that he was more subdued and accepting to stay on the ward. He was not allowed weekend leave and for the first time '? Abusing drugs' was noted. At review on 5 November 1990, Dr Mahadevan noted: 'pleasant, cheerful, no paranoid ideas. Plan a few hours home each day. See family with SW Ian Smith. ? weekend leave'.

3.8.5. Dr Mahadevan noted at review on 5 November 1990 that Naresh Bavabhai had been home for a day's leave and that his mother was interviewed with the assistance of a link worker fluent in Gujerati. He had been rather restless at home. He complained of this himself and appeared rigid. Dr Mahadevan reduced his medication to Chlorpromazine 100 mg at night, Procyclidine 5 mg three times a day, and Depixol to 40 mg 3 weekly.

3.8.6. On 12 November 1990, night nurses reported that he was staring at them in a hostile way. When seen on his own by Dr Mahadevan he found him hostile in manner, reluctant to speak and refusing to have his depot medication. The consultant increased his dosage to 60 mg, cancelled his leave and instituted close observations. His behaviour was the same on 15 November 1990, when he was mute on the ward and to his mother. His Chlorpromazine was increased to 200 mg three times a day.

3.8.7. At review on 15 November 1990, Dr Mahadevan noted the Naresh Bavabhai was 'feeling fine, making things in woodwork'. He admitted that he 'gets irritable' and 'doesn't trust people because everyone is a sinner - I'm wary'. Close observations were retained. Nursing staff reported that he was fairly settled but still rather suspicious. His mother was seen again.

3.8.8. On 22 November 1990, Dr Mahadevan noted that he was much brighter in mood, with no paranoid ideas and 'assures me he will not abuse marijuana in the future'. He wished to go home for a few hours leave and was making plans to see a Disablement Resettlement Officer (DRO). On 26 November 1990, having gone home for few hours, Naresh Bavabhai himself informed Dr Mahadevan that his family was getting on top of him 'they are always ordering me about. They are unsympathetic'. He said he became 'all worked up' at home, and Dr Mahadevan noted that he was to discuss this with Mr Smith and that he wished to move to a place of his own.

3.8.9. On 29 November 1990 nurses reported that he had been very well and was going out to St. George's Day Centre. When seen by Dr Mahadevan he noted 'despondent about returning home to his critical family. Mr Smith will work with family to

modify the behaviour if possible'. His sister Sumi and mother were seen who were 'quite happy with this'. The plan was for weekend leave and for Mr Smith to work with the family.

3.8.10. At review on 3 December 1990 Dr Mahadevan noted that nurses had reported Naresh Bavabhai was rather angry and uncommunicative on his return from leave. When seen he complained to the consultant that he thought he heard voices at home when no-one was talking and said he had had that experience before. However, he felt the weekend went well, had gone to church and visited a friend. His family were trying to be more considerate. He planned to go to a funeral that day and to an employment seminar the next day.

3.8.11. On 10 December 1990 at review he again complained of hearing voices and his Depixol was increased to 100 mg two-weekly, his Chlorpromazine was reduced to 200 mg bd.

3.8.12. Dr Mahadevan noted at review on 13 December 1990 that Naresh Bavabhai had been quite settled but had been 'staring intensely' that day and told him 'I'm not on top of the world. It's like everything is premeditated. I feel I'm cold – like an object, cold. No feeling'. He was rather stilted in manner. The plan was to increase Chlorpromazine to 200 mg three time a day and Depixol to 150 mg two weekly, with no weekend leave. On the same day Dr Mahadevan wrote to Dr Astil, the community physician, for assistance with rehousing. By 14 December 1990, Naresh Bavabhai reported feeling a little better.

3.8.13. On 17 December 1990: he admitted he had been using marijuana heavily and assured Dr Mahadevan that he will 'try to give up'. Some staring and hostile behaviour had been noted and he complained of feeling drowsy. His Chlorpromazine was reduced to 200 mg twice daily. He was counselled by nurses: 'discussed negative consequences of using cannabis... took cannabis whilst on leave'.

3.8.14 Reviews on 20 and 24 December 1990 indicated that he had been very well, visiting home most days, cheerful and with no paranoid ideas. Weekend leave was successful and he showed no psychotic symptoms.

3.8.15. The nursing report at review on 27 December 1990 was that he was quite settled but there was some suspicion that he was still smoking cannabis. When seen

by Dr Mahadevan he was cheerful and denied using cannabis. The plan was for weekend leave, with a discharge review the next week and he was regraded to informal status.

3.8.16. At review on 31 December 1990 he was reported to have returned from leave two days early, claiming that he had been bored. At interview he said he had come back from home prematurely feeling a little depressed and restless. He denied hallucinatory experiences. It was agreed that he could be discharged that day to Rivington Day Hospital and the depot clinic, attend St. George's Day Centre, be seen at home by Mr Smith and to continue regularly on medication – Chlorpromazine 200 mg nightly, Procyclidine 5 mg three times per day, Depixol 150 mg fortnightly.

***3.8.17. Comment** In his written evidence to the Inquiry, Dr Mahadevan concludes in relation to this admission that 'by this time it was evident that this man was suffering from a paranoid schizophrenic illness. He was not very compliant with oral medication and I therefore commenced him on treatment with long acting injections of Depixol. Although Naresh showed his usual rapid improvement this episode had a fluctuating course in that he would improve and then again become hostile and begin staring at people. It transpired that he was smoking cannabis heavily and he received counselling about illicit drug misuse both from myself and ward staff'.*

3.8.18. An attempt had been made to identify the social factors of Naresh Bavabhai's schizophrenia and to address the continuing issues therein. The Community Psychiatric Nurse was involved at home prior to the admission, the social worker was introduced and there were contacts with his employing agency. There was considerable involvement with the family on the ward and at reviews, facilitated by the involvement of a link worker for Mrs Bavabhai.

3.8.19. This admission is thoroughly documented in the medical and nursing notes. A discharge plan was made and a clear summary was sent to the GP, but there appear to have been no specific interventional strategies set into place regarding his substance abuse, even though there was a clear history of this, nor were plans carried through to help Naresh Bavabhai with the conflicting feelings about his home and family seen during the admission. Mr Smith recalls that his last contact with him at that time was on 8 January 1991.

3.9. BETWEEN HIS FOURTH AND FIFTH ADMISSIONS

3.9.1. On 2 January 1991 at review Naresh Bavabhai appeared quite well, although restless and his Procyclidine was increased. At review on 9 January 1991 Dr Mahadevan noted 'has been quite settled: Ian Smith was helping with accommodation: Discharge depot clinic 2/52 fu (follow up) OPC 1/12.'

3.9.2. He was noted to be well on 20 February 1991, and on 19 March 1991 he was discharged by the Senior House Officer (SHO) from the out-patients' clinic with follow up by attendance at the depot clinic for his medication. The SHO wrote to his GP on 20 March 1991 'This paranoid schizophrenic patient has been perfectly settled since discharge from hospital apart from complaining of some restlessness. He has been sleeping well, his appetite is good and he appears euthymic. There has been no relapse of hostile and aggressive behaviour and no further psychotic phenomena. He should continue on his present medication of Chlorpromazine 200 mg nocte, Depixol 150 mg every two weeks and Procyclidine 10 mg. He will be followed up at the depot clinic.'

3.9.3. Between April and September 1991 he received depixol injections at the John McKay Clinic and practical support from CPN Mrs K Gettins.

3.9.4. On 29 August 1991 his mother expressed concern that Naresh Bavabhai was being aggressive and that he had had no depot medication since 8 July 1991.

3.9.5. Medical note entries after March 1991 are out of sequence. The next dated entry is 14 October 1991, when Dr Mahadevan saw Naresh Bavabhai because he was 3 weeks overdue for his depot injection. He complained of tremor and side effects. Nothing abnormal was detected on his mental state and no paranoid ideas were evident. The consultant emphasised the importance of attending for depot regularly and noted 'continue on 100 mg Depixol 3/52.'

3.9.6. On 10 January 1992 Mrs Gettins noted 'No further contact. Reported to be attending John McKay Clinic for depot I/m. Discharged CPNS.'

3.9.7. The next entry in the medical notes is dated 9 October 1992. Dr Mahadevan recorded 'not had depot (or tabs) since March. Feels well. No paranoid ideas. Does not hear voices. Continues to live with his mother. Attending college p/t to do GCSE. Not

smoking cannabis now. Discharge'. In his letter to the GP on 12 October, he reported the above and concluded 'he did not wish to continue attending the psychiatric clinic and I am therefore discharging him back to your care. I will of course be happy to see him at your request'.

3.9.8. On 30 November 1992 Dr Mahadevan noted 'letter from patient ? requesting medical recommendation for rehousing. To obtain this from GP, as he is no longer under my care. SW Ian Smith may be able to help, contact on his behalf'. Mr Smith recalls being contacted by Naresh Bavabhai about this, liaising with the Housing Department and having a number of discussions about Naresh Bavabhai with the Housing Resettlement Officer who was aware of his psychiatric background.

3.9.9. The first page of Naresh Bavabhai's above letter covers in detail his frustrated attempts to secure rehousing for himself. The second page continues 'I am turning to you in desperation. I realise you might not be able to do anything more but any assistance you can give would be much appreciated. I know I didn't tell you about my situation the last time I saw you although you mentioned it, partly because when you see me you only ask questions to see if I'm 'sane', not smoking dope and what I'm doing. I can understand why you do this but this takes up all the time and I haven't got much time to talk about the other things at length.' His letter then emphasised the importance he attached to obtaining Dr Mahadevan's support and it concluded with a post-script 'If you did see me I could tell you of the difficulties I am encountering through living at home and believe me they are not silly.'

3.9.10. On 30 January 1993 Naresh Bavabhai wrote again to Dr Mahadevan, a letter three pages in length. 'I am writing to you as a person who is in a dilemma. I am having difficulties in building a rapport between my GP and I, Dr Singh, bear in mind it takes me a long time to place trust in a person who threatens my freedom. Since Dr Singh took over the surgery two years ago I have been very patient with him and more recently told him things I haven't ever told you. Yesterday was the last straw. I'd rather tell you now.' Naresh Bavabhai then detailed his concerns about the recommendation which Dr Singh was to provide regarding a driving licence and his resentment that recently Dr Singh had issued medical certificates required by the Department of Social Security to his mother rather than to him as before. He wrote of his concerns that Dr Singh was not a specialist in the field of psychiatry. He acknowledged that Dr Mahadevan had discharged him but asked if he would see him again. He added 'the things I told my GP were;- I have never stopped hearing voices, I don't think I ever will unless I'm heavily sedated 'dead to the world'. The voices are not offensive or loud but rather quiet and seem distant. You can't hear them as you can an external voice, they are from within it seems. They are not voices of instruction but more of an inquisitive

type and sometimes voices of assurance. They can, however, sometimes be annoying and one can be mistaken by other distractions (voices) and interpret them as voices when perhaps they would have been legitimate'. Naresh Bavabhai gave a schedule of the medication he had taken since he last saw Dr Mahadevan in September 1992, but said that they were pills issued in June 1992. He ended ' I am aware that you deal with patients who have just come out of hospital or who have 'more severe' disorders than myself but I would be grateful if you could find the time to see me at your convenience.'

3.9.11. Comment Naresh Bavabhai was discharged on 31 December 1990 from his fourth hospital admission in less than two years. This admission was because of an acute episode of illness which had demanded his detention under the Mental Health Act, periods of close observation, restrictions on home leave and careful adjustments to his medication. Nevertheless he was discharged from outpatient follow-up within three months to be seen thereafter at the depot clinic.

3.9.12. He had no contact with Dr Mahadevan from October 1991 to October 1992 when he discharged him from his care. In his written statement, Dr Mahadevan concluded, 'he remained well on Depixol and continued to maintain his improvement despite discontinuing all medication in March 1992'.

3.9.13. The limited records available do give the appearance that this was seen as a relatively stable period in the clinical history of Naresh Bavabhai, when he was living at home, despite his concerns about his family's critical comments. However his compliance remained variable and ceased in March 1992. It must be of some concern that because he did not want to attend the psychiatric outpatient clinic Naresh Bavabhai was discharged from psychiatric care in October 1992 without greater encouragement to attend, as his subsequent admission proves.

3.9.14. Although Naresh Bavabhai's letter of 28 November 1992 began with his requests for practical help, it also contained his clear message that he felt in need of Dr Mahadevan's clinical support. That letter was, however, responded to at face value, confirming Dr Mahadevan's view that Naresh Bavabhai remained well without medication or contact with psychiatric services.

3.9.15. Naresh Bavabhai's second letter confirmed the message contained in the first that he felt in need of continuing specialist psychiatric support. He had identified symptoms which were of concern to him and in the second letter

disclosed that he had been medicating himself from his stock of unused chlorpromazine tablets.

3.9.16. The two letters are the only accounts in Naresh Bavabhai's own hand to be found in the records. They demonstrate something of his ability to communicate and his level of understanding of his illness, although they were ostensibly written primarily to achieve his practical ends.

3.10. HIS FIFTH ADMISSION BETWEEN 4-12 FEBRUARY 1993

3.10.1. On 4 February 1993 Dr Singh's partner, Dr Holland, requested Naresh Bavabhai's re-admission as he had not been taking any medication for at least ten months, had been acting strangely for three days, was dishevelled and complained of hearing voices telling him to study. He was agitated, pacing about and his family was concerned that he was deteriorating again. There was also the suspicion that he might have been abusing cannabis. He had a fight with his younger brother that afternoon when he admitted to occasional cannabis abuse. He was once again admitted to K2 ward.

3.10.2. The admitting doctor noted that he showed little spontaneous movement, was staring at the floor and walls, had poor eye contact and rapport and seemed distressed, distracted and possibly to be experiencing hallucinations. He continued to behave strangely the next day, and was mute and inaccessible.

3.10.3. At review on 8 February 1993, Dr Mahadevan noted that he sat in silence for several minutes, said 'I had a fight with my brother', and lapsed into silence again. Clorpromazine 100 mg three times per day and 200 mg at night and Depixol 40 mg were started. The same day he threatened to leave the ward and accepted that he should speak to staff before going for a walk. On 9 February 1993 he wanted his medication reduced and to go home for good. He felt his admission was precipitated by pressures at college and the fight with his brother. He was tense and found it difficult to communicate, hence the muteness. He denied ever having auditory hallucinations, felt better and ready for home, He could accept the diagnosis of schizophrenia though he thought he was on too much medication. He appeared tense and agitated and agreed to stay on the ward.

3.10.4. Dr Mahadevan noted at review on 11 February 1993 that Naresh Bavabhai felt a lot better. He described how his attention shifted, how he heard voices discussing

him in the third person e.g. 'what's he doing that for' but that they were very quiet. He complained of feeling very drowsy on the Chlorpromazine. He had been abusing cannabis, but only occasionally. The plan was to see the family, allow a few hours leave at the weekend if he remained well and reduce his Chlorpromazine to 100 mg four times a day.

3.10.5. On 15 February 1993 at review, Mrs Bavabhai was interviewed with the link worker present. She is recorded as saying that Naresh Bavabhai was better 'but not back to normal'. He talked a lot, which was unlike him. She did not want him home yet and she was afraid that he could become violent. She would not mind having him on a day's leave. She reported that she and her husband had separated five years previously when their daughter refused to have an arranged marriage. Dr Mahadevan also noted 'patient assured me that he feels back to normal. Days leave, ? followed by weekend leave with a view to discharge on Monday.'

3.10.6. Dr Mahadevan decided at review on 22 February 1993 that Naresh Bavabhai was well enough to be discharged that day. He noted 'mother feels he has improved happy to have him back at home'. He was discharged home but with plans for follow up at the depot clinic and to see the social worker. His medication was Chlorpromazine 100 mg at night and Depixol 100 mg 2/52.

3.10.7. His general practitioner identified the family's concerns that he had been abusing cannabis and their fears that he would become violent. There is evidence that the family was encouraged to be involved at various stages in the management of Naresh Bavabhai.

3.10.8. Little attention appears to have been given to the self-medication and substance abuse that appears to have precipitated this episode of illness, but compliance has been better addressed on this occasion.

3.11. BETWEEN HIS FIFTH AND SIXTH ADMISSION

3.11.1. Mr Smith recalls that in April 1993 Naresh Bavabhai was rehoused by the Housing Department at Cromford Close, Bolton, where he visited him on 19 April 1993. He understood that Naresh Bavabhai would not be using the support of the warden who resided at the flats, but he was helped in the move by the Resettlement Officer, who would also offer help with budgeting and in the day to day running of the new home. He remained well, attending outpatients' and St George's Road Day Centre.

3.11.2. The next entry in the medical notes is by the SHO on 24 May 1993, who noted 'hearing voices – paranoid ideas projecting his ideas. Studying GSCEs in Manchester Road'. His flupentixol was reduced to 80 mg fortnightly.

3.11.3. Mr Smith saw Naresh Bavabhai at home on 30 June 1993 and found he had settled, was receiving benefits advice from the Resettlement Officer and was claiming Disability Living Allowance. At Naresh Bavabhai's request, he spoke to the Bolton Employment Support Team about a part-time work placement. After this Naresh Bavabhai appeared to be coping and declined Mr Smith's offer to refer him to the local Mental Health Network which could offer day to day support to supplement his living skills.

3.11.4. On 13 September 1993 the SHO noted 'no problems, not hearing voices, going to join a course in Open University.' The flupenthixol was again reduced, to 80 mg three weekly.

3.11.5. On 14 October 1993 Dr Mahadevan noted that Naresh Bavabhai had remained well since February 1993, was doing preparatory work for an Open University degree and living on his own in a nice flat. He occasionally heard voices, otherwise no psychotic symptoms were evident. He received flupenthixol 80 mg three weekly, Chlorpromazine 50 mg twice daily. He added 'to try reducing if stopping Procyclidine'.

3.11.6. On 23 December 1993 Naresh Bavabhai's GP obtained a urine sample from him which provided the first objective evidence of cannabis use.

3.11.7. The next page of the medical notes contains three entries. The first is Dr Mahadevan's above note on 14 October 1993. The next entry is on 23 March 1994 by the Clinical Assistant – 'Fine, voices not at all'. Sleeping and appetite were good and he was coping well. The third entry was on 1 February 1995, when the Clinical Assistant noted 'Well, mentally sound, unable to get Disability Allowance. Refusing to have injections. Monetary problems, ask to reapply. See 6/12'. The doctor reported this to the GP on 3 February 1995, adding 'We cannot of course force him to have his injection. We advised him to see if you could help in any way and we also suggested that he contact the Social Services. He will be reviewed again in 3 month's time'.

3.11.8. On 21 February 1995 Dr Mahadevan noted '3 weeks overdue for depot injection. Refused depot in protest against Social Security refusal to grant him Disabled Living Allowance. No deterioration in mental state so far. As before hears voices occasionally telling him to be careful and not to mix with his friends.' His brother told Dr Mahadevan that Naresh Bavabhai could not cope for himself very well, that he had his own flat but was always at his mother's, who cooked for him. He was often up at night wandering aimlessly. Dr Mahadevan noted that he had ideas of reference, that he did not go about much in the day and was dependent on his family for help with shopping and paying bills. He had not taken any oral medication for 18 months. He made a note to stop Chlorpromazine and Procyclidine, to continue Depixol 80 mg every month and to send a letter to DLA/SS. On 8 March 1995 he sent a letter of support regarding Disability Living Allowance.

3.11.9. Dr Mahadevan saw Naresh Bavabhai next on 8 August 1995 and noted that he remained well on depot, but that he still had strange experiences. For example, 'when he goes out that he is playing a part in a movie. Hears voices 3 or 4 times a week, sometimes talking about him in the third person but the voices are not pronounced'. He was on no oral medication, just 80 mg Depixol every 4 weeks. On the same day Dr Mahadevan sent a letter supporting an application for housing with Making Space.

3.11.10. On 4 September 1995, as a result of the sectorisation of psychiatric services in Bolton, Dr Mahadevan passed over the care of Naresh Bavabhai to his consultant colleague Dr M Brownlee.

3.11.11. In September 1995 Naresh Bavabhai discussed with his GP 'a fear about some sexual problems, sexual disease'. On 5 October 1995 he was seen by appointment, at the request of the Genito-Urinary Medicine Clinic, by Mr R Rawle a nurse member of the Community Drugs Team (CDT). He said he was using 1 mg of amphetamine by injection every two weeks and smoking £2 worth of cannabis a day. Further appointments were made but not kept.

3.11.12. Dr Brownlee saw Naresh Bavabhai on 4 December 1995, when he recorded 'a reluctant transfer of care, wants to stay with KM, [Dr Mahadevan] still feels frightened of other people, locks himself in house sometimes'. He also noted 'occasionally hears voices – don't really bother him. Overall better since depot reduced and car bought. He had turned down a flat with Making Space and was attending St George's Day Centre three days a week. He had stopped cannabis and hardly drank alcohol. He appeared cheerful and optimistic with no psychotic ideas. He had insight

that he had been ill but knew he would not say this next time!' He was to be seen again in three months. Naresh Bavabhai also reported nocturnal eneuresis over the past twelve months and occasional encopresis, worse when he was frightened at night. He also requested more social activity. Dr Brownlee made a note to ask the depot nurses about that and the eneuresis.

3.11.13. In March 1996 Naresh Bavabhai asked to see Mr Smith to discuss attending additional activities and they met at St George's Day Centre on 23 March 1996. He then told Mr Smith of his abuse of amphetamines and his awareness that it was inadvisable in view of his schizophrenia. His feeling of paranoia worried him and he had attended counselling sessions at the CDT. He was due to start a course at Bolton College in October and wanted to participate in other social activities in the meantime. Mr Smith thought that short-term education courses might be of benefit and support from the Mental Health Network. They met again at Naresh Bavabhai's flat on 28 March, when he told Mr Smith that he no longer wanted or needed additional support or activities. The reason he gave was that his father had been admitted to hospital recently and would need his help when discharged.

3.11.14. On 3 April 1996 Naresh Bavabhai made a phone call to the Community Psychiatric Nurse service, stating that he felt threatened by people ringing his door bell and wanted to kill them. He was advised to attend the John McKay Clinic and when he did so he refused to see Dr Brownlee, saying that he reminded him of an authoritarian police officer. The SHO at the depot clinic was, however, able to make a full assessment, noting that he appeared restless and hyperactive, and for two months had had paranoid ideas and ideas of killing people. He knew these were not rational and tried to suppress them. He reported auditory hallucinations in the third person of 'people talking about him' especially when he was alone at night. He knew they were not real. The doctor also noted '? Visual Hallucinations – sees ants on the mantelpiece'. He showed good insight that his thoughts were not logical and 'believes thoughts about killing people are irrational', and 'willing to co-operate with medication, he knows he is unwell'. The plan was to speak to Dr Brownlee about increasing the flupenthixol, to refer to a Community Psychiatric Nurse and to discuss urgent referral. On the same day Dr Brownlee wrote to Dr Mahadevan asking him to resume care of Naresh Bavabhai as he had refused to see him. Naresh Bavabhai was referred for psychiatric nursing support in the interim.

3.11.15 Naresh Bavabhai was seen at home by Mr Catterall, Community Psychiatric Nurse on 4 April 1996 who noted that he appeared 'to have had a relapse of his paranoid psychosis. The only significant stress he could relate to is the transfer made to Dr Brownlee which he was most unwilling to accept'. Mr Catterall completed a Stage

One Assessment for the Care Programme Approach (CPA), a Risk Assessment and a Health of the Nation (HoNOS) Score Sheet. The CPA documents consisted of four pages, headed psychological, sociological, biological and political factors. The psychological factors were identified as 'Mr Bavabhai has felt unwell for two weeks. He has felt angry and aggressive towards other people because he fears they may harm. He fears that people may want to rob his flat. He thinks people are talking about him in a critical way because he smokes and swears, that he must be a hypocrite for attending Church. Worried by violent feelings he has been having. Three weeks ago threatened a friend with a knife because he thought he stole his house keys. He is particularly worried about people coming to his flat, esp(ecially) strangers. He feels quite safe and generous towards some people.' The risk assessment noted 'feels angry and aggressive towards other people, especially strangers'. The HoNOS Score Sheet gave above average scores for overactive, aggressive and disruptive behaviour, cognitive problems and problems with hallucinations and delusions, but gave a 'nil' score to problems related to non-accidental self injury and problem drinking or drug taking.

3.11.16. On 10 April 1996, Dr Mahadevan saw Naresh Bavabhai at the Rivington Day Hospital. He found that 'he was preoccupied by Code 2069, which is a menacing procedure. Strange thoughts come into his head that people are talking about him. He thinks people in the street say he is a hypocrite because he goes to Church but also smokes and swears. He knows that it's not true though. He understands his illness'. Dr Mahadevan increased his flupenthixol to 100 mg every two weeks and started Chlorpromazine 100 mg twice daily. He noted that Naresh Bavabhai's father had a heart attack and that his sister was under the care of Dr Brownlee. He also noted Mr Catterall 'reports patient was brandishing a kitchen knife 3/4 weeks ago at a friend'. This reported incident and other information was included in a letter from the consultant to the GP on 16 April 1996.

3.11.17. Comment The records again suggest that the period from April 1993 to April 1996 was seen to be a relatively stable period in Naresh Bavabhai's story. In his written statement to the Inquiry Dr Mahadevan concluded 'he was generally compliant with medication although the dose of depot injections had to be negotiated and was gradually reduced to 80 mg each month. He continued to have some residual psychotic symptoms'.

3.11.18. In his verbal evidence to the Inquiry, Navin Bavabhai said that during 1993 or 1994 Naresh Bavabhai had told him of his thoughts of taking a car up to the moors and committing suicide with exhaust fumes. This information was not, apparently, communicated outside the family circle.

3.11.19. He received adequate care with which he complied without running into difficulty until the time when the sectorisation of services meant the transfer of care to his catchment area consultant, Dr Brownlee, whose assessment on transfer concurred with the existing diagnosis. It did, however, reveal that Naresh Bavabhai was manifesting paranoid feelings and some quite extreme bodily reactions when under stress at night, to a degree that would have made it difficult for him to share a bedroom. The significance of the latter in terms of self-esteem and relating to Naresh Bavabhai's sexual needs and their fulfilment appear to have remained unexplored.

3.11.20. Appropriate steps were quickly taken when Naresh Bavabhai made it clear that he wished to remain under the consultant care of Dr Mahadevan. By April 1996, however, his mental state appears by all accounts to have deteriorated with some violent thoughts and actions, for example ideas of killing people and brandishing a knife. In his verbal evidence to the Inquiry Dr Mahadevan said his recollection was that no one had actually thought that it was a particularly serious threat or that he would have actually harmed his friend.

3.11.21. There appear to be some objectively stressful factors including his father's heart attack and his sister's referral to a psychiatrist, in addition to the sequelae of sectorisation.

3.11.22. Mr Catterall completed a full assessment on 4 April 1996, but it appears from the absence of any reference on the CPA forms, the HoNOS Score Sheet and the running record in April 1996 that problems of drug use were not evaluated.

3.11.23. The appointment with the Community Drugs Team in October 1995 seems to have been a separate matter, unrelated to Naresh Bavabhai's care and treatment by psychiatric services and not made known to them.

3.11.24. From the absence of notes in the running record and correspondence and from Mr Smith's recall it appears that once Naresh Bavabhai had settled at Cromford Close in June/July 1993 he had no continuing contact with Mr Smith. His case paper remained open in order to ensure that should Naresh Bavabhai or his family require help they would have direct access to Social Services' mental health team. Mr Smith told the Inquiry that there were no subsequent involvements, and the case paper was closed in 1995. His next contact was at

Naresh Bavabhai's request in March 1996. In his written statement Mr Smith said 'as there was no file open at the time and this was an informal contact for information/advice only, these meetings were not recorded except in my work diary'. Nevertheless, Dr Mahadevan told the Inquiry that he regarded Mr Smith as the keyworker at that time.

3.11.25. It is noted that Naresh Bavabhai's first disclosures in relation to his abuse of amphetamines was to the Community Drugs Team and Mr Smith, but there is no record that the information was then communicated to the consultant psychiatrists.

3.12. NARESH BAVABHAI'S ADMISSION TO RIVINGTON DAY HOSPITAL BETWEEN 16 APRIL AND 4 SEPTEMBER 1996

3.12.1. On admission to the Rivington Day Hospital on 16 April 1996, the admitting nurse, Mrs K Gettins completed an admission checklist, which noted that Naresh Bavabhai denied the use of illicit drugs. He said he did very little with his time but was planning to go to college in September and would like to do a degree course. He reported paranoid ideas regarding people breaking into his flat at night and that he heard voices but they did not bother him. He was to attend the day hospital 3 days per week.

3.12.2. On 19 April 1996 Mrs Gettins recorded a phone call from Naresh Bavabhai's brother in Bristol expressing concern for his welfare. He had been very angry and this seemed to be related to taking drugs. Naresh Bavabhai would not speak to Mrs Gettins, saying that he 'did not like the things that were coming out of his mouth'. He was then seen by the duty doctor, who recorded Naresh Bavabhai's report of an argument between him and his brother as a result of his use of recreational drugs. 'This argument upset Naresh, however he claims to feel alright, but feels the voices are increasing, not had depot [since] 2 weeks.' The doctor completed a mental state examination, noting an increase in second and third person hallucinations and that Naresh Bavabhai complained of voices increasing 'this is causing a major upset for him, would like the voices to go away, becoming slightly tearful.' The plan was recorded as 'missed Depixol, for depot 80 mg today'.

3.12.3. Mrs Gettins also phoned the Community Psychiatric Nurse service that day, and after discussion they agreed that it would be more appropriate for her to speak to the GP regarding the need for a domiciliary visit. In her verbal evidence to the Inquiry,

Mrs Gettins said that she would not routinely have been provided with copies of the CPA and other assessment forms completed by Mr Catterall on 4 April 1996.

3.12.4. On 24 April Mrs Gettins recorded that he was attending very erratically and for short periods only, joining in with few activities but he appeared more settled. At review that day Dr Mahadevan noted that he had been using £20's worth of amphetamines intravenously a week and now wished to give it up. He was referred to the Community Drug Team. His attendance at the Rivington Day Hospital was increased to five days per week and he was due to see a counsellor at St. George's Day Centre. It was noted that he had discontinued Chlorpromazine and Procyclidine and that his flupenthixol was 80 mg each fortnight.

3.12.5. The Community Psychiatric Nurse continued to be in contact with Naresh Bavabhai until 24 April 1996, when following a discussion with Mrs Gettins he was discharged by the Community Psychiatric Nurse Service on 13 May 1996, in view of his continuing attendance at the Day Hospital.

3.12.6. On 1 May 1996, having heard at review that he continued to use amphetamines, and wished to go to a rehabilitation unit, Dr Mahadevan noted that he would discuss this with the Community Drugs Team (CDT) and with the social worker, Mr I Smith. He increased the flupenthixol to 100 mg two weekly.

3.12.7. Mrs Gettins recorded on 2 May 1996 that Naresh Bavabhai was attending the Rivington Day Hospital more regularly but tended to leave early. On 8 May 1996 contact was made with the CDT, which offered an appointment for 14 May 1996. At review on 8 May 1996, Dr Mahadevan noted that he had used £20 of amphetamines the previous day and that he complained of hearing voices. On 15 May 1996 he recorded at review that Naresh Bavabhai had used £10 worth on 14 May 1996, the day of his assessment by Ms D Smith of the CDT.

3.12.8. Ms Smith's record of her discussion with Naresh Bavabhai is contained on a pro forma summary. She noted that he 'had used cannabis at 14 occasional use, increase paranoia; 16-20 alcohol, increased aggression; LSDx4 no real effect; 20's magic mushrooms, psychotic hallucinations and paranoia; amphetamines occasional oral use, no effect. He had started to inject amphetamines in September 1995, was injecting £20 amphetamine weekly and had done so for 4 weeks. He had not been drug free during the past 6 months, had not shared injecting equipment in the last four weeks but had shared in the past. Ms Smith had no concerns about his mental state

and with his minimal drug use his name was put on the waiting list. A urine sample taken that day subsequently proved strongly positive for amphetamines.

3.12.9. Attendance at Day Hospital was more regular until 22 May 1996, when he was contacted by phone and said that he was not using illicit drugs. He repeated this on 28 May 1996, when he told Dr Mahadevan that he still felt a bit paranoid at times.

3.12.10. On 6 June 1996 at review the duty doctor noted that Naresh Bavabhai felt alright but was disappointed about using amphetamines recently. He did not feel depressed but still felt slightly paranoid. On 19 June 1996 Dr Mahadevan noted 'has been abusing amphetamines and as a result has been feeling violent. However, did not abuse yesterday. To ask Dr Dougal's opinion, especially on rehab/therapeutic unit. Would CDT expedite appointment?'

3.12.11. On 26 June 1996 he noted that Naresh Bavabhai continued to abuse amphetamines and that CDT would see him in 4 weeks. On the same day he contacted Dr W Dougal, Consultant Psychiatrist in Substance Misuse requesting her opinion.

3.12.12. During June and July 1996 Narersh Bavabhai's attendance at Day Hospital and/or participation in activities was erratic. He complained of the cost of travelling there, had two episodes when he was physically unwell and on one occasion was asked not to attend when under the influence of drugs. He was attending St. George's Day Centre on Thursdays and Narcotics Anonymous as necessary.

3.12.13. He was seen by Dr Dougal on 5 July 1996. In her written evidence to the Inquiry she stated that 'he gave a history of substance misuse from his teens, problematic use of alcohol (16 to 19), inter-related aggression, paranoid ideation and perceptual disturbance inter-related with magic mushrooms and LSD use (20s), paranoid ideation inter-related with cannabis use – erratic pattern of use from age 14 to present day. There is a history of regular use of amphetamine by injection over the preceding 12 months (confirmed by urine drug screen). There is a suggestion of irritability and aggression inter-related, withdrawal lows, paranoid ideation though denial of suicidal thoughts. There were additional health concerns regarding injected and sharing behaviour patterns. Precipitating and maintaining factors in pattern of drug use appear to have been a combination of boredom, dysphoria, enjoyment, with some peer group influence. He claimed to spend between £30 and £40 a week on amphetamine and cannabis use and admitted to use of benefit as funding source'

Dr Dougal had completed a mental state examination. Her impression was that of dual diagnosis – paranoid schizophrenia, substance misuse – cannabis and amphetamine misuse current. She stated 'he acknowledged substance misuse/sequelae and had some insight into triggers and maintaining factors and told me he was keen to address amphetamine misuse but was not sure about cannabis'. She had suggested a trial of fluoxetine to help reduce amphetamine lows and cravings and he was started on 20 mg daily. She felt he would benefit from CDT involvement but at that point consideration of rehabilitation units was inappropriate.

3.12.14. On 10 July 1996 at review Dr Mahadevan noted that Naresh Bavabhai had 'used, but only a £10 bag last week'. On 17 July 1996 he reported that he had not been using amphetamines, had been attending narcotics anonymous and was tolerating fluoxetine.

3.12.15. At her scheduled review on 24 July 1996 Dr Dougal was told by Naresh Bavabhai that he had not used amphetamine for over a week. He described cravings and felt there had been some benefit from fluoxetine and that he was attending Narcotics Anonymous. There was no real change from the mental state she had seen at assessment. His mood appeared stable, he described occasional paranoid thoughts and voices. She suggested that he continue with fluoxetine and arranged to review the situation in a month.

3.12.16. Naresh Bavabhai's attendance at the day hospital remained erratic during August 1996. On 9 August 1996 Mrs Gettins noted that he said 'he went on a bender over the weekend, used quite a lot of amphetamine and spent Monday and Tuesday coming down. On 14 August 1996 she noted 'used about £10 worth of amphetamine last night'. She also noted that a referral had been sent to the Community Psychiatric Nursing department. The referral form gave a brief history of the admission to the day hospital and concluded 'in view of a specific mental health need i.e. paranoid schizophrenia, exacerbated by drug misuse, and the number of disciplines involved he needs to be assessed for CPA. Ian Smith has been involved for some time so this will need to be discussed/negotiated with him'.

3.12.17. Mr Smith recalls that in early August 1996 he received a telephone call from Navin Bavabhai. This was his first contact with the family since January 1991. Navin Bavabhai told him that Naresh Bavabhai was attending the day hospital and had not been very well recently. Navin Bavabhai was concerned that when he saw him in the previous two days he was low in mood and expressing suicidal ideas. Mr Smith agreed to see him at the day hospital and to discuss his condition with the staff. When he

called, Naresh Bavabhai was not there. The staff as he recalled, had no concerns about his mental health and he relayed Navin Bavabhai's information in order that it could be noted and considered in his assessment and treatment.

3.12.18. On 14 August 1996 at review Dr Mahadevan noted 'spent £60 on speed yesterday. Says he has thoughts of raping people. Father arranging a marriage for him. Rather pressured in speech. Has been seen by Dr Dougal. ? for discharge in 2/52. Community Psychiatric Nurse/SW support.'

3.12.19. On 15 August 1996 the nursing care plan noted 'Problem: Continues to use amphetamine erratically; Goals: for Naresh to be discharged from Rivington Day Hospital with appropriate support.' A schedule of 10 nursing actions was listed. At mealtime that day, Naresh Bavabhai told a staff nurse that he was 'using drugs again type and amount not discussed. Says he lost all his money yesterday and stated that he was getting urges to rape females which he felt he could not discuss with female staff. Says he tried to discuss with Dr Mahadevan at last review but felt inhibited by presence of female staff. Discussed with Karen Gettins who will discuss this with Naresh.'

A further nursing note the same day records Naresh Bavabhai saying that he had 'used about £60 worth of amphetamine last night. Still appears to be under the influence-slurred speech, overtalkative. Says he has been having thoughts of raping women but no intent. Also worried that his father is rushing ahead with plans for an arranged marriage for Naresh. Continue with plan for discharge in a few weeks.'

3.12.20. At review on 21 August 1996 Dr Mahadevan noted 'Has not been using. Still craves but not been using. Thinking of doing GCSE at Bolton College. For discharge next week.'

3.12.21. The Community Psychiatric Nurse referral was received by Mr I Chisnell, Associate Community Psychiatric Nurse on 20 August 1996. He tried unsuccessfully to speak to Mr Smith that day and left a message. Having received no reply, he rang again on 27 August 1996, again with no response. Eventually he arranged a joint visit with his supervisor, Mrs Swift on 6 September 1996.

3.12.22. Naresh Bavabhai did not attend the day hospital on 28 August 1996 and it was noted at Dr Mahadevan's review that day that 'he has been burgled.' Mr Smith

recalls that he had been informed of this 'pre-discharge review', but had been unable to attend because he was requested to attend Astley Bridge Police Station, where Naresh Bavabhai was being detained on suspicion of burglary, having been arrested at his father's house. It transpired that Naresh Bavabhai, had visited his father, could not get a reply and being concerned because of his father's poor health, had broken a window and entered the property. This had been reported to Police by a neighbour and they had made the arrest. Whilst in custody the Police disclosed that someone had actually broken into Naresh Bavabhai's flat, and he needed to return there to check if anything was missing and to repair the door. Mr Smith says that he explained why he could not attend the day hospital and gave alternative dates when he could be present at a review. He later was told of a revised date, which was one of those not possible for him.

3.12.23. On 4 September 1996 Dr Mahadevan recorded at review that he had been arrested by mistake for breaking into his father's house. He denied using amphetamines and was pleased to report having a girlfriend. He was discharged from the Rivington Day Hospital with an out-patient appointment in six weeks. He was to have contact with his social worker Mr Smith, his community psychiatric nurse Mr Chisnell, attendance at the depot clinic, a follow-up appointment with Dr Dougal and a further assessment by the Community Drug Team. A discharge summary was sent to his GP, with a copy to Mr Chisnell, but it included no risk assessment or reference to harm to self or others. Under 'Treatment and Course' this stated 'Naresh complained of craving for amphetamines and continued to use the drug intermittently in the first few weeks of his admission. He received counselling at the day hospital and was also referred to the Community Drug Team and to Dr Dougal, Consultant in Substance Misuse. He seemed quite determined to give up drugs despite his lapses. When he wasn't attending the day hospital he went to St. George's Day Centre. He gradually began to gain some control over his drug misuse and by the time of discharge was only using amphetamines very rarely. He acquired a girlfriend and enrolled for GCSE's in mathematics and information technology at Bolton College. He appeared very cheerful.'

3.12.24. Comment. On admission to the Rivington Day Hospital on 16 April 1996 the process of assessing Naresh Bavabhai's condition and circumstances was started afresh by his named nurse Mrs K Gettins, despite the fact that her Community Psychiatric Nurse colleague Mr Catterall had completed extensive documentation on 4 April 1996. His assessment had not covered important issues relating to drug misuse, but it represented a very useful starting point for an evaluation under the Care Programme Approach which could have been of benefit during his time at the day hospital and in planning for his eventual discharge. No written summary of the Community Psychiatric Nurse's

assessment was provided to, or expected by Mrs Gettins under the working practices at that time.

3.12.25. During this period of attendance at the Rivington Day Hospital efforts were made in better co-ordinating his treatment and investigating his substance abuse with the help of the Community Drugs Team and Dr Dougal. Although the extent of the abuse he reported was not regarded as substantial it appeared to cause him great concern, with feelings of aggression and violence which are consistent with an amphetamine binge. There was a clear relationship established on 14 August 1996 between an amphetamine binge, paranoid thoughts and aggressive feelings, yet the significance of this connection does not appear to have been recognised.

3.12.26. His attendance at Day Hospital was erratic and his compliance with medication continued to fluctuate. On those days he did attend, he often seems to have stayed only for short periods and on one recorded occasion he was dissuaded from attending when he had used illicit drugs. There appears to have been no discussion with him about his motivation and his hopes about the therapies he was receiving. The significance of his night fears and the pattern of his nocturnal activities appear to have remained unexplored. Work with Naresh Bavabhai on this area of his life could have been an appropriate focus for continued involvement by the Community Psychiatric Nursing service rather than via the static daytime schedule of the day hospital, and might have provided a bridge to community support after his discharge.

3.12.27. The overall service remained disjointed with the key providers outside the day hospital never meeting to co-ordinate a care package or to share their understanding of his difficulties and their own problems in attempting to meet them. There is no evidence that CPA planning continued or that treatment and care goals were shared with Naresh Bavabhai, his carers and other services involved. However, Dr Mahadevan's and Mrs Gettins' records and correspondence continue to be of a good standard as clinical records in themselves.

3.12.28. It is notable, bearing in mind their previous frequency of participation at reviews, that family members were not involved at the day hospital other than when the brother from Bristol raised his concerns in April 1996. The contact with Mr Smith in August does not feature in nursing or medical records. Mention is

made of a girlfriend, but her role, status and possible involvement in a caring relationship seem unevaluated.

3.12.29. The reasons for his discharge from the Day Hospital are not specified, nor apparently are targets set for the Community Psychiatric Nurse and social worker who were to be involved in his continuing care. Reviews in August and before discharge, which Mr Smith was unable to attend, do not appear to have attached significance to his repeated revelations regarding thoughts about rape and earlier feelings of violence. His clear request to discuss with a male member of staff the thoughts of rape was not acted upon.

3.12.30 There appear to have been significant difficulties in communication between Mr Chisnell and Mr Smith, so that the recommencement of CPA planning, which had been requested on 14 August 1996, before the anticipated discharge, was not started until 6 September 1996, and then in the absence of Mr Smith, who had been proposed as the most appropriate keyworker. He states that he first knew of this and of Mr Chisnell's involvement with Naresh Bavabhai on 19 September 1996. Furthermore Mr Smith says he was not then made aware of the thoughts which Naresh Bavabhai had revealed at the review on 14 August 1996.

3.13. PRIOR TO HIS SIXTH ADMISSION 4 SEPTEMBER TO 4 OCTOBER 1996

3.13.1. Mr Smith was phoned by Naresh Bavabhai, he thinks, on 9 September 1996, to say that the police were dropping the case relating to the break-in at his father's house, he had been discharged from the day hospital and he felt well and did not express concerns.

3.13.2. On 6 September 1996 Mr Chisnell noted 'message left for Ian Smith to contact me to discuss CPA and keyworker designation. Informed he is on leave until 23.9.96.' He then made a home visit to Naresh Bavabhai with Mrs Swift present. He completed another Stage One Assessment and a further set of the forms used by his service for the Care Programme Approach. The Risk Assessment section identified no risk of harm to self or to children and other family members. A risk was identified as 'potential for aggressive feelings towards others and has threatened a friend with a knife in the recent past.' The other risk factor was shown as 'relapse of illness'. Under the standard headings 'sociological, psychological, biological and political factors' Mr Chisnell recorded information which corresponded in its details with other health records, with few exceptions. The most notable of these refers to '...spending time with his girlfriend x 3 per week. Supported by girlfriend, mother and professionals.' On one

of two accompanying Community Psychiatric Nurse forms, Mr Chisnell noted: 'Problem: Naresh suffers from paranoid schizophrenia aggravated by amphetamine abuse with auditory hallucinations and suspicious thoughts. Plan: monitor mental health particularly degree of auditory hallucinations and paranoia. Offer alternative coping strategies'. Under Interventions he listed 7 items; visiting, monitoring, discussion, counselling, compliance, liaison with consultant, discussion with social worker. On the other form he noted: 'Problem: social needs re budgeting and shopping/cooking, educational needs and social support, enhancement of leisure activities. Plan: discuss with SW Ian Smith re meeting social needs and key worker role. Interventions: liaise with Ian Smith on return from annual leave. Mr Chisnell informed Dr Mahadevan of his plan by letter on 17 September 1996.'

3.13.3. Naresh Bavabhai attended the John McKay Clinic for his depot injection on 11 September 1996. He failed to attend a fortnight later and on 3 October 1996 his name was included in the defaulters list sent to consultants. 'Last done 11.9.96, no response to letter: to be visited.'

3.13.4. Mr Chisnell phoned Mr Smith on 19 September 1996, to say that he was Naresh Bavabhai's Community Psychiatric Nurse and they agreed in view of Mr Smith's previous knowledge that he would become the keyworker under CPA procedures. Mr Smith was to be on leave from 23 to 30 September 1996 and they agreed to see Naresh Bavabhai together on his return. On the next day Mr Chisnell visited Naresh Bavabhai's home, to find a window boarded up and an iron gate fixed across the doorway. He contacted Mrs Bavabhai, who told him that the house had been broken into, but that Naresh Bavabhai was still living there. She would notify him of the appointment for 30 September 1996.

3.13.5. On 30 September 1996 Naresh Bavabhai phoned Mr Chisnell to say that he was currently homeless and living with a friend in Manchester, but still visiting his mother several times a week. He said he did not need to see Mr Chisnell 'until Mr Smith has sorted out some accommodation'. He felt well and was just worried about being homeless due to giving up his flat. Mr Chisnell then spoke to Mr Smith 'who will be sorting out accommodation with Naresh and will inform me of further developments.' Mr Chisnell also spoke to staff at the John McKay Clinic, who were 'liaising with Mrs Bavabhai regarding Naresh's depot as he is overdue by a few days.'

3.13.6. On 30 September 1996, Ms Sumi Bavabhai contacted Mr Smith to express concern that Naresh Bavabhai and his family were not getting enough support. Mrs Bavabhai was finding it hard to cope with Naresh Bavabhai's demanding behaviour

and verbal threats and needed help from an Asian social worker who could communicate with her in her mother tongue. She said Naresh Bavabhai's mental health had deteriorated to the point where he was vulnerable and could not adequately be cared for with the current level of support. Mr Smith explained CPA planning and that the family would be involved. He also explained that in addition to mental illness the amphetamine abuse might be creating difficulties. He added that 'apart from occasional contacts with the department Naresh Bavabhai had neither requested nor required to his knowledge regular input other than advice and information.' He agreed to keep her informed and arranged for Ms D Kotecha a Gujerati-speaking social worker to visit Mrs Bavabhai. He then related this information to Mr Chisnell and agreed to call to see Naresh Bavabhai at home.

3.13.7. Mr Smith called three times between 30 September and 3 October 1996 without reply. On 3 October 1996 he received a call from Naresh Bavabhai to say that he would phone back, but he did not. He contacted Mr Chisnell and agreed to go to the John McKay Clinic for his depot injection. Mr Smith called at the Clinic on 4 October 1996 when Naresh Bavabhai was due to see the doctor on duty and receive his Depixol. He found that the duty doctor had requested Dr Mahadevan to see him in view of his mental state. Dr Mahadevan noted that he looked tense and agitated, he admitted to using amphetamines 'a lot' and had some in his system now. He had 'moved out of his council flat because he had a letter from the police.' He was not sectionable but was willing to be admitted that day.

3.13.8. On admission to ward K2 on 4 October 1996 a further Stage One Assessment for CPA was completed, this time without a risk assessment. He was also seen by Dr Khawaja, the SHO, who completed a full examination and notes. Naresh Bavabhai admitted to recent amphetamine abuse, spoke of hearing 'the night voices'. A full mental state examination disclosed agitation, fidgeting, suspicious thoughts and auditory hallucinations of people talking about him. On the same day a quantity of white powder was volunteered by the patient on the ward and was removed by the police. Mr Smith saw him at the time of admission and described him as sullen, irritable and suspicious.

3.13.9. A letter of complaint dated 4 October 1996 was sent by the family to Mr Gallagher, Director of Social Services, with copies to Dr Mahadevan, Mr Smith, Mr Chisnell and Ms J Buckley Principal Officer at Social Services. The family requested a change of social worker, a planning meeting as a matter of urgency, a regular review of Naresh Bavabhai's care to which they should be invited, an emergency stand-by plan which the family could operate, direct access to his medical carers and advisers so that they could be sure of what they should and should not expect in terms of his behaviour

and condition, and that if after six months there was no palpable improvement in Naresh Bavabhai that the department compile and implement plans for his long term residential care.

3.13.10. Comment ***The chaotic pattern of behaviour evident whilst Naresh Bavabhai was attending the Rivington Day Hospital intensified after he became an out-patient, fuelled by non-compliance with medication and substance abuse. His paranoid symptoms seem to have been attributed more to his pre-existing mental illness than to amphetamine abuse. This is important because the link between command hallucinations and amphetamine abuse is widely recognised.***

3.13.11. After discharge from the day hospital on 4 September 1996 and Mr Chisnell's assessment visit two days later, Naresh Bavabhai received little support or treatment other than his depot medication on 11 September 1996. He then failed to attend the John McKay Clinic. He was abusing amphetamines, but physical exhaustion, withdrawal effects and financial pressures could have been constraining factors. The pattern of abuse was not clearly identified, although it appears to have involved periods of bingeing several times a day over a few days.

3.13.12 This period culminated in the Bavabhai family being concerned enough to summarise their concerns in precise terms. Although addressed to the Director of Social Services, the issues raised were directed at all of the providers of services who were expected to work jointly together, including Health workers.

3.13.13. By 4 October 1996 Naresh Bavabhai had been the subject of three Stage One Assessments under the CPA (in April, September and October), none of which was taken on to completion. The process of planning was frustrated by non communication in April, poor co-ordination in August, and gaps in communication in September 1996 which appear to have been exacerbated by misunderstanding of the dates of Mr Smith's annual leave. The plan prepared by Mr Chisnell on 6 September 1996 largely repeated the views of Mr Catterall in April and did not refer to thoughts of rape and of self-harm which had emerged in August. That documentation was not shared with Mr Smith, being regarded as a set of working papers for the Community Psychiatric Nurse service. Under the local CPA policy the drawing up of a care plan was the responsibility of the appointed keyworker. Mr Smith returned from a week's leave on 30 September 1996, when he expected to take up keyworker responsibilities, but he could not

find Naresh Bavabhai and the process was then overtaken by the re-admission to ward K2 on 4 October 1996.

3.13.14. At the time of his admission to K2, the extent of his involvement in criminal activity and with associates from the local drug sub-culture began to unfold. It is evident from contemporary records of all agencies that the latter factors were unknown to them at the time, but also that they were not close enough to him to perceive these possibilities.

3.14. HIS SIXTH ADMISSION BETWEEN 4 OCTOBER 1996 AND 4 NOVEMBER 1996

3.14.1. The nursing record completed on ward K2 in the evening on Friday 4 October 1996 noted that he had been overactive, with increased psychomotor agitation and pressured speech. He was complaining of a sore arm from an abscess from injecting drugs. He said he was 'speeding' due to taking £50 worth of amphetamine that morning. Dr Mahadevan had requested that PC Atkinson should delay interviewing him on deception and burglary charges on the following Monday due to his agitated state. However, with the discovery of the white powder, it became necessary for the police to see him straight away. On 7 October 1996 he was seen by PC Atkinson as arranged.

3.14.2. At review on 7 October 1996 Dr Mahadevan noted that Naresh Bavabhai 'was a lot better'. He had begun using drugs again and was against going back to his flat because drug dealers kept coming round offering amphetamines. He recorded 'contact SW Ian Smith URGENTLY re accommodation'. The nursing record that day stated 'Naresh seen - feels much better. 'speed every day - craving. Naresh denies knowledge of what police want to see him for.' Dr Mahadevan saw brother Navin Bavabhai later that day when he 'explained patient problems due to amphetamine abuse'. In his testimony Dr Mahadevan informed the Panel that Navin Bavabhai personally handed him a copy of the letter of complaint addressed to Social Services and Dr Mahadevan had gone through the contents in detail with him then and there.

3.14.3. On 8 October 1996 Mr Smith saw Naresh Bavabhai on the ward and found him brighter and more communicative. He explained his unhappiness with his flat because of break-ins and harassment by drug taking acquaintances. Mr Smith advised him to withdraw his notice because he could be considered intentionally homeless. Naresh Bavabhai said he did not know why PC Atkinson had seen him. Mr Smith later spoke to the police and established that the investigations were for deception.

3.14.4. On 10 October 1996 at a review attended by Mr Chisnell, Dr Mahadevan recorded that Naresh Bavabhai was still hearing voices 'they speak out his thoughts, he has discussions with them, they are sensible voices, he's not sure if its his imagination. Insists he has heard the voices for a couple of years now they are no more than usual'. He had been quite settled on the ward, was not experiencing any paranoid ideas, insisted on leaving and there were no grounds for his compulsory detention. It was agreed that he could go on weekend leave and stay at his mother's and feedback from the family was requested. Later that day Mr Smith saw him at Rivington Day Hospital to discuss a possible tenancy at the Creative Support Scheme.

3.14.5. On 11 October 1996 Naresh Bavabhai went for an assessment at the Community Drugs Team by Ms D Smith, when he described escalating amphetamine abuse up to £20 per day. He reported enjoying the effects of the drug.

3.14.6. On 14 October 1996 the first of a scheduled series of counselling sessions with Ian Chisnell took place and a part of the second stage of a Community Psychiatric Nurse care plan was completed. Mr Chisnell noted 'my input for CPA plan given to Ian Smith who confirms keyworker role himself'. The standard form which was completed by Mr Chisnell and copied to Mr Smith, recorded three specific problems/needs, with the actions to be taken by identified persons, as follows.

1. Need for ongoing assessment and monitoring of Naresh's mental health.

    a) Community Psychiatric Nurse to assess and monitor mental health (initially on 1–2 weekly basis): Ian Chisnell.
    (b) Naresh to attend out patient reviews as arranged with Dr Mahadevan: Dr Mahadevan
    (c) Liaison between all agencies involved: Consultant, GP, Community Psychiatric Nurse and SW.

2. Need for Naresh to discuss the nature of his mental health problems and ways to minimise risk of relapse

    (a) Community Psychiatric Nurse to offer mental health counselling: Ian Chisnell
    (b) Educate re mental health and discuss risk factors in breakdown of mental health: Consultant Community Psychiatric Nurse and SW
    (c) Offer alternative coping strategies to relieve stress and irritability: Ian Chisnell
    (d) Offer advice and support to Naresh and family: Consultant, GP, Community Psychiatric Nurse and SW.

3. Need for Naresh to continue with medication and to monitor efficacy and side effects of medication.

(a) Efficacy and any side effects of medication will be monitored and communicated to Dr Mahadevan and GP: Dr Mahadevan, GP, Ian Chisnell, Tony Widdowson.
(b) Naresh will continue to attend John McKay Clinic for administration of his depot injection currently X mg every two weeks. If Naresh fails to attend depot clinic staff to inform Consultant, GP, Community Psychiatric Nurse and SW: Tony Widdowson, JMC staff.

3.14.7. On the same day Dr Mahadevan noted at a review attended by Mr Chisnell and Mr Smith that Naresh Bavabhai 'has been charged by the police for stealing £4K from a branch of the Halifax. Patient denies the charge. Took some speed after being interviewed by the police because (he says) he was craving for it... patient insists on going home... has an appointment with CDT on Wednesday.' An outpatient appointment was to be made for six weeks time and Dr Mahadevan added 'family concerned. Patient agrees to go on leave until Thursday. No grounds for compulsory detention.'

3.14.8. The nursing note of that review reads 'recent charges by the police discussed. ...due to see the CDT on Wednesday. Wants to go home to his mother... merits or otherwise of his status discussed ? sectionable, no real evidence on mental health grounds. Discharge unless family have any strong objections/reasons... leave until Thursday. Mother doesn't want him home.'

3.14.9. On 16 October 1996 he was seen by Dr Quinnell at the Community Drug Team's base in the town. He was concerned by Naresh Bavabhai's mental state but had little to offer apart from the Needle Exchange Scheme which he was using already. Dr Quinnell telephoned the hospital to raise his concerns for him and followed this with a letter. In his written statement to the Inquiry, Dr Quinnell said 'at the time of interview I formed the opinion that he was acutely psychotic, showed flattened affect, slow monotonous speech, marked passivity, concrete thinking with occasional thought blocking and some delusional ideas.' A urine sample taken that day was reported two days later to have been strongly positive for amphetamines.

3.14.10. At review on 17 October 1996 Dr Mahadevan recorded that Naresh Bavabhai seemed tense and agitated. He admitted to using amphetamines intravenously since being out on leave and had been at his own flat, not at his mother's home. Dr Mahadevan noted that Naresh Bavabhai had seen Dr Quinnell 'but was

offered no further appointments'. He appeared suspicious but agreed to remain in hospital.

3.14.11. At review on 21 October 1996 he appeared very settled and had not been abusing drugs in hospital. Dr Mahadevan spoke to Dr Dougal and also recommended attendance at the day hospital.

3.14.12 On 22 October 1996 Mr Chisnell visited Naresh Bavabhai on ward K2 and spoke to Dr Mahadevan. He noted 'Naresh will remain an inpatient for another week or so as he continues to use amphetamines. He will be seen by Dr Dougal.' On the same day Mr Smith had an extended interview with Mrs Bavabhai and brother Greesh, which his note describes as 'to assess mother's view of Naresh Bavabhai's problems and their own needs, also to discuss Naresh's behaviour on leave visits from hospital.' The family described how over the last few months he had become more demanding, restless and disruptive. 'On recent visits at night he will demand his Mum makes him a cup of tea in the middle of the night. He then spends the night pacing up and down the downstairs rooms, sometimes going out. His Mum has taken his key off him in an attempt to stop him calling in the early hours, but this only aggravates Naresh.' Mr Smith noted the need for Naresh Bavabhai to be helped with budgeting and 'with support he may be able to wean himself of his family and become more independent'. He added 'I think a key factor will be his resolve to kick amphetamines.'

3.14.13. At the next review on 24 October 1996, Dr Mahadevan recorded 'no paranoid ideas; contact the Community Drugs Team for appointment'. The chlorpromazine was reduced to 100 mg nightly.

3.14.14. On 25 October 1996, the ward nursing staff noted that Naresh Bavabhai had handed in £1,950 in cash to be kept in the night safe. On the following day they recorded a phone call from his brother, who had been told by Naresh Bavabhai about this money, that he would be getting a cheque on Monday and that he wanted his brother's name on it as he had not got a bank account himself. The brother wished it to be known that he wanted nothing to do with the money at all. When asked about it, Naresh Bavabhai became quite anxious and stated that the money was part of a back payment from his disabled living allowance. In view of their concerns, the ward staff spoke to a woman police constable, and recorded that she would pass this information to PC Atkinson who was already involved with Naresh Bavabhai. On 28 October 1996 the nursing notes record that the police 'will not be interviewing Naresh due to lack of any evidence. Naresh is on bail to them until 12.12.96. Could we inform them when he is discharged.'

3.14.15. Ward reviews on 28 and 30 October 1996 were conducted by the SHO, Dr A Bashir in the absence of Dr Mahadevan. At the first of these she noted that there was no change, he was settled, there was no mention of drugs and that he was to 'stay in for now'. Mr Smith also attended the ward review on that day to report on the problems for the family of Naresh Bavabhai's functioning at home. His note recorded 'discussed with Naresh about use of drugs at home and that he would not be welcome if he uses at Mum's. Naresh understands this but denies that he is a problem to his mother.' On 30 October 1996 Dr Bashir recorded 'patient wanting to go home says he does not want to stay on the ward any longer. Has been well on ward, apparently mother happy to have him home.' She noted 'has not heard from CDT yet' and recorded a mental state examination with no symptoms of thought disorder present. She recorded that he was to be allowed leave and was to return on Monday for review.

3.14.16. On 1 November 1996, in the fifth week of his admission, Naresh Bavabhai was re-examined by Dr Dougal. She recorded that he continued to use amphetamine, liking the 'rush' and the 'effect'. She noted that psychotic symptoms were 'under control with depot/chlorpromazine' and concluded 'I wonder if he may be an appropriate candidate for dex-amphetamine sulphate. I will discuss with north-west consultants and if he seems suitable arrange assessment appointment'. [Dr Dougal has explained to the Inquiry that by this she meant the Regional special unit based at Prestwich hospital.]

3.14.17. At review on 4 November 1996 Dr Mahadevan noted that Naresh Bavabhai had only used amphetamines once whilst on leave over the last four days. He continued to hear voices and complained that his mother was 'too restrictive'. Mr Smith agreed to speak to his mother and his name was placed on the waiting list for accommodation from Creative Support. He was discharged on 4 November 1996 to Rivington Day Hospital, attendance at the St. George's Day Centre and an understanding that Dr Dougal was going to refer him to Prestwich (north west consultants) and that the CDT 'may or may not be able to help'. The application for accommodation from Creative Support was made by Mr Smith on that day, identifying himself as the key worker. Naresh wished to be discharged from hospital and Dr Mahadevan considered that there were no grounds to detain him under the Mental Health Act. Mr Smith in his written evidence stated as there were no high risk factors indicating that Naresh would harm himself or others as a result of his mental illness and no indication that he would not comply with prescribed medication, Naresh was subsequently discharged to his flat.

3.14.18. Comment From the time of his admission on 4 October 1996 up to 22 October 1996, grave concerns were being expressed about Naresh Bavabhai's ability to look after himself, to manage his affairs and his rapidly escalating

substance abuse. He now manifested physical harm to himself as a result of substance abuse, for example the thrombosed vein found on admission, but he appeared to give conflicting messages to the different agencies about his actual amphetamine abuse. The increasing amphetamine abuse had resulted in a deterioration in his mental state but he remained compliant, in general terms, with his treatment on the ward.

3.14.19. The fluoxetine regime had not helped sufficiently in the treatment of his substance abuse, leading Dr Dougal to consider him for maintenance/substitute amphetamine treatment. The seriousness of the substance abuse was acknowledged by this important decision, which never reached fruition because of subsequent events, yet the relationship between mental illness and substance abuse, though intrinsic to his functioning was still not fully explored, nor was the extent of the interaction between the two fully appreciated.

3.14.20. From the notes of Dr Mahadevan's review of 14 October 1996 and from Dr Quinnell's assessment of Naresh Bavabhai's mental state on 16 October 1996, it appears that he was borderline in terms of the need to be detained under the Mental Health Act at that time. Nevertheless it seems that he was to be allowed to go to his mother's home, despite her reservations and the family's recent complaint regarding the planning and co-ordination of care.

3.14.21. During this escalation of his abuse, Naresh Bavabhai no longer saw his drugs counsellor at the St. George's Day Centre or attended Narcotics Anonymous, but it appears that the medical team were unaware of this. He did, however, make the effort to see Dr Quinnell at the Community Drug Team some distance from the hospital, but Dr Quinnell considered him too mentally disordered to be accessible to the CDT's help. Naresh Bavabhai described to the Inquiry feeling very disappointed after seeing Dr Quinnell, because he felt that he should have gone into a detoxification unit, but 'could not get in one'. There is no note in the medical records of Dr Qinnell's telephone call of 16 October 1996, neither does the import of that call or of his letter of l8 October 1996 appear to have registered, apart from Dr Mahadevan's note 'was offered no further appointments' (3.14.10). On 30 October 1996 Dr Bashir appears to have thought that the CDT appointment was still awaited and at discharge on 4 November 1996, Dr Mahadevan's entry in the medical notes indicates 'CDT may not be able to help.'

3.14.22. The process of completing a CPA plan proceeded patchily following Naresh Bavabhai's admission to hospital. Mr Chisnell's formulation at 3.14.5. made no mention of drug misuse and mainly identified medical and nursing staff as the principal figures in the action plan. Nonetheless, Mr Smith was to continue to take up the role of keyworker, although he had not received information on risk assessment and had for example no knowledge of the knife incident or the thoughts of rape, and of problems of non-compliance with medication. There was no multi-disciplinary discharge plan on 4 November 1996, or any discharge letter to the GP of the kind sent after previous admissions. Although Dr Mahadevan was of the view at the time of discharge that detention under the Mental Health Act could not be justified, the view of Dr Kahn, an expert in dual diagnosis, in his evidence to the Inquiry was that sufficient grounds to justify such a detention could have existed.

3.14.23. Naresh Bavabhai's contact with the police began to assume a life of its own, particularly when a large sum of money suddenly appeared suggesting much greater involvement with the drugs subculture than was previously thought. Although these matters are increasingly mentioned in passing in his records, their significance in relation to his drug abuse and mental state are uninvestigated up to the time of his arrest.

3.14.24. Members of the family persisted in expressing their concerns to health and social services staff, and in their complaint to the Director of Social Services. Dr Mahadevan and Mr Smith then gave their immediate attention to the concerns raised, and appropriate arrangements were made for Mrs Bavabhai to see Ms D Kotecha, a Gujerati speaking social worker.

3.14.25. The medical and nursing records in October/November 1996 do not reflect the extent of Naresh Bavabhai's highly disordered and disorganised lifestyle. Those images are more clearly defined in social work records, but that information does not appear to have been communicated to health colleagues other than in discussions which were not recorded.

3.14.26. This may correspond with the absence of an exchange of information between the Community Psychiatric Nurse service and social worker referred to in 3.13.13 and 3.14.22. Certainly by early November 1996, it was becoming increasingly important to draw together the various strands of information relating to Naresh Bavabhai's behaviour and symptoms in order to establish a mutual understanding of his increasingly compound disorder and a joint

aproach to his needs. A single management plan was required for continuing treatment and care in hospital, in the day hospital and in the community which would familiarise all concerned with the growing implications of Naresh Bavabhai's dual diagnosis, to which Dr Dougal had first made reference on 5 July 1996 (3.12.13).

3.14.27. It is apparent from the contemporary records and from the evidence of witnesses that information was shared verbally, both at reviews and by informal exchanges between doctors, nurses and social workers. Their running records, however, were maintained separately and none of them summarised a shared view of Naresh Bavabhai's illness and its treatment. Mr Chisnell's written formulation (3.14.6) was a step in this direction but was incomplete and it is uncertain when the copy was received by Mr Smith, who eventually wrote a Care Plan within the terms of local CPA procedures on 2 December 1996.

3.15. AFTER HIS FINAL ADMISSION 5 NOVEMBER 1996 ONWARDS

3.15.1. On 7 November 1996 Mr Smith made a home visit to Naresh Bavabhai who told him that he had lost his keys and had arranged for a joiner to change a lock. He appeared well and in good spirits though his flat was very disorganised and untidy.

3.15.2. Mr Chisnell attempted a home visit on 12 November 1996 but could get no reply and went to his mother's house and found he was also not there. Mr Chisnell recorded 'Mrs Bavabhai was anxious regarding Naresh. Says he has been abusing drugs again turning up at her house at various hours of the day (sometimes night). He had been argumentative and occasionally verbally hostile towards her and his family. Tends to be like this when injecting drugs. She sometimes does not see him for two days, then he turns up for meals. Went out at 12 o'clock today with £100 and she thinks she won't see him for a couple of days. Says he is currently living at his flat but won't answer the door to anyone as he thinks it may be drug dealers or the police. Note posted through the door to arrange a visit for tomorrow.'

3.15.3. Mr Chisnell contacted Dr Mahadevan that day and noted 'discussed mother's concerns and Naresh Bavabhai's potential for becoming psychotic. If needed he will readmit Naresh.' Mr Chisnell then passed this information on to the GP and to the worker responsible for liaison between the ward and the day hospital. He also left a message for Mr Smith who was not available until the next day. He later made telephone contact with Naresh Bavabhai who said he had been 'at the social' and apologised for not being at home. A further appointment was made for 14 November 1996.

3.15.4. Also on 12 November 1996, Ms Kotecha sent an e-mail to Mr Smith to report that she had received a call from Mrs Bavabhai, 'She is very distressed. Says that Naresh is being verbally aggressive and it's constant. He comes and goes. He is taking drugs and is not keeping his hospital appointment. He had apparently cancelled two appointments. She says she is worried for Naresh and feels that he needs more help.'

3.15.5. Although the discharge arrangements from ward K2 had included attendance at Rivington Day Hospital on three days per week and the St. George's Day Centre two days per week, Naresh Bavabhai was not admitted to the day hospital until 13 November 1996. At that time a full admission record was completed by his named nurse Mrs K Gettins, who encouraged him to contact his counsellor at the Day Centre and to resume attendance at Narcotics Anonymous. She noted that he had injected amphetamines four days previously and said that he wanted to come off it. He complained of hearing voices but said they were just his own thoughts. She added 'denies any ideas of self harm though says he has previously had ideas of harming other people.' She completed an Individualised Treatment Plan which identified his problems/need as 'continues to abuse amphetamines which tends to aggravate his schizophrenia'. The short-term goal was 'for Naresh to fill his time with structured activities'. The long-term goal was 'for Naresh to stop using amphetamines'. Mrs Gettins identified eight forms of intervention.

1. Encourage Naresh to attend RDH 3 days per week. Observe and record same.
2. Following discussion with Naresh, formulate a programme of activities. Observe and record level of participation.
3. Observe and record any inclination that Naresh is under the influence of illicit drugs.
4. Encourage Naresh not to attend if he is under the influence of illicit drugs.
5. Discuss with Naresh other ways of filling his time away from RDH.
6. See Naresh each week on a one-to-one basis. Discuss use of amphetamines.
7. Liaise with other members of MDT.
8. Feedback at MDT review.

3.15.6. Dr Mahadevan conducted a review on 13 November 1996, noting Mrs Bavabhai's complaints to Mr Chisnell and adding 'Naresh Bavabhai claims to have been round to the drug dealer's three weeks ago with a hammer for selling him bad stuff'. On the same day he was seen at home by Ian Smith and the manager of Creative Support where he was found to be co-operative but 'tired and vague at times'.

3.15.7. Mr Smith was later told by brother Greesh that Naresh Bavabhai had been taking drugs over the weekend, once again causing problems for his mother.

3.15.8. On 14 November 1996 he was seen by Mr Chisnell at his mother's home, where he found him 'cheerful, sociable and relaxed. Admits to still using amphetamines says he has a craving, when he has the money uses about once a week. Admits to feeling irritable and stroppy with his mother and family whilst using. Intends to see Dr Dougal and CDT. Feels well currently only problem being debt. Says the voices have reduced considerably over the past few weeks. Will stay away from family whilst using. Sleeping and eating well. Spends time between his mother and his flat.' A joint visit was arranged for 25 November 1996 with Mr Smith.

3.15.9. On Monday 18 November 1996 (the morning after the killing) Naresh Bavabhai attended the day hospital for the morning only, saying that he 'needed to go to the social to sort out his money'. He failed to attend the review at the Rivington Day Hospital in the morning on Wednesday 20 November 1996. Later that day the CID rang to say that Naresh Bavabhai had been arrested for burglary and was also being investigated in relation to a death in suspicious circumstances of Kenneth Horrocks two days before.

3.15.10. Comment The vital five days prior to the killing saw Naresh Bavabhai's carers believing he was committed to attending various agencies for support, counselling and specific work on his well known problem areas. However, there was failure to detect that his life had become considerably chaotic as a result of his substance abuse. This made compliance with treatment and care plans a problem, but his psychiatrists, his community nurse and his social worker do not appear to have been aware just how serious things were becoming.

3.15.11. Despite intensive input, particularly by Mr Chisnell, Naresh Bavabhai failed to comply with his management. The continuing delay in completing a Care Plan demonstrates the extent of the fragmented service, which is not surprising given the number of agencies and individuals involved. It remained Mr Smith's responsibility as keyworker under the CPA to draw the threads together, although there were continuing gaps in his knowledge particularly relating to known risk factors.

3.15.12 There was an unacceptably long delay between discharge from hospital on 4 November 1996 and starting at day hospital on 13 November 1996. During that time Naresh Bavabhai was clearly unwell, to the extent that Mr Chisnell found it necessary to discuss with Dr Mahadevan the need for readmission to ward K2. His attendance at day hospital thereafter was minimal

and he was seen once at home in the days before his arrest. Clearly his mental health was unstable at that time and the extent of his drug abuse was uncharted, but it would have been more difficult to do so if he was obeying the request not to attend day hospital when under the influence of illicit drugs, as the intervention list had indicated.

3.15.13. In his evidence to the Inquiry, Naresh Bavabhai asserted that by November 1996 he was using amphetamines every day. This would be at the very minimum once a day and at the most ten times per day, at about £10's worth for each injection. He also said 'when I was coming down off amphetamines I was getting hallucinations and started hearing voices'. Dr Dougal and our expert witness Dr Kahn indicated that the larger amount would have had a considerable impact on functioning, even to one habituated to amphetamines. Dr Kahn has also reminded us that drug abuse in these circumstances may often represent, at least in part, an attempt at self-medication to control hallucinations. Naresh Bavabhai's record of self-medication had first emerged in January 1993.

3.15.14. Although his behaviour was increasingly chaotic, the submissions by Counsel and the Judge's sentencing comments referred to Naresh Bavabhai's ability to devise and execute a complicated plan over several days, culminating in the killing of Ken Horrocks. It seems very unlikely that he would have been capable of formulating and executing this elaborate subterfuge if he was bingeing on amphetamines up to eight times each day in the days leading up to the killing. Naresh Bavabhai's last statement before the killing regarding his current level of amphetamine abuse was to Mr Chisnell on 14 November 1996, when he confirmed that he abused amphetamine once weekly. At that time he was engaged in the subterfuge to gain access to Mr Horrocks' money, a process which involved detailed planning and multiple impersonation.

3.15.15. Naresh Bavabhai appears to have disclosed his psychotic symptoms only to health professionals when they specifically enquired about them. To his family the symptoms emerged as disturbed and aggressive behaviour. This appears to be the case whether or not these symptoms arose entirely from schizophrenia or entirely from substance abuse, or as a result of a combination of both. His threatening attitudes with his drug dealers (3.15.6) may well be related to increasing usage, insufficient funds, or indeed to poor quality amphetamine as he said at the time.

3.15.16. The increasing complexities presented by Naresh Bavabhai's combination of paranoid schizophrenia and substance abuse certainly justified his referral by Dr Mahadevan from the general psychiatric service to the CDT's special services. Dr Dougal then undertook a thorough examination but the interventions she was able to propose did not answer the need and she subsequently started the process of referral to regional specialists. Similarly, Dr Quinnell immediately acknowledged that his team could not treat Naresh Bavabhai because he was too mentally ill. All of this confirms the necessity for his dual diagnosis to have been identified and understood. However, local services were at that time insufficiently familiar with these implications and were not responding to the increasing cues, other than to refer on to specialist services outside Bolton.

3.15.17. Naresh Bavabhai's family were evidently aware of a deterioration in functioning and behaviour and considered the amphetamine abuse responsible. Whilst being concerned and alarmed by his substance abuse, Mrs Bavabhai seemed powerless to prevent him abusing street drugs. This feeling appeared also to have been reflected in Mrs Gettins' assessment on 13 November 1996, in which she recorded that he should not attend at the day hospital when he was using drugs. The records show that apart from a brief appearance on the morning of 18 November 1996 he did not attend. This is consistent with his statement to the Inquiry that he was using drugs daily at that time, but the extent of use remains uncertain.

3.16. AFTER ARREST ON 20 NOVEMBER 1996

3.16.1. On Wednesday 20 November 1996, Mr Smith attended Astley Bridge Police Station, Bolton, to act as Appropriate Adult when Naresh Bavabhai was interviewed by Police relating to incidents of deception and burglary going back to September 1996. It was noted that the victim of those alleged incidents was Kenneth Horrocks who had been found dead in his flat on the morning of Monday 18 November 1996, having been burgled the previous evening. On the same day he was interviewed in relation to the killing of Kenneth Horrocks, but on that occasion without a solicitor or an Appropriate Adult in attendance.

3.16.2. Later on 20 November 1996, Naresh Bavabhai admitted to two offences of deception and one of burglary and remained in Police custody to appear at Bolton Magistrates Court the next day.

3.16.3. On 21 November 1996 he was seen at the Police Station by a Community Psychiatric Nurse who administered his flupenthixol injection. That same day he was remanded back to Police custody for three days by Bolton Magistrates. Mr Smith again attended when he was interviewed by Police on 23 November 1996.

3.16.4. At Bolton Magistrates Court on 25 November 1996 Naresh Bavabhai was remanded on bail for two weeks, to reside at Chataway Nursing Home, his flat having been sealed by Police. The placement was arranged by Bolton Social Services. On the following day Mr Smith took his medication there and noted that he had settled in and was giving no problems. Mr Smith also took him shopping for clothes, at which time he appeared symptom free and was pleasant in demeanour. A care plan meeting scheduled for that day was cancelled because of the arrest.

3.16.5. On 27 November 1996 Naresh Bavabhai was seen by Dr Mahadevan at the John McKay Clinic. He appeared very well and was staying off amphetamines, but complained of salivation and akathisia. Dr Mahadevan reduced his chlorpromazine to 100 mg nightly, his flupenthixol to 100 mg every three weeks and maintain his dose of procyclidine at 5 mg od and fluoxetine at 20 mg od.

3.16.6. On 28 November 1996 Mr Smith received a phone call from Chataway Nursing Home to say that Naresh Bavabhai had been arrested by Police on suspicion of murder. Mr Smith again attended the Police Station as Appropriate Adult. He maintained contact with the family and arranged the involvement of an Asian social worker in Ms Kotecha's absence on a training course.

3.16.7 On 29 November 1996, Naresh Bavabhai was remanded in custody for the murder of Kenneth Horrocks. After a discussion with Naresh Bavabhai's solicitor and a member of the probation service, Mr Smith noted 'The evidence appears to be not particularly strong which may bode well for bail, however this would not happen today, probably next week.' He then made arrangements to retain the placement at Chataway Nursing Home and recorded that his principal officer Mrs J Buckley would investigate placement at a nursing home with secure facilities.

3.16.8 On 2 December 1996, Mr Smith wrote up the Care Plan which specified as follows...

1. **Intervention (Action Plan and Person Responsible)**
   Ongoing weekly support by SW and CPN and continuing assessment of needs – Ian Chisnell and Ian Smith. Involvement by and support to immediate family / carers.

2. **Needs Assessment (identification of Problems)**
   1) Naresh has difficulty budgeting and is overly dependent upon his mother.
   2) Current accommodation unsuitable due to isolation and harassment.
   3) Behaviour towards carer leading to breakdown of support and relationships.
   4) Ongoing misuse of amphetamines causing deterioration in behaviour.
   5) Lack of social/educational activities leading to aimlessness and boredom.
3. **Goals and Objectives**
   1) For Naresh to move into supported accommodation which will offer help with budgeting, personal care etc. lessening dependence on carer.
   2) To recommence at St George's Road Day Centre and plan structured activities and educational opportunities.
   3) Encourage attendance at CDT and monitor drug misuse.
   4) Offer and provide Gujerati speaking SW to main carer for support, counselling.
4. **Key Indicators of Breakdown (Warning Signs)**
   1) Increased paranoid ideas.
   2) Auditory hallucinations becoming a pre-occupation.
   3) Increasing use of amphetamines.
   4) Deterioration in behaviour and self care.

3.16.9. Comment The Care Plan was written by Mr Smith after Naresh Bavabhai had been remanded in custody on a charge of murder. The Plan quite rightly makes no reference to those proceedings or any assumptions about their outcome.

3.16.10 Mr Smith's notes regarding the strength of the evidence and his contingency plans for continuing nursing home placements may also reflect the extent of his and his colleagues disbelief that Naresh Bavabhai could have committed such an offence. In their written and their verbal evidence to the Inquiry witnesses frequently referred to the surprise and shock they felt at that time.

3.16.11. The Care Plan takes up several of the elements in Mr Chisnell's first stage plan. It also identifies more clearly the extent of Naresh Bavabhai's dependency on his family as carers and his poor ability to cope with his own personal needs. However, it includes no reference to established factors of risk, either to himself or to other people, which were still unknown to Mr Smith.

CHAPTER IV

4.0. THE EVENTS WHICH WERE THE SUBJECT OF CRIMINAL PROCEEDINGS

4.1. INTRODUCTION

4.1.1. The publicly available record of the events which led to Naresh Bavabhai's imprisonment, having pleaded guilty to offences of burglary, attempted theft and manslaughter is provided by the transcript of the proceedings at Manchester Crown Court on 14 July 1997, before The Honourable Mr Justice Poole.

4.1.2. The names and identifying details of members of the public who were mentioned in that transcript but were not party to Court proceedings or involved in this Inquiry have been anonymised.

4.2. TRANSCRIPT OF PROCEEDINGS

4.2.1. The submission by Mr M Steiger QC on behalf of the Crown Prosecution Service in relation to the offences of burglary and attempted theft was as follows:

> ***'MR STEIGER:*** My Lord, the victim of this incident was a Mr Kenneth Horrocks, who was 68 at the time of his death. He suffered from mental illness, and lived in sheltered accommodation at number 4 Cromford Close in Bolton. This was a flat on the first floor with an entrance way on the ground floor, supervised by a warden. The defendant who was also a mental patient, suffering as we understand it from schizophrenia, lived as a near neighbour of Mr. Horrocks at number 12 Cromford Close. The defendant appears to have taken drugs and from time to time needed money to buy in particular amphetamines.
>
> Mr. Horrocks went to Scotland for a five day holiday in September of 1996, in fact on the 15th, and whilst away on that holiday the defendant Bavabhai burgled Horrocks' flat, taking DHSS benefit books and a National Savings Account passbook, a Halifax Building Society passbook and a passport and

various other documents, including a birth certificate, and it seems from a discovery made by the police in November that the defendant appears to at least have contemplated on checking Horrocks' whereabouts by pretending in the telephone call to be a Detective Siksmith speaking to the warden. What then happened was that the defendant forged an application to withdraw the sum of £7,659 to himself on the deceased's National Savings account. The bank did indeed send a cheque, but made it payable to Horrocks, and after some correspondence forged by the defendant the bank became suspicious and funds were transferred to a new account, and the new account passbook was sent by the bank to Horrocks at his flat at Bolton on 4 November.

At the time of the first burglary, if I can call it that, the defendant, employing the Halifax Building Society passbook, used it dishonestly to withdraw £4,375 from Horrocks' account as a cheque payable to himself. The defendant, displaying some ingenuity, then paid that cheque in at one branch of the bank to withdraw it out the same day as cash, in fact the sum of £4,320. In due course the defendant came under suspicion for the burglary of Horrocks' flat and the consequent obtaining and attempt to obtain funds, and he was interviewed under caution by the police on the 10th of October of last year, but on that occasion he denied being responsible and he was bailed to attend an identification parade in December.'

4.2.2. In relation to the offence of manslaughter, the submission by Mr M Steiger QC was as follows:

'Mr. STEIGER: We now turn to the events of Sunday the 17th November, and at nine-thirty p.m. that day a man was seen breaking into Mr. Horrocks' first floor flat through a window above the ground floor entrance. The police were called and a witness statement was taken from Mr. Horrocks in which he described the intruder on that occasion as being a dark-skinned male who had demanded the keys to his flat. The broken window was boarded up and at about ten p.m. the deceased, Mr. Horrocks, was seen to be in a satisfactory state.

Then what happened was that at about twenty-past midnight this time in the early hours of Monday the 18th of November the defendant Bavabhai made a telephone call to Careline, who supervise the welfare arrangements for those of the sheltered accommodation, and in this call he pretended to be Kenneth Horrocks. He made further calls to that organisation at twelve-twenty seven and one-twenty eight, on this occasion purporting to be Police Constable H, and the

purpose behind the defendant's masquerade as Horrocks and then a police officer seems to have been to attempt to persuade the authorities to install in Horrocks' flat a lock to which he, the defendant, had the key so that the defendant would then be able to enter at leisure Mr. Horrocks' flat and presumably steal property, borrow documents or look at mail which might include cheques that he had initiated.

It seems that Mr. Horrocks was still alive at half-past one in the morning of the 18th of November, because at that time he was heard over the Careline intercom speaking to the Careline staff at the office, and at that time there was a police officer knocking on the door which was overheard in the conversation. What then appears to have happened is that the defendant made a number of telephone calls in the early hours of the 18th of November displaying, the prosecution would say, a distinct anxiety to get drugs or to get money for drugs, and many of the calls made before about five o'clock in the morning were to acquaintances connected with the drugs scene in Bolton. In particular he, phoned people at [a Bolton address] on no fewer than six occasions between half-past one and five o'clock in the morning, and this was the home of a woman called A, and present there was a friend of her's and the defendant's called B. Although it is a little difficult to be clear about precise timings, what seems to have happened is that at five o'clock the defendant told B on the telephone that he had by then £200 in cash, and he wanted to buy drugs with an associate called C. When indeed Mr. Horrocks' flat was in due course examined, it was discovered that a number of documents known to be there were missing and no cash was found, although he normally kept about £100 on the premises. That morning the defendant told a person called D, this time at number [address] in Bolton that he, the defendant, had broken into an old man's flat which previously he had burgled, and the defendant then made this admission to D that he had suffocated the man inside, and it seems clear that the money which the defendant had with him at five o'clock in the morning had come from Horrocks' flat after the defendant had done the killing. This admission was also heard by another occupant of number [same address], a man called E, and although he claims to have pretended that the defendant was acting in a jocular manner, he burned the defendant's clothes at the request of the defendant, and in due course a scientist was able to match fabric from a fire at that address with the fibres recovered from the entry point at Horrocks' flat, and it seems therefore that the defendant killed Horrocks between three and five o' clock in the morning of the 18th of November during a burglary to get money for drugs, the burglary being made necessary by his failure in having locks changed at Horrocks' flat, and when the body was recovered by the authorities at about half-past one in the afternoon of the 18th of November, a pillow was found over the head and

pills had been forced into Mr. Horrocks' mouth, perhaps in an attempt to fake the appearance of suicide.

What then happened was that the defendant made an attempt to recover money from the new National Savings account, and he did this by submitting a request dated the 18th of November, in the early hours of which day the killing had occurred, and he did this by means of asking for a cheque to be sent to F. F is a fellow patient of the defendant's at the local hospital where the two of them are treated, and the defendant's attempt here was to involve F in a dishonest money changing scheme. When, as I have mentioned to your Lordship the defendant was interviewed on the 10th of October about the first burglary, he denied it. He was interviewed at some length between the 20th and 28th of November, and on this occasion he admitted that he had in fact committed the first burglary at Horrocks' flat. He further admitted to the police that on the 17th and 18th of November he had pretended to be both Horrocks and Police Constable G on the telephone, but denied being involved in any further burglary in the course of that night. He did accept that his object had been with a view to fixing the lock to Horrocks' flat, which he, the defendant had opened, and he told the police that he put through the letter box a lock and keys in separate envelopes so that they could be installed, although the position from which they were found on the stairs of the flat suggests that the defendant must nonetheless have entered the premises.

The defendant made no comment in questions about the killing, but he did after the last interview make a detailed admission to Detective Sergeant H. He told H that he pretended to Horrocks that he, the defendant, was a council workman, that he had come to the flat to repair a window broken in the burglary and that he had bundled Horrocks upstairs and smothered him with a pillow to stop his screaming. Later he was to tell Mr. H that he had given Horrocks tablets to calm him down, and so the evidence is a little unclear about whether the tablets recovered from Horrocks' mouth had been put there before or after death, the defendant apparently having said both things. In his off the record conversation with Detective Sergeant H the defendant told how he used part of a mirror from his own flat to assimilate [sic] the noise of glass that a workman would have with him to install the new window, and indeed after this conversation had taken place, a mirror from beneath Horrocks' bed was recovered, which on the evidence is shown to have been in the defendant's flat.

There was a further conversation on this occasion between the defendant and a man called J on the 30th of November whilst the two were in custody, in the

course of which the defendant admitted suffocating Horrocks and complained to J that E had failed properly to burn his clothes after the killing.

In summary, therefore, the facts of this sad case suggest that the defendant knew that Horrocks was a wealthy but a vulnerable target for burglary and fraud and that the defendant must on the evidence have broken in on at least one occasion during the night of the 17th/18th of November of last year, after his attempt to have the locks changed had failed. The defendant on his own admissions appears to have used a pillow to suffocate Horrocks to prevent him making a noise or raising the alarm, and in doing so he was clearly acting unlawfully. The defendant appeared to have made attempts to make matters resemble suicide, and as I have mentioned, arranged to have the incriminating clothing burned, but despite all that, on the 18th of November he made a clear minded attempt to exploit the National Savings passbook which he must have stolen from Horrocks' flat in that burglary on the night of the 17th and 18th of November.'

4.2.3. The submission by Mr A Turner QC on behalf of the defendant was as follows:

'Mr. TURNER: MY Lord, we do not ask for a pre-sentence report. We ask your Lordship, please, to proceed to sentence. My Lord, we have provided your Lordship with a copy of a psychiatric report prepared by Dr. Snowden.

What that report indicates in summary is that it is true that the defendant has been a mental patient, has had severe psychiatric problems in the past and treatment for those problems and is on continuing medication, but the report if I may say so is reassuring in this respect, that it is not suggested that his psychiatric problems played any part in this offence or these offences.

Now, my Lord, the background has been admitted by the defendant, by a candid plea of guilty on a much earlier occasion and admissions made in interview. The offences relating to the bank book and obtaining money by deception showed some sophistication, they also showed in our submission extraordinary naivety, because the money that was obtained was paid directly into his bank account, which meant that inevitably he would be traced and he would be charged, as was the case.

The same can be said in respect of the replacement bank book, the National Savings book, which it is true to say was sent off after the death in a vain and hopeless attempt to obtain money from the National Savings bank. Again some sophistication, but again amazing naivety because on the book, on the envelope and on the accompanying documents were the defendant's fingerprints.

Now, my Lord, the defendant was being so dishonest because he was addicted to amphetamine, and a very different man stands before your Lordship now to the man who committed these offences in desperation to feed his habit. He has had difficulty, considerable difficulty in coming to terms with what he did, and today one has to say it is only because of the very public spirited way in which his brother spoke to him that he has been ready to confess himself guilty. My Lord, it is a terrible thing that he took this man's life. He did so without any intent to do just that. What he said to Detective Sergeant H in a candid confession, albeit off the record, was the truth. He pushed him upstairs on to the bed. The man was shouting to stop him screaming, he put the pillow over his head and that is when he stopped struggling.

Now as my learned friend has very properly and fairly pointed out, the medical evidence obtained by the prosecution from Dr. Rutherford is consistent with there being a vagal inhibition which could have caused death in precisely the way in which the defendant referred to it in interview. My Lord, we have obtained a report from Dr. Lawler. I perhaps need not show it to you, Dr. Lawler being well known to your Lordship as well, but he reached the same conclusion; "Death may have supervened very rapidly. It could have been due to vagal cardiac inhibition, perhaps following relatively gentle compression of the neck during an assault or following obstruction of the mouth and nose during a suffocation attempt", but, my Lord, because of this act, this unlawful act, a man lost his life, and that is something that the defendant must bear and he must bear the punishment for doing that.

When he knew, when he realised that his act had unwittingly killed Mr. Horrocks, he tried to make it look like suicide. That is why the pills were all over the body and the bag, and then he panicked and the many telephone calls that were made later that night are testimony to the defendant's panic. My Lord, he is a very relieved man that he can now confess to what he has done.

My Lord, he knows that he must go to prison, but he is able to say to your Lordship that he has pleaded guilty.'

4.2.4. The Honourable Mr Justice Poole's comments on passing sentence were as follows:

'Mr. JUSTICE POOLE : Naresh Bavabhai, I take full account of everything that has been said on your behalf by Mr. Turner, and indeed he has said everything that can be said in all the circumstances of the case. I take full account of your pleas of guilty, of the fact that at the material time, and I glean this from the very careful report of Dr. Snowden, you were addicted in particular to amphetamines and had been a consumer too of other drugs that had probably had a serious effect upon you. I take into account of course the absence here of an intent to kill or to cause grievous bodily harm, an absence which on all the evidence presented to it very properly the Crown has accepted and there is a likelihood that the mechanism of death here was a vagal inhibition, and I take account too your own long standing psychiatric problems. So all of those matters and of everything urged on your behalf by Mr. Turner I take full account, but there remain nonetheless very grave offences. You preyed on a man who had severe mental difficulties of his own, a man who was 68 years of age and who had spent decades of his life in psychiatric confinement and who had been not very long before these events released into care in the community and who was therefore, as you must have known, a very vulnerable citizen. Your first assault on his home and his property was in September. You violated his home by kicking in the door, and while he was away on a holiday in Scotland, by helping yourself to his property. Various items of property, including for example bank documents and building society documents with which you hoped to enrich yourself and with which indeed you did enrich yourself at least to the tune of £4,375, which he had deposited in one of these accounts. There was a further attempt by you to enrich yourself to the tune of some £7,600 from another account, and that attempt was unsuccessful, and what greeted Mr. Horrocks when he came back from holiday in September was a demolished front door and the departure of his property, a man not very rich but with some wealth which you were determined to help yourself to. All of that happened in September.

In November you renewed your assault on his home, and on about the 17th and 18th of November in a carefully thought out plan, though admittedly there were elements as Mr. Turner has argued of naivety in it, you sought to gain admission and on one occasion did gain admission to his property while he was there, and then having caused damage, formulated the plan of depositing within the house a mortice lock which you hoped would be fitted to the front door, having held back yourself a key to that lock so that at a later time at your leisure you could easily gain access to the premises, and in support of that scheme you made

numerous telephone calls hoping to expedite the fitting of that lock to the premises.

This all culminated in the early hours of the 18th of November with you visiting Mr. Horrocks' property again whilst he was alone and in the property. Nobody will know precisely what happened in the early hours between approximately two o'clock and five o'clock, but there is no doubt that you dealt with him on that occasion with some violence, albeit not with the intent necessary for murder, and that in that way tragically and no doubt at a time when he was quite terrified by your presence and your behaviour in the flat, you ended his life by suffocating him.

That was not the end of it. You then visited acquaintances and enlisted their help in an attempt to conceal some of the evidence, although that attempt was not entirely successful because forensic experts thereafter were able to match fibres from the green coat that you had sought to destroy with fibres left at the point of entry, and again at a time when you must have known, indeed did know that Mr. Horrocks had met his death at your hands. You sought to enrich yourself knowing that by making a deprivation, unsuccessfully, on his National Savings account. That was an exceedingly cold blooded way to behave at that time.

These then in my judgment are very grave offences, notwithstanding the lack of intent that has been accepted. The sentences of the court will be as follows: for the offence of manslaughter in these circumstances during a burglary and with all the particulars that are laid before me, you will go to prison for eleven years. For the offence of burglary in September, for the offence of the theft of the cash from Mr. Horrocks' Halifax account, £4,300 worth of cash, and the attempted theft from the National Savings account of £7,600, you will go to prison for two years. Each of those sentences of two years will run concurrently with each other, and those sentences I tell you now would have been considerably longer, but for the regard that I had and must have to the totality of sentence in this case. Those sentences of two years will run consecutively to the sentence of eleven years that I have passed in respect of the manslaughter, making thirteen years in all.'

4.3. COMMENTS

4.3.1. The Inquiry has noted that the proceedings in Court on 14 July 1997 involved the disclosure of a complex picture relating to Naresh Bavabhai's activities, acquaintances and pattern of life during 1996 which appears nowhere in his medical, nursing and social work records.

4.3.2. The only witness to the Inquiry to have spoken of his contacts within the drug subculture in Bolton was Mrs J Rushton, the warden of Cromford Close. We have already noted that Naresh Bavabhai did not request her support. In her evidence to the Inquiry she said that during his time as a tenant she received no more information than the basic identifying details which were given to her in 1993 and she had no ongoing contacts with Mr Chisnell or Mr Smith. Mrs Rushton indicated, however, that information has been more widely shared since 1997, when local procedures began to be more inclusive of housing matters.

4.3.3. Although Naresh Bavabhai's admission to Ward K2 on 4 October 1996 came immediately after an apparent crisis relating to his housing and involved two assessments regarding his drug abuse, the interrelationship of those events was not identified. Naresh Bavabhai was, however, trying to distance himself from those subculture pressures at the end of September and was hoping, with help from Mr Smith, to move elsewhere. The reasons for this, which were taken at face value at the time might have merited further investigation.

4.3.4. The nature of Naresh Bavabhai's dependency on his relationships with other drug users and providers was not considered in the autumn of 1996. It was to be described by the prosecution at some length, but was not examined further at the time of sentence in July 1997. Thus the process of his treatment lacked an important psycho/social dimension up to the time of his arrest and the process of disposal by the Court saw that dimension as incidental to his psychiatric history.

4.3.5. The Court transcript discloses a pattern of close involvement and familiarity between Naresh Bavabhai and his acquaintances. He had referred to a girlfriend in his discussions with CPNs during 1996, but the possibility that a female friend might be from the drug using subculture appears not to have been identified. It could have shed light on Naresh Bavabhai's psycho-sexual nature, an area which the Inquiry has found to be unfathomed throughout the course of his treatment and care from 1989 to 1996.

4.3.6. All in all, the information disclosed to the Court lifts the lid on a range of issues which were active components of Naresh Bavabhai's way of life and psychological make up in the period from September to November 1996. The health and social services professionals involved in his treatment and care needed to understand these issues then, and that need continues to the present day.

4.3.7. These aspects should now be incorporated as an ongoing part of his personal history, which as we have already indicated, has yet to be defined and understood in a systematic way (see 2.2.7 to 2.2.10).

CHAPTER V

5.0. THE FINDINGS OF THE INQUIRY

5.1. RESOURCES

5.1.1. The records show that from the time of his initial referral in March 1989 Naresh Bavabhai received treatment and care from a range of NHS, social services and associated agencies. The Inquiry has asked all witnesses to identify any shortcomings in the quality or quantity of resources. The majority of witnesses have not spoken of resource pressures, but those who have done so suggest a common view in relation to 1996.

5.1.2. Dr Mahadevan wrote 'There is little question that during 1995/6 and indeed even now, there were resource and work pressures, but I do not believe that this affected the care provided to Mr Bavabhai.' He went on to say that 'the main difficulty is in recruitment of psychiatrists, and that Bolton has had two vacancies in general adult psychiatry and one in old age psychiatry. This has meant that along with my colleagues I have been providing a service for a far larger population than the Royal College [of Psychiatrists] thinks reasonable.' Dr Mahadevan also pointed out that as a result of his years of service he had inevitably 'acquired a particularly large number of chronically ill and difficult to manage patients like Naresh Bavabhai. Also my sector is a particularly deprived one. These factors contributed to work pressures.'

5.1.3. These views were echoed by Dr F Reed the consultant psychiatrist responsible between 1993 and 1996 for Kenneth Horrocks' care, 'there was a shortage of Consultant Psychiatrists which placed significant pressures on those within the service.'

5.1.4. In relation to drug misuse, Dr Mahadevan said that 'As drug misuse becomes more widespread especially in areas like Bolton, which has many of the characteristics of an inner city area, so dual diagnosis with all its attendant management difficulties is becoming more common. I believe that in Bolton we should be looking at developing services specifically catering for such patients and I believe we are doing so.'

5.1.5. Dr Dougal, in referring to those pressures on drug abuse services in 1996 and at present, wrote 'There are high and almost overwhelming demands upon the service from primary and secondary health care (mental health and general hospital setting), community alcohol and drug teams, probation, mentally disordered offenders panel.'

5.1.6. Other reports of pressures on resources in 1996 relate primarily to social services. Mrs C Parker, the team leader responsible for supervising Mr I Smith wrote 'The team is always under pressure and over the years has welcomed the use of Care Programme Approach as a useful framework and system to work with other services, service users and carers. In August and November draft criteria were drawn up to identify cases to be referred to Mr Smith and there was discussion of a 'ceiling' being placed on his caseload in recognition of his development role and tasks. 'Unfortunately at the end of 1996 two experienced Approved Social Workers were off on sick leave and another going on maternity leave which impacted on Mr Smith.' In describing the pressures of 1995 and 1996 to the Inquiry, Mr Smith's written statement said 'I am satisfied that my management team were taking appropriate action to rectify matters, though I had been of the opinion for many years that the LA had not given sufficient consideration to temporary replacement of staff on long term sick leave and vacant posts e.g. through retirement of agency staff. I am pleased to say that since 1996 there is evidence that this problem has been addressed.'

5.1.7. Ms Kotecha referred during this period of having been 'under quite a lot of pressure... but I do not feel that this hindered my involvement in Mr Bavabhai's family.'

5.1.8. Mrs Parker added that 'What did not receive enough attention at that time was the administrative side of the work – that is to say assessment were undertaken and care delivered but not always documented at the time.' Mr Smith acknowledged this in his statement 'There was a problem during this period maintaining written records to the standards which would now be required.'

5.1.9. Mrs J Buckley, Principal Officer for Mental Health, described the situation in these terms 'The position in 1996 was that whilst there had been some expansion in the numbers of field workers as a response to the introduction of Community Care, the major influx of new staff, which has increased the number of field social workers by six, had not occurred. The team was therefore under additional pressure to ensure appropriate responses to their range of responsibilities throughout the year.'

5.1.10. Comment These images are consistent with the picture which has emerged for the members of the Inquiry Team, in terms of the resource pressures in 1996. The Inquiry has identified three particular factors which are likely to have influenced the course of events.

(i) There was a shortage of consultant psychiatrists. As a result Dr Mahadevan's workload was excessive throughout 1996 so that his contacts with Naresh Bavabhai were brief at a time when an extended, reflective review was increasingly needed. In particular the significance of dual diagnosis needed to be defined, understood and shared.

(ii) Dr Dougal's and Dr Quinnell's specialist inputs to that end were thorough but encapsulated as one-off assessments in October/November 1996. At that time Naresh Bavabhai's condition required joint assessment followed by joint discussion and care planning involving all those who would be involved in his care but notably, Dr Mahadevan, Dr Dougal/Dr Quinnell, Mr Chisnell, Mrs Gettins and Mr Smith.

(iii) Mr Smith's involvement as keyworker did not in effect commence until the readmission to Ward K2 in October 1996. He then took up his responsibility for the CPA Care Plan but the lack of documentation thereof is reflected in his records as well as by his and his supervisors' evidence regarding his workload and the need to refocus his working schedule. When he eventually completed the Care Plan on 2 December 1996 it did not include a risk assessment because relevant information had not been shared with him.

5.1.11. It should not be disregarded, however, that from April to November 1996, Naresh Bavabhai was provided with an extensive range of treatment and care resources by health, social services, housing and voluntary agencies in Bolton.

(i) His care was readily transferred form Dr Brownlee back to Dr Mahadevan at his request in March/April 1996 and thereafter he was regularly seen by the consultant psychiatrist and/or his junior medical colleagues.

(ii) He was given regular appointments for depot medication and outpatient reviews at the John McKay Clinic.

(iii) He regularly attended the St George's Day Centre, until September 1996 where he was offered counselling and helped to make contact with Narcotics Anonymous.

(iv) He was rapidly assessed by CPN Mr Catterall after the referral in April 1996 and CPA planning commenced.

(v) He was readmitted to Rivington Day Hospital from April to September 1996 and a nominated nurse Mrs K Gettins was allocated.

(vi) He was referred to and soon assisted by Mrs Smith of the Community Drugs Team in May 1996 and by Dr Dougal consultant psychiatrist in drug misuse in July 1996 who completed a full review and saw him again in November 1996.

(vii) He was again referred to the CPN service in August 1996 and quickly seen by Associate CPN Mr I Chisnell who started a further CPA assessment and maintained contact with him until the time of his arrest.

(viii) He was referred in September 1996 to Mr Smith, Senior Social Worker, who had already seen him in March 1996 and had previous knowledge of him.

(ix) He resided in sheltered accommodation where he had been offered support by the resident warden, and he was being helped to find other accommodation in November 1996.

(x) He was readmitted to hospital in October 1996 and on discharge re-referred to the day hospital.

5.1.12. All of this reflects the fact that Naresh Bavabhai was a well-known patient and of long standing, to whom a significant range and amount of service were provided.

5.1.13. There were, however, evident shortcomings in the exchange of information and understanding within health services and between them and social services. This is most clearly demonstrated in the repeated attempts to commence a CPA plan for Naresh Bavabhai in which Mr Catterall, Mrs Gettins and Mr Chisnell completed the documents without passing their conclusions from one to another and finally to Mr Smith.

5.1.14. The reviews, which were commendably often presided over by Dr Mahadevan, did not achieve the communicating links which were increasingly needed, as Naresh Bavabhai's clinical status changed during September, October and November 1996 to one of dual diagnosis. The implications of that and of the consequences in planning his care and treatment then needed urgently to be acknowledged and understood, notably by his consultant, his CPN, the day hospital staff and his keyworker.

5.1.15. In particular the process of care planning and risk assessment required much more exacting attention at that time.

5.2. CARE PLANNING

5.2.1. The delivery of Naresh Bavabhai's treatment and community care from 1989 was undertaken by Dr Mahadevan and by his social worker, Mr Smith. Planning at the

outset was satisfactory but appeared to settle into understandings of each other's roles based on some misapprehensions.

5.2.2. The medical notes of Dr Mahadevan on 29 October 1990 commented that Naresh Bavabhai was 'despondent about returning home to his critical family... Ian Smith working to modify their behaviour if possible.' Dr Mahadevan in evidence to the Inquiry elaborated upon this, explaining 'there is research evidence that patients who live in households where there is high expressed emotion which can often be due to critical comments, do not do so well and are more likely to relapse' and 'I felt that some of the effects of these factors on his illness could be modified. These are the sort of discussions that took place between myself and Ian Smith to look into these things.'

5.2.3. Yet Mr Smith had no recollection of any such referral to himself and said he did not undertake any of this kind of work with the family. He described his involvement with Naresh Bavabhai thus: 'Between October 1990 and August 1996 I had limited involvement in the planning and provision of care to Naresh... my intervention during this period after the Mental Health Act Assessment was mainly advice, help in getting Naresh re-housed and offers of support with social activities and domestic tasks.' From 1990 until 1995 Naresh Bavabhai's case remained open on Social Services Department records although 'no ongoing social work involvement was required.' In August 1996 Mr Smith had his first contact with Naresh Bavabhai's family since 1990.

5.2.4. Dr Mahadevan told the Inquiry that Mr Smith had always been the keyworker and that 'he knew Naresh for a very long time.' Mr Chisnell believed that Mr Smith had 'been involved with Naresh for approximately six years.' Guided by that he considered it appropriate for Mr Smith to be the keyworker for the purpose of the CPA in September 1996.

5.2.5. Operating according to a model of task-centred social work intervention used in Bolton, Mr Smith has described how his involvement was led by the demands of Naresh Bavabhai for most of the time. In fact Mr Smith says that he had little contact with Naresh Bavabhai between January 1991 and November 1992, no referrals having made for his assistance. He was seen twice in 1993 for practical assistance and his case paper was closed in 1995.

5.2.6. In 1993 Bolton Health and Social Services began to introduce the Care Programme Approach, requiring the establishment of care plans and appointment of keyworkers according to levels of care appropriate to the needs of each patient. Within

that process the purpose of a care plan is to ensure that an integrated plan is put into place, agreed between professionals in hospital and community. The purpose of a keyworker is to ensure that there is one person responsible for organising and co-ordinating the care plan.

5.2.7. The Inquiry was helpfully provided by the Social Services Department with a package of the Care Programme Approach documentation in use from September to November 1996. Three levels of intervention were used in Bolton. Level one was initiated by the completion of a Stage One Assessment at which was the point of entry onto the scheme, with subsequent movement onto level two or three. A keyworker would usually be identified at a 'link meeting' involving ward link nurse, CPN and social worker. An extended assessment would then be undertaken by the keyworker, including a risk assessment, although there were no forms for this part of the process. Finally, the Care Plan itself would be completed by the keyworker.

5.2.8. There were three separate completions of the Stage One Assessment form on Naresh Bavabhai, dated 4 April 1996, 6 September 1996 and 4 October 1996. The first completed by Mr Catterall and the second by Mr Chisnell included additional assessment documentation, including risk assessments, which the Inquiry heard were purely for CPN purposes and not provided to Social Services. The third Stage One Assessment comprised only one sheet of paper and its author is not known.

5.2.9. In August 1996 when Naresh Bavabhai was discharged from day hospital the role of keyworker was thought at the pre discharge review to be appropriate for Mr Smith in view of his long knowledge of his condition and circumstances. Mr Smith was not, however, able to be present as arranged at the planning meeting on 28 August 1996 because he was with Naresh Bavabhai at Astley Bridge Police station after the arrest in relation to the suspected break-in at Naresh Bavabhai's father's house.

5.2.10. The allocation of keyworker role to Mr Smith was then agreed in a telephone conversation between Mr Chisnell and Mr Smith on 19 September 1996, but the date chosen for a review meeting was during Mr Smith's absence on annual leave and in his evidence he says that he told Mr Chisnell this. In the meantime Mr Chisnell completed documentation, which was useful and accurate, but which he did not then send to Mr Smith.

5.2.11. On 24 September 1996 a letter was sent to Mr Smith by the CPA support worker reminding him that an appropriate care plan with check list should be sent to the Mental Health Act administrator as soon as possible.

5.2.12. Events were then overtaken by Naresh Bavabhai's readmission to Ward K2 during the month of October 1996, and appear to some extent to have been stalled whilst the complaint from the Bavabhai family was processed by the Social Services department. Nevertheless, Mrs Parker, who was Mr Smith's team leader, was clear in her evidence that she would have expected the process of assessment to continue during the hospital admission.

5.2.13. During that admission, confusingly, Sister Kenyon, who was the K2 Ward Sister and also the Link Nurse, was under the impression that Mr Chisnell was the keyworker because he had completed the Stage One Assessment which she took to be the care plan. The link meeting of 11 October 1996 thus records Mr Chisnell and Mr Smith as being keyworkers. Then on 31 October 1996 a Notification of Change in Keyworker form was completed describing the present keyworker as Mrs Gettins, at the Rivington Day Hospital and the new keyworker as Mr Smith. By October 1996 Mr Chisnell describes himself as 'getting a bit fed up that there was not being a care plan formulated' and he personally gave to Mr Smith his own plan of what he expected his involvement would be.

5.2.14. After Naresh Bavabhai's discharge from Ward K2 on 4 November 1996, Mr Smith resumed the process of care planning, now guided by the synopsis of Mr Chisnell's previous work in September 1996 but without a copy of the risk assessment and with no awareness of earlier concerns regarding Naresh Bavabhai's threat to harm other people.

5.2.15. Naresh Bavabhai was thus discharged from hospital without a written care plan. Dr Mahadevan and Mr Smith were both certain in their evidence that all of the team working with Naresh Bavabhai were very clear what the different components of the care plan were and that this had involved a comprehensive assessment of Naresh Bavabhai's needs. Mr Smith told the Inquiry 'I did not think that the absence of a signed care plan prejudiced Naresh's care during the period 4 November to 20 November as all the professionals involved were aware of what was expected of them.'

5.2.16. There was then a delay in recommencing day hospital attendance. Mr Smith gave his first attention to housing needs rather than to completing the Care Plan.

Following the complaint by Naresh Bavabhai's family Mr Smith describes wanting to ensure that the care plan was acceptable to Naresh Bavabhai's mother, and he arranged a meeting with her for 25 November 1996. By the weekend of 16/17 November 1996, the process was overtaken by events. The Care Plan meeting set for 25 November 1996 was cancelled and it was not until 2 December 1996 that the Care Plan was written by Mr Smith.

5.2.17. Comment There was miscommunication at the start in 1989 as to Mr Smith's role, with Dr Mahadevan believing that he was to provide therapeutic work with the family which Mr Smith says was never his own understanding. Subsequently Mr Smith was credited by Dr Mahadevan and Mr Chisnell with a depth of knowledge about Naresh Bavabhai over the years that it is doubtful he had.

5.2.18. If Mr Catterall's first Stage One assessment documentation for CPA had been passed on to Mrs Gettins at the day hospital, her observations could have been added. This would have enabled Mr Chisnell to become aware of Naresh Bavabhai's earlier threatening behaviour in April 1996 and recent revelations concerning thoughts about rape in August 1996.

5.2.19. These vital threads were missing from the second Stage One CPA assessment completed by Mr Chisnell in September 1996, but in any case, these documents were not subsequently shared with staff on Ward K2 and with Mr Smith in October 1996.

5.2.20 When Mr Smith accepted the role of keyworker on 19 September 1996 others believed that he was already in possession of a wealth of information about Naresh Bavabhai and his family gleaned over many years. In fact that was not so. The telephone conversation was an inadequate means of conveying the complexity of Naresh Bavabhai's needs and an assessment of the risks involved at that time. That discussion should have then been followed up by a letter and a copy of the information contained in the community nursing records to aid the completion of the full Care Plan.

5.2.21. In most senses, Mr Smith was starting afresh in his CPA assessment, and the summary provided by Mr Chisnell did not highlight the risks which needed to be considered (3.14.6). The appropriateness of Mr Smith's continuing designation as the keyworker appears not to have been reconsidered, even

though by October 1996 Naresh Bavabhai's clinical condition had necessitated his readmission to hospital and reinvestigation by doctors of his dual diagnosis. Those investigations showed that his condition was at the limit of what local health services could treat and manage.

5.2.22. The CPA documentation was confusing and it remains unclear why there were three completions of the Stage One Assessment form. There was a belief on Ward K2 that this form was in fact a care plan and Mr Chisnell the keyworker. Assessment for Level Two of CPA should have been undertaken by Mr Smith as the keyworker but there was no formal documentation for this and no evidence was seen of such an assessment in Social Services records. Mrs Parker stated in evidence that the CPA documentation was relatively new and due to work pressures people could not always fill it in. The formal assessment forms which did exist were community nursing records and were not circulated to others involved in Naresh Bavabhai's care, including Mr Smith and Rivington Day Hospital. Some tension seems to have been felt by Mr Chisnell regarding the progress of care planning, resulting in him formulating a part of the care plan for Mr Smith's use.

5.2.23. This sequence of half started, inadequately shared planning represents a waste of time, a grossly inadequate sharing of information and an inability to co-ordinate valuable human resources. Above all, vital opportunities were lost to assemble a cumulative understanding of Naresh Bavabhai at a time when his mental illness and personal circumstances were changing considerably. The process appears largely to have been reactive to events and dictated by Naresh Bavabhai's movements from one part of the range of local care/treatment resources to another.

5.2.24. The absence of a written care plan upon discharge on 4 November 1996 would not have been so significant for Naresh Bavabhai's care had it been possible to say that all necessary information was conveyed by other means to all necessary people during the discharge review. That was not the case. Mr Smith still had no information as to Naresh Bavabhai's risk to others. It was not clear whether the Community Drugs Team would offer anything further for Naresh Bavabhai. Rivington Day Hospital arrangements had not been adequately set up and he did not start there until 13 November 1996. Mrs Bavabhai had said she did not wish to have Naresh Bavabhai home with her and Mr Smith considered that to discharge him there would be 'unendurable' for her. Yet the day after discharge it was evident that he was in fact living with his mother.

5.2.25. The failure to address these issues in the co-ordinated manner expected by local CPA procedures prior to Naresh Bavabhai's discharge from Ward K2 on 4 November 1996 reflects badly on all of the health professions involved. Mr Smith might have provided a safety net, in his role as keyworker, but this did not happen. A written completion of the care plan following multi-disciplinary discussions could have forced a more careful and reflective pace upon the process of discharge and the planning of continuous treatment and care. Co-ordination of care might then have been tighter and misconceptions fewer.

5.2.26. The system as operated by those responsible for Naresh Bavabhai's care and treatment failed to draw together in an incremental way the information which had been emerging in 1996. Thus Mr Smith's summary in December 1996 varied only a little from that completed by Mr Catterall in April 1996. The main variation was that Mr Catterall mentioned risks and Mr Smith did not, although these had been mounting in the intervening months.

5.2.27. In fact, the records which were completed at the time of discharge from Ward K2 on 4 November 1996 are notably lacking in the assessment of risks, although Naresh Bavabhai's clinical status was at the limits of what local services were able to define and deal with and was likely to remain so until he was seen by the regional specialist drug abuse service at Prestwich Hospital.

5.3. RISK ASSESSMENT AND MANAGEMENT

5.3.1. At the time of his referral to the regional drug abuse service it would have been important for the referrers to have traced through Naresh Bavabhai's history to look at any emergent pattern of aggressive thoughts or acts and especially where those were accompanied by auditory hallucinations or paranoia. The Inquiry has needed to examine how information gathered from different sources was passed on and whether it was satisfactorily collated to create a picture of risk. When an assessment of risk was made it has to be asked whether that was done satisfactorily and how that information was then used and circulated to those responsible for Naresh Bavabhai's care.

5.3.2. His history reveals a pattern of psychotic breakdown, which from the outset included aggressive behaviour. The first admission in March 1989 (3.1 and 3.2) was triggered by features which included aggression, threatening gestures, the smashing of a mirror and paranoia. The second admission in April 1989 was described (3.4.1) as a

lapse into aggressive schizophrenia and there was reference to expressions of suicide. On his third admission in May 1990 (3.6) he was described as 'very paranoid again.' Leading up to the fourth admission in October 1990 he was very hostile and angry, standing eye to eye in front of his siblings for up to 20 mins and had bouts of aggression (3.7.6). During that period in hospital he had to be returned by Police from his home where he had been very hostile and angry to his mother, brother and sister (3.8.3). In hospital the same day he was staring in a hostile manner (3.8 3). On 12 November 1990 he was again staring at nurses in a hostile manner and was also hostile to Dr Mahadevan (3.8.6).

5.3.3. Between the fourth and fifth admissions Naresh Bavabhai's G.P. noted that he said he heard voices of a boy and girl and that he "wishes Mum could kill him", This remark was never followed up. The first evidence of violence was on the fifth admission in February 1993 when he had had a fight with his younger brother (3.10.2). His mother said that she did not want him home yet because she was afraid he would become violent again (4.10.5). In September 1995 Naresh Bavabhai described feeling frightened of other people and was locking himself in the house. He said to Dr Brownlee that he had been suffering eneuresis and sometimes encopresis for the past 12 months when he went to bed fearful of being attacked in the night (3.11.12). Naresh Bavabhai's brother Navin gave evidence that in March 1996 Naresh Bavabhai had attempted suicide on the moors. He told no-one of this at the time. On 3 April 1996 Naresh Bavabhai telephoned the CPN service stating that he felt threatened by people ringing his door bell and wanted to kill them (3.11.14). That same day he reported to the SHO that for two months he had had ideas of killing people (3.11.14). Naresh Bavabhai told the Inquiry that those thoughts were the same thing as the voices: they were saying "if anybody comes to the flat, kill them".

5.3.4. The first recorded formal risk assessment was that completed on 4 April 1996 by Community Psychiatric Nurse Mr Catterall. This was attached to the first completed Stage One Assessment for Care Programme Approach form. There was said to be no risk of self-harm and no risk to children or family members. A risk of aggressive/violent behaviour was identified with the comment added "Feels angry and aggressive towards other people especially strangers". He was described as "worried by the violent feelings he has been having. Three weeks ago he threatened a close friend with a knife because he thought he stole his house keys". A HoNOS Score Sheet rated Naresh Bavabhai positively for aggressive and disruptive behaviour (3.11.15).

5.3.5. When Naresh Bavabhai was seen by a Community Psychiatric Nurse on 5 April 1996 he repeated that he had ideas of killing people. On admission to the Rivington Day Hospital on 16 April 1996 Naresh Bavabhai reported paranoid ideas

about people breaking into his flat (3.12.1). A mental state examination on 19.4.96 noted that Naresh Bavabhai had thoughts of self-harm, suicidal ideation, and again ideas of killing people. In August 1996 Naresh Bavabhai's brother Navin said that Naresh Bavabhai been expressing suicidal ideas (3.12.17). At a review on 14 August 1996, and later to nursing staff, Naresh Bavabhai revealed that he had been getting urges to rape women (3.12. 18). By this time he had also gone to the length of putting an iron grille over his front door to keep out intruders.

5.3.6. Upon discharge from Rivington Day Hospital on 4 September 1996 a full discharge summary was sent by Dr Mahadevan to Naresh Bavabhai's G.P., Dr Walker but it made no mention of any risk to self or others. Mrs Gettins' statement said 'During the period September to November 1996 there were no formal procedures for risk assessment in use at the Rivington Day Hospital. However, risk was assessed as part of the initial assessment, continued on an ongoing basis and any identified risks were incorporated into the care plan.' Sister Kenyon, from Ward K2 stated to the Inquiry that 'risk assessment was not an overt process.'

5.3.7. The second formal risk assessment was completed on 6 September 1996 by Community Psychiatric Nurse Ian Chisnell as part of the completion of a second Stage One Assessment under the Care Programme Approach. No risk was indicated of self-harm or to children and family members. A risk of aggressive/violent behaviour was identified and the comment was added 'potential for aggressive feelings towards others and has threatened a friend with a knife in the recent past'. This assessment appears simply to have used information already given in the previous risk assessment (see 3.13.2).

5.3.8. Just prior to Naresh Bavabhai's last admission his mother described finding it hard to cope with his demanding behaviour and verbal threats. On admission on 4 October 1996 he spoke of hearing voices at night, had suspicious thoughts and had auditory hallucinations of people talking about him (3.13.8). The third Stage One CPA form completed on 4 October 1996 was without any attached risk assessment.

5.3.9. On 14 October 1996 Mr Chisnell completed his CPN part of the Care Plan for Stage 2 and sent this to Mr Smith, but it contained no reference to any risk of aggressive or violent behaviour.

5.3.10. Upon his discharge on 4 November 1996 Naresh Bavabhai was still hearing voices, but no mention was made of related risks in the medical notes of the review.

The discharge summary completed by Dr Mahadevan and sent to G.P., Dr Walker, likewise made no mention of aggression towards others or risk of self-harm.

5.3.11. When a Community Psychiatric Nurse visited Mrs Bavabhai on 12 November 1996 she described Naresh Bavabhai as argumentative and verbally hostile especially after injecting drugs. He was refusing to answer the phone or door, thinking it might be drug dealers or the police, On 13 November 1996 at Rivington Day Hospital he stated that three weeks ago he had been to a drug dealer with a hammer for selling him "bad stuff".

5.3.12. In his evidence to the Inquiry Naresh Bavabhai claimed that in the few months before the killing he had the thought that people from the drugs scene were out to kill him. He said that in the few days before the killing a voice had told him he should kill someone in the street: "it was a clear voice and I felt I had to do what it said".

5.3.13. Comment Naresh Bavabhai gave varying accounts to different people at different times. For example in January 1993 he said 'I've never stopped hearing voices' (3.9.10) but in February 1993 denied ever having auditory hallucinations (3.10.3). On 19 April 1996 he was noted to have ideas of killing people but the admitting nurse at Rivington Day Hospital who assessed him on the same day according to the Roys model found no evidence of risk of self harm or of harming others. The organiser at St George's Day Centre gave evidence that Naresh Bavabhai was pleasant and sociable, never revealing any sign of aggression whilst there. Likewise, Mr Smith commented in evidence, that eleven days before the killing Naresh Bavabhai was his usual self, pleasant and in good spirits. In contrast, his family have consistently revealed details of his aggressive behaviour at home up until and including the week before the killing and the Warden of the Sheltered Housing felt uneasy about Naresh Bavabhai, describing him as agitated and excitable.

5.3.14. It is notable that on 30 January 1993 Naresh Bavabhai wrote a letter to Dr Mahadevan wherein he described his feeling that he 'is making a nuisance of himself when he keeps seeing his G.P.' He asked for an appointment with Dr Mahadevan, saying 'I am aware that you deal with patients... who have more severe disorders than myself but I would be very grateful if you could find the time to see me, at your convenience'. In his evidence to the Inquiry, Dr Walker, his GP in 1996, remarked 'It is not easy coming to see us and admitting to being mentally ill... it takes a degree of insight... and a degree of courage.'

5.3.15. Yet it remains true that Naresh Bavabhai clearly presented himself differently in different settings, thus making consistent risk assessment a difficult task. He revealed himself to some people and on some occasions as an aggressive and hostile man harbouring violent thoughts, to others and at other times he appeared compliant, intelligent and personable. It remains unclear how much Naresh Bavabhai concealed his symptoms, perhaps through pride or to please and appease those who sought to help him. It will never be known how much more he could have revealed with more careful probing. Whatever the reason, it seems probable that apparently contradictory impressions resulted in a dilution of the perception of risk, such that Dr Mahadevan remarked in his evidence to the Inquiry 'He had been annoyed with a friend and he had brandished this knife, but the impression I got was that no-one actually thought that he would have actually harmed his friend... I had never felt that he was the sort of person who would want to harm somebody else'. Likewise, almost without exception, witnesses to the Inquiry expressed great surprise at the news of Naresh Bavabhai's responsibility for the killing of Kenneth Horrocks.

5.3.16. In effect, aggressive and violent presentations had been effectively neutralised by compliant, intelligent and personable presentations. Confusion resulting from these contrasting presentations has been compounded by a breakdown in communication between other people. For example, Naresh Bavabhai did not disclose his attempt at suicide in March 1996 to any professional, nor did his brother inform anyone. A month later the first risk assessment listed no risk of self-harm. Despite a Mental State Examination later in April 1996 making reference to suicidal ideation and his brother's remarks in August that Naresh Bavabhai was expressing suicidal ideas, the second risk assessment again indicated no risk of self-harm. The Inquiry heard that since his remand and sentence in prison Naresh Bavabhai has twice made suicide attempts.

5.3.17. The Inquiry consider it surprising that long-standing reports from Naresh Bavabhai's family about his threatening behaviour to them did not trigger some concern as to his risk in relation to them especially bearing in mind the widely acknowledged fact that family and carers can be at notable risk, (see for example national advice issued in May 1994 to all NHS Trusts in NHSE Circular HSG 94/27, and research evidence by Gunn & Monahan et al).

5.3.18. Whilst risk in relation to strangers was correctly noted in the formal risk assessments, it was an unsophisticated analysis, based on only the one incident with a knife. In combination with a history of paranoia concerning

intruders, thoughts of killing, continued reference to voices the content of which was never fully explored, and an increase in amphetamine use, the picture is more concerning. The model for assessment used at the time provided no opportunity for assessing degree of risk, giving only a yes/no option as to existence.

5.3.19. With information only partially available and obscured by inconsistency, the formal risk assessments assumed crucial importance despite their limitations. Mr Smith was the social worker from early in Naresh Bavabhai's illness and the keyworker from 19 September 1996 and yet in evidence to the Inquiry he said that he had not been sent either of the risk assessments: 'at the time of my appointment to be key worker there were no concerns explained to me indicating that Naresh was at risk, or was a risk to others'. This is despite Mr Chisnell's recollection that he went through his assessment on the telephone with Mr Smith on 19 September 1996. Mr Smith gave evidence that he did not know up until the killing, or indeed until this inquiry, that Naresh Bavabhai had had thoughts of killing people, nor did he have any knowledge of the incident with the knife or any mention of thoughts about rape. His own conversations with Naresh Bavabhai had not revealed any detail of aggressive thoughts and actions. Mr Smith was quite clear in his evidence that he knew of no incidents since 1989 that would have caused him concern about Naresh Bavabhai's potential risk to others. No information as to risk was provided to the Warden, partly because there was no formal procedure for her to receive it and partly because her liaison was with social services, who did not have that information.

5.3.20. Although the Inquiry heard that risk assessments were 'part and parcel' of the medical process of history taking and of mental state examination, other than looking back through notes there was no accumulated and easily locatable history of risk. That information, although in the possession of a number of professionals who worked together, was not distilled into a formal multi-disciplinary risk assessment.

5.4. CLINICAL FORMULATION

5.4.1. We think it necessary by way of an overview to offer a dynamic clinical formulation regarding Naresh Bavabhai as none exists in available records that takes into account all the information that has been made available to the Inquiry.

5.4.2 **Social Background.** Naresh Bavabhai comes from a very large family in which there were considerable parental tensions which led eventually to divorce when the children had grown up. This in itself is unusual in conventional Asian family life. Naresh Bavabhai was much closer to his mother than his father, largely due to the latter's shift work and violence towards him as, by his own account, 'the most troublesome of all the children.'

5.4.3. The children themselves were struggling to establish their own identity as first generation British Asians with some of them embracing Christianity, others entering the professions, and some resisting arranged marriages. The family did not fit in with the local Asian community, which led to their marginalisation. Mrs Shantaben Bavabhai, in particular felt the consequence of this due to her inability to speak in English, though she mostly understood what was being said to her. Her children also report problems communicating with her in Gujarati.

5.4.4. Naresh Bavabhai was undoubtedly a bright child, who won a free place at the local public school but turned it down in favour of going to the local grammar school. Then things started to go wrong in his teen years, with a period in a detention centre, experimentation with drugs, e.g. LSD, marijuana, magic mushrooms, oral amphetamines, experimentation with alcohol and finally leaving home after clashes with father over a girlfriend.

5.4.5. **Initial Diagnosis.** His first admission to a psychiatric hospital brought him under the care of Dr Mahadevan, who remained his RMO throughout, except for a brief period. A diagnosis of schizophrenia was made and there is no evidence available to refute this.

5.4.6. When sectorisation of psychiatric services some years later forced the reallocation of his case to Dr Brownlee he was identified as "a reluctant transfer". This culminated in him refusing to see Dr Brownlee on 3 April 1996 and led to the transfer of his care back to Dr Mahadevan, closely followed by admission to the Rivington Day Hospital on 16 April 1996. Dr Brownlee's opinion when examining Naresh Bavabhai on 4 December 1995 confirmed an initial impression of paranoid schizophrenia.

5.4.7. Naresh Bavabhai appears to have developed a close relationship with Dr Mahadevan, who in turn appears to have understood him to a greater extent than anyone else. Perhaps this led to Dr Mahadevan believing his assurances that "he will try to give up drugs". This belief was, however, based on information that Naresh

Bavabhai volunteered, which was occasionally supplemented by other members of his family and the multi-disciplinary team.

5.4.8. Dr Mahadevan may not have suspected the full extent of Naresh Bavabhai's substance abuse, perhaps because it appeared piecemeal over a number of years in a setting of a diagnosis of paranoid schizophrenia and partly because the true extent of this substance abuse was concealed from him either by design or by omission. Had this not been the case, a comprehensive history of substance abuse could have been recorded over time by an astute clinician whose other clinical observations are often particularly insightful. Credence must also be attached to Dr Mahadevan's evident surprise at the killing and his belief that neither schizophrenia nor substance abuse played a role in the killing itself. The sentiment of shock was also to be repeated time and time again by the other professionals who had been involved in his care.

5.4.9. **Specialist Assessment.** The referral to Dr Dougal, Consultant Psychiatrist in substance misuse, confirmed the past history of substance abuse but more worryingly 'a history of regular use of amphetamines by injection over the last twelve months (confirmed by urine drug screen)'. No attempt is recorded in July 1996 to consider the aetiology of 'the irritability, aggression and paranoid ideation' that was elicited and which could have arisen directly as a result of his paranoid schizophrenia alone, or the amphetamine abuse alone, or a combination of these together. On 1 November 1996, Dr Dougal was told by Naresh Bavabhai that he found Fluoxetine initially helpful but following prolonged use that there was no real benefit.

5.4.10. Naresh Bavabhai's contact with Dr Quinnell and the community drugs team in October 1996 had highlighted a more worrying pattern of amphetamine use suggestive of binge usage with dependency and tolerance. Dr Quinnell's findings on mental state examination, namely 'acutely psychotic, having flattened affect, slow monotonous speech, marked passivity' were so worrying that he telephoned the doctors on K2 ward to alert them of this. The letter he wrote did, however, reach Dr Mahadevan late.

5.4.11. The possible relatedness of the violent thoughts of raping and of harming with a hammer and knife also appeared to be similarly lost to those who made specialist assessments as they were in the other ongoing assessments by operationally disparate services.

5.4.12. **Dual Diagnosis.** Dr Mahadevan, as a general Psychiatrist, was struggling with Naresh Bavabhai's management because of the complicating factor of amphetamine abuse. Dr Dougal, a specialist in substance abuse, was in turn struggling with Naresh Bavabhai's management because of the complicating factor of schizophrenia. These two elements of local psychiatric services recognised the impact of both of these problems in Naresh Bavabhai's functioning, but combined psychiatric management was not available. However, services for dually diagnosed patients are poorly developed in this country and there are very few places which offered a specific service addressing these special needs at that time.

5.4.13. The question of why people with established mental illness may begin to abuse substances was eventually addressed by Dr Kahn, the expert witness to the Inquiry. 'People with mental illness take drugs sometimes to cope with negative symptoms (of schizophrenia) and the side effects of neuroleptics, and it is of no surprise that they will self-medicate and with cannabis. He then tries amphetamines and finds that he quite likes the effect of amphetamines because it has a stimulating effect'. The issue of sexual gratification and amphetamines has never been addressed previously and this, too, remains an unresolved area of consideration for the Inquiry. The pattern of amphetamine use was likely to have been 'of the binge type, two or three days at a time, and then he would recover in-between... once out of the exhaustion phase and withdrawal phase, then they get the compulsion to use it again...' There was the possibility that his first ever referral to psychiatric services was precipitated by cannabis abuse as the background to this was certainly present. This can, however, never be authoritatively confirmed now.

5.4.14. The extent to which his drug taking may have increased in order to find some relief from his schizophrenia, in the manner described by Dr Kahn, is a matter which will need to be considered by psychiatrists as Naresh Bavabhai completes his sentence.

5.5. COMMENT

5.5.1. On the balance of probabilities, it seems that whilst Naresh Bavabhai was abusing amphetamines in the week prior to the killing, the chances of him using amphetamines to the extent that he says he did is unlikely. His extensive involvement with the drugs subculture at that time, as recorded in court depositions after the arrest appears undeniable and the possibility cannot be completely discounted that he was abusing amphetamines to such an extreme extent that the killing took place for financial gain. He certainly had to fund an increasingly expensive drugs habit and this could well have been a second

burglary that went tragically wrong. Clearly a burglary had taken place previously, which had made Naresh Bavabhai aware of Mr Horrocks' financial resources.

5.5.2. It also remains true that the diagnosis of schizophrenia made by Dr Mahadevan in 1989 had been confirmed by Dr Brownlee in December 1995. Treatment for that disorder was intensified throughout 1996 and the diagnosis was reconfirmed by Dr Snowden in June 1997.

5.5.3. Dr Snowden's report for the defence which was considered by the Court related only to the offences of burglary and deception in September 1996. At the time of his clinical interview, Naresh Bavabhai was denying the charge of murder and Dr Snowden therefore did not investigate the psychiatric phenomena related to the killing in November 1996.

5.5.4. Dr Collins, the consultant psychiatrist responsible for Naresh Bavabhai's treatment at HMP Full Sutton, in his statement to the Inquiry said of him at present 'the fundamental diagnosis is that of schizophrenia rather than a series of psychotic episodes precipitated by drug abuse.'

5.5.5. The Inquiry's expert witness Dr Kahn said 'on the balance of probabilities this man suffers from schizophrenia, he also has been misusing a variety of substances and is showing signs of dependency on amphetamines.'

5.5.6. Naresh Bavabhai himself has described to the Inquiry his bingeing on amphetamines at the time of the killing (3.15.13). He also affirmed to the Inquiry that he was prompted to kill Kenneth Horrocks by voices telling him to do so. (1.0.12). He was sent a copy of the transcript of his verbal evidence which he acknowledged 'I believe this to be a true statement of myself. NK Bavabhai.'

5.5.7. The Inquiry considers it irrefutable that Naresh Bavabhai was suffering from paranoid schizophrenia in the period when he killed Kenneth Horrocks. It would not be credible to believe that this chronic illness had ceased in November 1996, even though Dr Mahadevan and Mr Smith did not observe symptoms when they saw him after his arrest.

5.5.8. The Inquiry concludes that it would be unreasonable to dismiss Naresh Bavabhai's evidence out of hand. What he has said is consistent with his form of drug abuse, although possibly exaggerated. Furthermore, his auditory hallucinations as recurrently described in his records are a common symptom of paranoid schizophrenia. These are to some degree consistent with the ideas of persecution relating to other people which were present as recently as September/October 1996, and his aggressive ruminations concerning harm to others which date back to April 1996.

5.5.9. The Court on 14 July 1997 did not receive a psychiatric report relating to the manslaughter offence. The Inquiry considers that in order completely to review Naresh Bavabhai's mental pathology and the treatment he needs his clinical status should now be thoroughly reviewed by a forensic psychiatrist and by a consultant psychiatrist with extensive experience of dual diagnosis.

CHAPTER VI

6.0. THE INQUIRY'S CONCLUSIONS AND RECOMMENDATIONS

6.1. INQUIRY CONCLUSIONS

6.1.1. Naresh Bavabhai is a young man from a dysfunctional Asian family, who failed to succeed in secondary school and was sent to a Detention Centre for a short period of time. He began to experiment with alcohol and illicit drugs prior to his first admission to hospital. He developed symptoms of schizophrenia probably about the time there was an escalation in his drug abuse though this cannot be certain. He did, however, have periods of illness when he really was very ill indeed to the extent that he needed detention in hospital, with non-compliance with medication as a possible precipitating factor. He then went into a quiescent phase in 1994/1995 but became acutely ill again early in 1996 and needed almost continuous attention for the last nine months prior to the killing from the various helping agencies in Bolton. As his illness progressed, so too did his substance abuse, perhaps because of the illness itself or the side effects of his medication or because of opportunism. The amphetamines exacerbated his mental illness because of increasing usage, making the likelihood of a dual diagnosis almost certain.

6.1.2. Assistance for his addiction to amphetamines was made available but this treatment appears to have been patchy and disjointed, with a relative quickness to consider maintenance medication at a time when a longitudinal approach with greater family involvement might have led to more effective management plans. The referral to the Regional Drug Dependence Service for assessment of Naresh Bavabhai's suitability as a candidate for stabilisation and structured withdrawal would have evaluated such a joint management strategy.

6.1.3. Doctors, nurses and the social worker who were responsible for his care never really understood his involvement in the drug subculture, the influence it played in his life and his attempts to be with this 'in-crowd'. The amount of amphetamine which Naresh Bavabhai reported he was using may have been exaggerated by him in the weeks prior to the killing, but nonetheless, it played an important but not exclusive role in the killing of Mr Horrocks.

6.1.4. The level of resources made available to Naresh Bavabhai was not in itself lacking. Rather the co-ordination of these services, the sharing of the information available and effective care planning was certainly absent, even towards the end of Naresh Bavabhai's care. All this might have been addressed if the principles enshrined within the Care Programme Approach had been more systematically and sequentially applied by members of the multidisciplinary team, both individually and collectively.

6.1.5. The plans which were undertaken reinforced existing notions about Naresh Bavabhai's personality, nature, needs and way of life at a time when these were changing significantly due to his abuse of amphetamines and his involvement in the subculture associated with that abuse.

6.1.6. There is clear evidence that members of the family were at different stages involved in Naresh Bavabhai's care and attempts were made to address Mrs Shantiben Bavabhai's specific language needs. The clinicians needed carefully to balance the patient's rights to confidentiality and the carer's needs to be involved in providing support and care even though the carers might occasionally be perceived as being critical by the patient himself. This happened in Naresh Bavabhai's case despite his tremendous reliance, particularly on his mother for even the most basic of needs, such as food, laundry and budgeting. Dr Mahadevan appears to have steered a praiseworthy path within these constraints.

6.1.7. The family's letter of complaint appears to have initiated attempts at more effective care planning and help in language needs from Social Services, even though the issues raised by them were pertinent to all the providers of care rather than for his social needs only. Events superseded the production of an agreed care plan until well after the killing.

6.1.8. Despite the family's letter of complaint, his care remained disparate, so preventing the principles of the Care Programme Approach being put into practice. This did not allow the full multidisciplinary risk assessment to take place or the implementation of the management plan, which could have played a role in reducing the level of risk posed with the tragic eventual outcome.

6.1.9. The Inquiry concludes that whilst the killing took place against this clinical background, it was precipitated by

i. increasing frequency and intensity of auditory hallucinations, because of increasing amphetamine use,
ii. financial constraints resulting from amphetamine abuse,
iii. his desperate need 'to belong', within his drug abusing subculture.

6.1.10. Earlier evidence in 1996 suggested that Naresh Bavabhai did pose a risk to others. Two CPN risk assessments in April and September had appropriately reflected that risk and they should have been the occasion to compile a history of violent incidents, aggressive behaviour and thoughts so that they did not thereafter get 'lost'.

6.1.11. There was no assessed risk in relation to self-harm or towards family members although the facts available suggest that there was such a risk.

6.1.12. The risk assessments should have been circulated to all those involved in Naresh Bavabhai's care. In particular they should have been sent to Mr Smith, the keyworker. At the time there was no administrative procedure in place for the circulation of that information which was considered to be for the exclusive use of the CPN service. This was unsatisfactory and it did not follow the national guidance issued by the National Health Services Executive in May 1994 (HSG (94)27).

6.2. INQUIRY RECOMMENDATIONS

6.2.1. The Inquiry panel's intention has been to write the full report in ways which will facilitate discussion and action on the part of the managers and staff of the services concerned. The 'comment' items draw attention to particular organisational and professional matters which need to be considered in relation to practices at present as well as in 1996.

6.2.2. The following recommendations should not, therefore, be regarded as a summary of all the matters which the panel would wish to see influenced by the Inquiry's findings. They do, however, cover the major items on which categorical recommendations should be made.

RECOMMENDATION 1 Health and Social Services should urgently review the existing Care Programme Approach arrangements, in order to formalise working

practices and policies within identified time limits, roles and responsibilities. Joint training, monitoring and research is likely to encourage good practices.

RECOMMENDATION 2 A risk assessment should be a comprehensive multidisciplinary summary compiled by the keyworker, with all relevant information derived from medical, nursing, CPN and social services records. That can be most satisfactorily achieved if completed at multidisciplinary review meeting.

RECOMMENDATION 3 Copies of risk assessments should be circulated to all those professions involved with a patient's care. There should be a review date for the revision of the risk assessment and in any event it should be updated before discharge of a patient from hospital. It should contain detail of all relevant indicators of risk and of any changes in those indicators.

RECOMMENDATION 4 Guidance should be given to all staff regarding the involvement of carers and other family members in the care and treatment and risk assessment of patients so that their views are sought and recorded when Care Programme Approach plans are made and reviewed.

RECOMMENDATION 5 Closer links should be established locally between Community Drug teams and other statutory services in substance abuse with encouragement for joint working, common case records and shared responsibilities. This should also include advice on line management arrangements and the supervision of medical staff.

RECOMMENDATION 6 The Department of Health and the Royal College of Psychiatrists should encourage the dual training in mental illness and substance abuse of psychiatrists, nurses, social workers and others appointed as keyworkers to service users who have dual diagnosis.

RECOMMENDATION 7 The National Health Service Executive should review the extent to which its guidance contained in circular HSG (94)27, has been adhered to nationally.

RECOMMENDATION 8 *The Home Office is recommended to call for comprehensive medical and social reports relating to the period from 1996 to the present to determine whether action under the Mental Health Act 1983 is now appropriate in relation to Naresh Bavabhai.*

RECOMMENDATION 9 *Workable systems should be set up to ensure the efficient transfer of information from the Health Service to Prison Services so that the continuity of the treatment and care provided by prison health staff is facilitated.*

APPENDIX A

EXTERNAL INQUIRY INTO THE CARE AND TREATMENT OF NARESH BAVABHAI – TERMS OF REFERENCE

1. With reference to the incident which took place on 19 November 1996, to examine the circumstances of the treatment and care of Mr Naresh Bavabhai, by the mental health services, in particular:

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

   (ii) the appropriateness of his treatment, care and supervision in view of:

   (a) his assessed health and social care needs;

   (b) his assessed risk of potential harm to himself and others;

   (c) any previous psychiatric history and any history of drug and alcohol abuse;

   (d) the number and nature of any previous court convictions;

   (e) statutory obligations, national guidance (including the Care Programme Approach HC(90)23/LASSL(90)11, Supervision Registers HSG(94)5, and the discharge guidance HSG(94)27) and local operational policies for the provision of Mental Health Services.

   (iii) The extent to which Mr Bavabhai's prescribed treatment and care plans were:

   (a) documented
   (b) agreed with him
   (c) communicated appropriately within and between relevant agencies and his family
   (d) carried out
   (e) complied with by Mr Bavabhai

2. To examine the appropriateness of the training and development of those involved in the care of Mr Bavabhai.

3. To prepare a Report of the Inquiry's findings and make recommendations as appropriate to Wigan & Bolton Health Authority.

APPENDIX B

EXTERNAL INQUIRY INTO THE CARE AND TREATMENT OF NARESH BAVABHAI – PROCEDURE TO BE ADOPTED BY THE INQUIRY

1. Every witness of fact will receive a letter in advance of their appearance to give evidence informing them:
   a) of the terms of reference and the procedure adopted by the Inquiry
   b) of the areas and matters to be covered with them
   c) requesting them to provide written statements to form the basis of their evidence to the Inquiry
   d) that when they give oral evidence they may raise any matter they wish, and which they feel may be relevant to the Inquiry
   e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation, or anyone else they may wish to accompany them, with the exception of another Inquiry witness
   f) that it is the witness who will be asked questions and who will be expected to answer
   g) that their evidence will be recorded and a copy sent to them afterwards for them to sign.

2. Witnesses of fact will be asked to affirm that their evidence is true

3. Any points of potential criticism will be put to a witness of fact, whether orally when they first give evidence, or in writing at a later time, and they will be given a full opportunity to respond

4. Representations may be invited from professional bodies and other interested parties as to present arrangements for persons in similar circumstances

5. Those professional bodies or interested parties may be asked to give oral evidence about their views and recommendations

6. Anyone else who feels they may have something useful to contribute to the Inquiry may make written statements for the Inquiry to consider

7. All sittings of the Inquiry will be held in private.

8. The findings of the Inquiry and any recommendations will be made public.

9. The evidence which is submitted to the Inquiry, either orally or in writing, will not be made public by the Inquiry, save as is disclosed within the body of the Inquiry's final report.

10. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on these findings.

11. At the conclusion of the Inquiry, the Inquiry records including witness statements and copies of transcripts of oral evidence will be held securely by the Health Authority as custodians under seal.

APPENDIX C

LIST OF WITNESSES CALLED

FAMILY MEMBERS

- Mr Naresh Bavabhai
- Mr N Bavabhai (Brother)
- Mrs S Bavabhai (Mother)
- Mr V Bavabhai (Brother)

BOLTON HOSPITALS NHS TRUST

- Dr A Bashir, SHO in Psychiatry *
- Mr I Chisnell, Community Mental Health Nurse
- Dr W Dougal, Consultant Psychiatrist in Substance Misuse
- Mrs K Gettins, Named/Primary Nurse, Rivington Day Hospital
- Mr B Hogan, Staff Nurse, K2 Ward, Rivington Day Hospital
- Ms R Jackson, CPA Support Officer, Bolton Hospitals NHS Trust *
- Sister P Kenyon, K2 Ward Manager, Rivington Day Hospital
- Sister J Lowther, Ward Manager, Rivington Day Hospital
- Dr K Mahadevan, Consultant Psychiatrist
- Mrs B Martin, Depot Clinic Nurse
- Dr P Reed, Consultant Psychiatrist *
- Mrs E Swift, Community Psychiatrist Nurse *

* Appointments at the time of the homicide.

BOLTON METROPOLITAN BOROUGH COUNCIL

- Mrs J Andrews, Residential Social Worker
- Mrs J Buckley, Principal Officer, Mental Health
- Mrs D Kotecha, Social Worker
- Mrs C Parker, Team Leader, Mental Health
- Ms S Potter, Residential Social Worker
- Ms J Rushton, Residential Warden, Cromford Close, Bolton
- Mr I Smith, Senior Social Worker

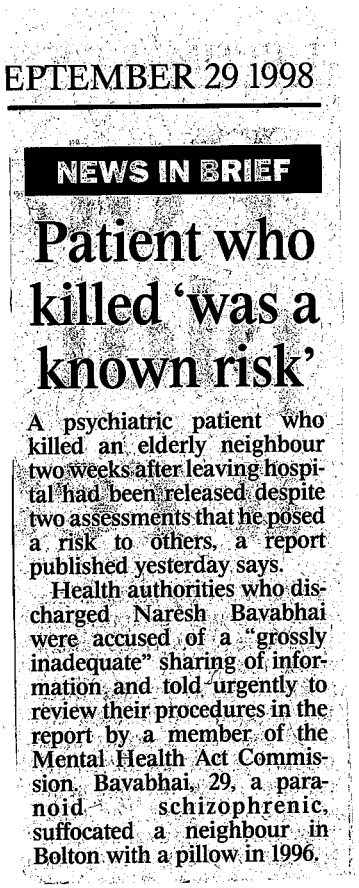
(continued overleaf)

OTHER WITNESSES OF FACT

- Ms C Andrews, Probation Officer, Bolton Probation Service
- Ms J Beale, Organiser, St George's Day Centre
- Dr P Collins, Consultant Forensic Psychiatrist, Wakefield & Pontefract Community Health NHS Trust
- Mr M Gildea, Counsellor, St George's Day Centre
- Dr AJ Quinnell, Senior Clinical Medical Officer, Community Healthcare Bolton NHS Trust
- Ms J Rushton, Residential Warden, Cromford Close, Bolton
- Dr P Saunders, Acting Senior Medical Officer, HM Prison Full Sutton
- Dr P Snowden, Consultant Forensic Psychiatrist, Salford NHS Trust
- Dr RJ Walker, General Practitioner

EXPERT WITNESS

- Dr A Kahn, Consultant Psychiatrist, Woodbourne Priory Hospital, Birmingham



EPTEMBER 29 1998

NEWS IN BRIEF

Patient who killed 'was a known risk'

A psychiatric patient who killed an elderly neighbour two weeks after leaving hospital had been released despite two assessments that he posed a risk to others, a report published yesterday says.

Health authorities who discharged Naresh Bavabhai were accused of a "grossly inadequate" sharing of information and told urgently to review their procedures in the report by a member of the Mental Health Act Commission. Bavabhai, 29, a paranoid schizophrenic, suffocated a neighbour in Bolton with a pillow in 1996.