Reports of the Independent Inquiry into the care and treatment of Simon James Coombe

And

David Gary McMahon

Commissioned by
the Dorset Health Authority and
the Dorset Probation Service

STRICT EMBARGO

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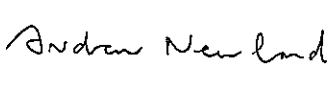
Preface

We were commissioned in September 2000 by the Dorset Health Authority and the Dorset National Probation Service – Dorset to undertake these Inquiries into the circumstances surrounding the care and treatment of Mr Simon Coombe and Mr David McMahon.

We have now completed our reports.

ASWINI WEERERATNE
Barrister



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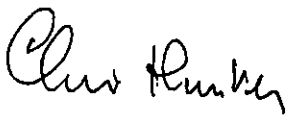

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Abbreviations

ASW	-	Approved Social Worker
CAT	-	Community Alcohol Team
CFT	-	Community Forensic Team
CICB	-	Criminal Injuries Compensation Board
CMHT	-	Community Mental Health Team
CPA	-	Care Programme Approach
CPN	-	Community Psychiatric Nurse
DHA	-	Dorset Health Authority
DSM-IV	-	Diagnostic & Statistical Manual of Mental Disorders (4^{th} edition)
DSS	-	Dorset Social Services pre-1997
MDO	-	Mentally Disordered Offender
MHA	-	Mental Health Act 1983
PDO	-	Potentially Dangerous Offender
RMO	-	Responsible Medical Officer
PTSD	-	Post-Traumatic Stress Disorder
RBGH	-	Royal Bournemouth General Hospital
VRAG	-	Violence Risk Appraisal Guide

JOINT INTRODUCTION

SIMON JAMES COOMBE

DAVID GARY McMAHON

1. This report sets out the findings and recommendations of two inquiries into the care and treatment of Simon Coombe and David McMahon. The inquiries are jointly sponsored by the Dorset Health Authority and the Dorset National Probation Service. They were established under NHS Executive Guidance (HSG(94)27) following the murder of Michelle Lock on 1 April 1998 by Mr Coombe and of William Bodle by Mr McMahon on 2 June 1998. Both are now serving life sentences for murder. Mr Coombe was sentenced following a guilty plea to murder on 24 March 1999. Mr McMahon pleaded not guilty to murder and was sentenced following conviction at trial on 22 February 1999.

2. The Inquiry Panel is the same as that which reported on the care and treatment of Shane Bath (July 2000). These two inquiries were formally established in September 2000 and were run in tandem through 2001.

3. Membership of the panel comprised Ms Aswini Weereratne, barrister (Chair), Dr Chris Hunter, consultant forensic psychiatrist and clinical director of the Caswell Clinic, South Wales and Mr Andrew Newland, mental health services consultant and former social services manager in Hampshire.

4. Due to substantial professional commitments, it was agreed that Dr Hunter's contribution to these inquiries would be limited to the preparation for, and attendance at, the hearings. He provided characteristically insightful comments during the writing process which was undertaken by the other panel members.

Simon James Coombe (d.o.b 30 January 1971)

5. Simon Coombe's main contact with Dorset mental health services was as an in-patient when he came under the care of the Community Forensic Team (CFT) and St Ann's Hospital, Poole in 1997. He had also been assessed in 1993, at the request of the probation service, by the CFT, Community Alcohol Team and a psychiatrist. He was subject to probation supervision in 1994. A further two probation orders (one with a condition of treatment) were made in 1997 and were in place at the time of the murder of Michelle Lock in April 1998.

6. Mr Coombe was not diagnosed as suffering from any mental illness. He did, however, display behavioural problems which required understanding and analysis together with the effects, if any, of a severe head injury in 1990 which was a complicating feature of his presenting problems. Prior to this he had been seen by a consultant at St Ann's as a result of his first criminal charge in 1989. He was assessed as developing a sociopathic personality disorder and no treatment was offered.

7. His history contained a few minor offences. There was no history of violence, proved or unproved prior to the murder, but a distinct penchant for grandiose stories, sometimes involving his own violent acts which were patently untrue. His father described him as living in a fantasy world which was unaffected by the 1990 assault and in respect of which he had subsequently shown some signs of maturity. As an inpatient at St Ann's

Hospital, Mr Coombe displayed an over-familiar interpersonal style with female staff and patients that was attributed to his immaturity.

8. Mr Coombe was assessed by Dorset mental health (and addiction) services as a probation referral (1993). He was supervised by the Dorset probation service following a probation order (1993/4) and again by the probation and mental health service on transfer from prison whilst on remand to in-patient status at St Ann's for assessment under the Mental Health Act 1983 (MHA). Thereafter he was seen by the probation and mental health service following a probation order with a condition of treatment (1997/98). The consultant forensic psychiatrist who assessed him after the murder of Michelle Locke (April 1998) on behalf of his defence team concluded that he was not suffering from any mental disorder which would bring him within the MHA, personality disorder, mental impairment or severe mental impairment or any mental illness. Our interview with him confirms that Mr Coombe remains an unusual young man who has woven a fantasy life involving gangs and a twin brother around himself.

9. Throughout his contact with services Mr Coombe was assessed to present a low risk of harm to others, an opinion with which we do not disagree.

10. Mr Coombe was seen by the Chair, Mr Newland and the Inquiry Manager at HMP Wakefield on 2 April 2001. Dr Hunter was unable to see Mr Coombe but was provided with the transcript and tape of the interview.

David Gary McMahon (d.o.b. 23 February 1965)

11. Mr McMahon's first contact with Dorset mental health services was also initially via the probation service when he was referred for assessment to the CFT, CAT and a psychiatrist in 1993 following a charge of actual bodily harm and then of driving with excess alcohol and criminal damage. Unlike Mr Coombe, it was clear that his background was one that involved a great deal of violence and from a young age; he was born and raised in the Protestant Ardoyne area of North Belfast. He was brought up in the thick of the "Troubles" and gave us a vivid description of his childhood when we interviewed him. He proceeded into Loyalist paramilitary activities and ultimately fled Belfast for England in 1986 after he was shot in both legs in what appears to have been a punishment shooting. His time in England was itinerant until he arrived in Dorset in about 1992, and characterised by a constant awareness of potential danger from Irish Republican sources. He was continually looking over his shoulder.

12. In 1994 he was subject to a probation order with a condition of attendance at an anger management group. This he breached and he was made subject to a two year probation order without conditions in early 1996. This order came to an end in March 1998, three months before the murder of William Bodle in June 1998.

13. Mr McMahon has a recorded history of violence, with a temper he had difficulty controlling and which was exacerbated by alcohol. Subsequent to the murder the evidence is that he is likely to suffer from a severe anti-social personality disorder of a kind falling within the definition of psychopathic disorder within the MHA. Additionally, probably as a result of his experiences in Northern Ireland and being shot himself, he developed symptoms of post-traumatic stress disorder which also is known to act as a trigger to the abuse of alcohol and violent behaviour. This was first noted in

1993. There was never a full assessment of these features of Mr McMahon's presentation, nor an appreciation of his potential for causing harm to others.

14. He committed two serious assaults in 1990 in Leicester resulting in convictions for grievous bodily harm and actual bodily harm and an eighteen month sentence of imprisonment. He suffered a paranoid episode on release and referred himself to the Leicester General Hospital. A MHA section was proposed but not supported by the approved social worker and he was discharged.

15. Mr McMahon experienced Dorset mental health (and addiction) services as a probation referral (1993) and he was under prolonged probation supervision between 1994 and 1998. There was a probation High Risk conference and a CFT referral in late 1997. Thereafter he was assessed on an urgent domiciliary basis at the end of May 1998 by his general practitioner and a consultant psychiatrist from the North Bournemouth Community Mental Health Team (CMHT).

16. Mr McMahon was interviewed by Dr Hunter on 17 January 2001, and later by the Chair, Mr Newland and the Inquiry Manager at HMP Kingston on 4 September 2001. It was not possible for him to be seen by all panel members at the same time due to illness.

Joint report

17. These reports are being published together because they concern (1) the functioning of the **CFT** in 1993 shortly after it was set up and again in 1997/98. They relate to the quality of its assessments and treatment on probation referral of out patients, of in-patients at St Ann's Hospital and follow up in the community. (2) The role played by the **probation** service in obtaining assessments of and supervising offenders with mental health needs. These are the main services referred to below. Other services commented on include social services.

18. The "Trust" referred to throughout this report is the Dorset Healthcare NHS Trust responsible for the CFT and St Ann's Hospital, Poole. The "probation service" is the Dorset Probation Service. The "social services" are those provided either by Poole or Bournemouth Borough Councils and identified accordingly within the text of the reports.

19. As far as the CFT is concerned the context is provided by the Shane Bath report (2000) and the criticisms made about the lack of forensic expertise and leadership within that team. This service is no longer in existence and has been replaced by the Dorset Forensic Service under the leadership of a consultant forensic psychiatrist. It is our belief that the findings and recommendations in these reports will be relevant to this new service.

20. Local forensic and probation services have a high public and media profile and are now expected to play a key role in offering protection to the public. In doing so, joint agency documentation espouses a clear commitment to the principle, promoted in the Reed Committee Report (1992), of delivering services within the least restrictive environment and which we endorse.

21. These two reports illustrate the difficulties faced by probation and community mental health services burdened by the demand to ensure public safety. Those with mental health needs rarely present services with clearly defined problems with clearly defined solutions. Services need to be able to deal with presentations that are more complex if they are to come close to meeting the expectations that exist of them. In the Shane Bath report, we referred to the need for a "holistic" approach. This goes beyond tackling the problems with the "core principles" which we discussed in that report, of information gathering, checking, communication, risk assessment and the use of the care programme approach. There are also important issues to do with the definition of services and what they are capable of dealing with, the use of unsubstantiated allegations (of violence and indecency in these two cases), hierarchies between services, risk assessment, including the wide spread introduction of actuarial tools and the use of and definition of terms such as "high risk".

22. It must also be recognised that the limitations, particularly of resources but also of expertise, within which these services function mean that they effectively operate to contain a situation until it explodes into a crisis. Prediction and prevention of harm are clear and laudable aims that are difficult to achieve.

23. Throughout the analysis of the events relevant to the murders of these two people, Michelle Lock and William Bodle, the Inquiry Panel has applied the standard of reasonable and acceptable practice on a balance of probabilities. Great efforts have been made to avoid analysis or criticism using hindsight. Ultimately, there are criticisms to be made and the Inquiry Panel has been guided by the desire to be fair and constructive in this process.

24. It is also possible in an inquiry process to lose sight of the fact that two people are dead. This is as much true of the inquirers as of those being inquired into. This is an intrusive and uncomfortable process but openness and accountability require that there be a proper, in depth and independent investigation with a view to providing robust services. Our aim is to promote accountable and defensible practices with a view to increasing public confidence in this sensitive area of service provision.

25. It should be stated that virtually no one we heard evidence from in this inquiry seemed to us to be uncaring, uncommitted or unwilling to consider that they may have made some mistakes. We should remember that they are working in a service bombarded by demands, not always appropriate, for advice, assessment and interventions. The work is often stressful and public expectations can be unrealistically high.

26. We present our findings and conclusions in relation to Mr Coombe first, followed separately by those relating to Mr McMahon. There is no significance in this order of presentation. There then follows a chapter on risk assessment and a concluding comments chapter in which we have attempted to draw together those issues which are common to both reports including management accountability.

Procedures

27. The Terms of Reference and procedures for these inquiries are reproduced at Appendices A and B. A list of witnesses written to and those who gave oral evidence is at Appendix C for the Coombe inquiry and at Appendix D for the McMahon inquiry. These include expert witnesses in various disciplines. A list of recommendations is at Appendix E.

28. Hearings were held on various dates throughout 2001 at the offices of the transcription writers Harry Counsell Limited in Fetter Lane, London. A daily transcript was produced.

Family

29. Members and friends of the Lock family were seen informally by the Chair and Inquiry Manager. We are grateful for their involvement and assistance. The immediate family of Mr Bodle was approached by the inquiry and the panel respects their wishes not to be directly involved in the inquiry process.

30. The Chair and Inquiry Manager were also pleased to be able to take evidence from the mothers of both inquiry subjects, Mrs Helen Coombe and Mrs Ruth McMahon. They were open with their evidence and provided the inquiries with invaluable information.

Acknowledgments

31. The simultaneous running of two inquiries with the attendant document gathering, sorting, witness liaison, and time-tabling is a feat requiring the utmost efficiency, doggedness and good humour. We were highly fortunate that all of these qualities were provided in ample measure by the superb Mr Andrew Hepburn. The fact that both inquiries have been completed in just over a year is a testament to his commitment and vigorous attention to detail.

32. We are also indebted to Mr Peter Lownds, a barrister at Doughty Street Chambers, who greatly assisted the considerable task of fact and issue management by his cool analysis and calm and thoughtful questioning of witnesses at hearings. We found that this procedure of having the questioning led by a non-Panel member acted to focus the sessions with witnesses and to keep them as brief as possible.

33. We would also like to thank all those who provided evidence to these inquiries for their co-operation and patience. We also thank Mr Coombe and Mr McMahon for their co-operation.

34. We must also thank Harry Counsel Limited and all its staff, firstly for providing excellent premises and facilities for the inquiry hearings at highly competitive rates and secondly, for being so friendly and flexible to our needs. We thank June Martin and Ivan Trussler in particular.

35. Lastly, we would like to thank the Governors of Her Majesty's Prisons Wakefield, Longlartin and Kingston for providing facilities for interviewing Mr Coombe and Mr McMahon.

Chapter 1

SIMON JAMES COOMBE
(d.o.b. 30 January 1971)

EARLY HISTORY AND BACKGROUND INFORMATION

MENTAL STATE AND BEHAVIOUR

Summary:

The available information about early history revealed, amongst other things:

a. Mild learning difficulties
b. Divorced parents
c. Lack of concentration and restlessness
d. Living in a fantasy world
e. Few friends and no girlfriends
f. Petty offending
g. Reference to adolescent psychiatrist
h. Immaturity
i. Peripatetic and unsettled lifestyle
j. Weak verbal skills
k. No mental illness

The only available attempt at a formal diagnosis was in 1990: "predominantly sociopathic type of personality disorder, and deeply ingrained immature and maladaptive patterns of behaviour, probably caused by the break up of his parents marriage".

Following the murder of Michelle Lock the childhood behaviour was considered to fulfil the criteria for a diagnosis of hyperkinetic conduct disorder. There was no assessed personality disorder (psychopathic), mental illness or mental impairment falling within the Mental Health Act 1983.

EARLY HISTORY: sources of information

1. We have uncovered little more than broad themes about Mr Coombe's behaviour during childhood and the details remain elusive. An educational guidance assessment in 1986 has been of assistance and provided a benchmark against which later assessments may be judged. The main themes include living in a fantasy world, attending a special needs school (although the educational guidance report when he was fifteen concluded that he could have been educated within a mainstream school), truancy, and lacking concentration. He is said to have taken the divorce of his parents badly, but there is nothing to suggest that his behaviour changed significantly after this time.

2. We have had the opportunity to speak to Mr Coombe's mother. We are grateful for her time in discussing with us matters that are clearly painful to her.

3. We have also relied on general practice records in putting together this summary of Mr Coombe's early history.

4. These sources provided important information for any assessment of Mr Coombe's mental state, behaviour and, in particular, the impact of a severe head injury received after an assault on Mr Coombe in 1990. It was readily available information. The educational assessment, was available to those assessing Mr Coombe from his first contact with mental health services at St Ann's Hospital, Poole in 1989, but not to Dr Nick Moffat, chartered clinical psychologist, who assessed him in March 1997.

5. Some of this information was gleaned by nursing staff during his in-patient stay at St Ann's hospital in 1997. The second half of this chapter summarises the various psychological and psychiatric assessments made of Mr Coombe's mental state and functioning before and after the murder.

Birth to 1991 (age 20)

6. Mr Coombe was born on 30 January 1971 at the British Military Hospital, Munster, Germany. He is the older of two children and has a younger sister who was also born in Munster. Their father was in the armed services.

7. The family lived in Munster until Mr Coombe was four years old when they moved to Catterick, Yorkshire for two years, and returning to Osnabruck in Germany for a further year. When Mr Coombe was aged about seven or eight the family moved again to Chester and then to Dorset. His parents divorced in 1981 and his mother has remained in Dorset. His father has remarried and lives in Chester.

8. From an early age he did not progress well at school and seemed to lack concentration. In 1978, he attended Beaucroft School, Wimborne a school for children with learning difficulties of a moderate nature. He had friends at school and played in the football team. There were no real concerns about him at this stage, but there are accounts of his living in a fantasy world even before his parents' divorce. In spite of attending a special needs school, it is recalled that he was always good at mental arithmetic and card games, a talent which he retains and has been noted more recently by prison officers.

9. Mr Coombe reacted badly to the divorce of his parents and he was seen by an educational psychologist at his mother's request at this time. Later he began to play truant from school and at around the time of puberty he started to become more isolated and engrossed in his own world.

10. He left school at sixteen and enrolled on Youth Training Schemes in carpentry and computer work with which he appeared to become bored. He had minimal contacts with the police as a result of two minor incidents of drunkenness and a broken window in a cash and carry. It is apparent that he was always easily led by others and this would get him into trouble.

11. When he was seventeen he suddenly left his mother's home for London and she had to fetch him home. On his return she had him referred via his general practitioner to an adolescent psychiatrist and this must have reflected her level of concern at his

behaviour. The response we have seen is from the social worker who conducted a joint assessment with a psychiatric registrar.

12. The GPs referral (our copy is very poor) notes a psychological assessment in 1977 at the request of his headmaster. This is likely to have been while the family was still in Germany and there is no copy of any report on the GP notes we have seen. The GP summarises the report however and notes poor concentration, and restlessness. It is possible to discern that he had very poor auditory memory and some language problems. The GPs comment is that *"this seems quite an aggressive set of [illegible] to make on a 6 year old"*. It had been concluded that Mr Coombe had characteristics of a psychologically abnormal child. The GPs impression was of a *"simple lad with a very flat affect, little ambition and little idea of what he wants to do with his life."* The Army had rejected him.

13. The social worker's response (September 1988) agreed with the comments in the referral letter. Mr Coombe opened up to him and the psychiatrist, and they felt he was living in something of a fantasy world. No follow up was offered except for contact in the future if there were any concerns. Mr Coombe was almost eighteen by this time.

14. He left home again when he was eighteen. At this time, he was still an immature boy and it is recorded that some of his family considered that he had a mental age of about an eleven to thirteen year old.

15. He returned home to live with his mother again briefly in about April 1991 when he was twenty after receiving treatment in hospital, following an assault resulting in a serious head injury in late 1990 (chapter 2). This was the last occasion on which he lived at home for any length of time. He then began living in various bed-sits in the Bournemouth and Boscombe areas. He maintained periodic contact with his mother thereafter. This pattern of living continued up to the time of the murder of Michelle Lock in 1998.

16. There is no mention of any lasting relationships with women at any time in his history. He referred to himself as bisexual during his in-patient period in 1997 and has at times also referred to being raped by an unknown man.

17. Mr Coombe and his sister have been described as "chalk and cheese". She has completed her education to university level and is now married. Mr Coombe has never held a job for any period and has had an unsettled, peripatetic lifestyle. There is no record that he abused drugs and alcohol before the age of nineteen in 1990. Thereafter, it does feature in his presentation largely through self-report, which is confounded by his tendency to exaggerate rather than objective measurement. The level of his subsequent abuse of drugs and alcohol has never been determined with any accuracy but it seems likely that he exaggerated his use of both.

ASSESSMENTS: MENTAL STATE AND BEHAVIOUR

Educational guidance report: 10 June 1986 (aged fifteen)

18. On a Wechsler Intelligence Scale for Children (revised) administered for the purposes of this report, Mr Coombe achieved an IQ score of 105 which is in the upper half of the

average range. This was said to conflict with his attendance at a special needs school. Although this was noted to be above the average range for children who took CSE examinations, it was below the average for those taking 'O' levels and it was suggested that his education be planned with CSE examinations as the goal.

19. It was noted that Mr Coombe's verbal skills were considerably weaker than his non-verbal skills and a significant 24 points difference was noted. At this time, his reading age was consistent with an age of 10.2 years and spelling at 9 years. This is consistent with testing after the killing of Michelle Lock. The report concluded that Mr Coombe's education had been affected by a moderate degree of specific dyslexia "together with the normally associated weakness in immediate verbal memory, in the setting of otherwise average underlying ability". His mental arithmetic, on the other hand, was above average for his age (there is other evidence of his ability of this from his mother and, more recently, prison staff).

20. On other tests (Kuder Preference Record) the report concluded that Mr Coombe would be suited to a career involving office work, book-keeping or accounts. On personality factors, he scored "very high" on "deference", which indicates a willingness to give in to the wishes of others. He also scored "above average" on "nurturance", a liking for looking after the welfare of others, "affiliation", a liking for group work and loyalty and "succourance", a need for the support of others. Taken together, the author states that these scores indicate a preference for "functioning as a member of a mutually supportive team, rather than solely as an individual". This fits with Mr Coombe's propensity to be easily led, which was a regular feature of his life.

21. The report concluded on a positive note that:

> "*in the long run, it is quite clear that Simon is more than capable of maintaining a totally independent existence, and there is no reason why he should not achieve a fruitful life, both in terms of career and socially as well.*"

It is clear from his later life, that Mr Coombe did have sufficient basic living skills to survive on his own and find his own accommodation.

22. We have tried to investigate as far as possible the differences between these findings and those of subsequent assessments, in order to determine whether the head injury in 1990 had any impact on his cognitive functioning and behaviour. The facts surrounding this event are dealt with in chapter 2. Although this report appears in the Dorset Healthcare records, it was not available to those Trust psychologists who assessed Mr Coombe prior to the murder.

Subsequent assessments: effect of 1990 head injury

23. These were carried out at St Ann's by Dr Nick Moffat, chartered clinical psychologist, in 1997 and after the murder by Dr Mary Hill, chartered clinical psychologist at Broadmoor Special Hospital. They concluded that Mr Coombe's intellectual ability lies within the poor to average range with an IQ of 77 i.e. lower than in 1986. His reading age is ten years and six months i.e. on a par with his general intellectual resources. Neuropsychological testing has also suggested that his abilities are unlikely to have been significantly affected by the head injury in 1990. He was not assessed as suffering a degree of mental impairment sufficient to fulfil the criteria within the Mental Health Act 1983.

24. Dr Hill concluded:

> *'Both the variability in Mr Coombe's test attainment, and the nature of some specific disabilities, e.g. poor attention, are suggestive of some degree of underlying pathology, but it remains unclear how far this can be attributed to the head injury..... and how much this could have been present throughout life'*

25. Neither Dr Moffat nor Dr Hill had available the 1986 report. The Inquiry was keen to find out whether there was any discernible effect on Mr Coombe's functioning and behaviour caused by the head injury in 1990. The test results show some variation but these cannot be attributed to any organic cause such as the head injury in 1990.

26. Dr Andrew Payne, a consultant forensic psychiatrist from Broadmoor Special Hospital, who assessed him in October 1998 pre-trial, was of the opinion that his behaviour in childhood fulfiled the criteria for a diagnosis of a hyperkinetic conduct disorder. In his view, however, features of Mr Coombe's behaviour at this time and subsequently did not amount to a personality disorder, nor particularly a psychopathic disorder within the meaning of the MHA. Nor in his view does he have a diagnosis of mental illness within the MHA.

27. Prior to this the only psychiatric diagnosis of significance was contained in the court report of Dr S. Rastogi, consultant psychiatrist, based at St Ann's Hospital, Poole in April 1990. In this it is noted that Mr Coombe started to steal from about the age of ten and has the "ambition to become an international criminal." Dr Rastogi concluded that Mr Coombe suffered from a

> *"predominantly sociopathic type of personality disorder, and deeply ingrained immature and maladaptive patterns of behaviour, probably caused by the break up of his parents' marriage. He does not suffer from mental illness."* (see chapter 2).

This assessment was echoed by Dr Franklin, consultant psychiatrist, in 1993 in another court report (see chapter 4).

28. There was no diagnosis or formulation of Mr Coombe's mental state during or following his admission to St Ann's in 1997. He was admitted to hospital due to his odd and anxious behaviour. A diagnosis of "depression" was used to justify the use of the MHA at that time, but there was no evidence of any depression. Dr Rowton-Lee favoured the term "covert depression" to refer to what was in his view the likelihood of an underlying illness which had yet to manifest itself. This was a default diagnosis which he relied on regularly in our experience and which is not described in standard psychiatric texts (Shane Bath and David McMahon. See chapter 7 paras 78 and 86 for more on this diagnosis).

29. Indeed the best description of Mr Coombe is that he is an inadequate and vulnerable young man who lived a fantasy life which appeared to become more intense at times of trouble, and which was there from childhood. His fantasies included having a powerful twin brother with whom he swapped identities. In his imagination, the brother had underworld connections and would turn up in difficult times to help him out. Mr

Coombe also often said he had several children of his own, including twins living in Alaska. He was fascinated with gangsters and being tough. At the time of admission to St Ann's he spoke of shooting six policemen in San Francisco. This was clearly untrue. He was easily led and a number of his offences which were on the whole minor, were committed in the company of other more experienced offenders.

30. The fantasising was at least on one occasion described as a "confabulation", the precise definition of which is the fabrication of "imaginary experiences as compensation for the loss of memory" (*Concise Oxford Dictionary (1990)).* It also has a more limited technical use in this sense within psychiatry also. There is no evidence that this was the way in which it was used in relation to Mr Coombe and although he had been referred for the assessment of self-reported "absences" prior to the head injury in 1990, any potential confabulation was never further investigated.

31. There is no proper documented evidence of physical or verbal aggression prior to the murder. We have seen one report of some aggression to those he considered weaker than himself in 1993. This was made to the police after the murder. A reference to aggression at Dorset Lodge by the Community Forensic Team CPN, Phil Rowe in 1997 was not elaborated upon. By contrast he has also been described as being disarmingly polite -e.g. holding doors open for women. The only act of violence is a rather unusual one in which he slashed another prisoner while on remand in prison in late 1996. A prison adjudication found that this was at the request of the other prisoner.

32. Mr Coombe was always assessed as a low risk of harm to others and this is not open to criticism.

Chapter 2

1990: FIRST CONTACT WITH ST ANN'S HOSPITAL, POOLE AND PROBATION SERVICES

SERIOUS ASSAULT AND HEAD INJURY

Summary:

These first assessments as an adult show that Mr Coombe's mother was having difficulty coping with his behaviour at home. They also record the same type of fantasies recounted at later stages and so would have been important for subsequent assessments. They do appear on his Trust records and would have been available to those assessing him later. His vulnerability was increased following a severe assault which resulted in a serious head injury, after which there was a lack of formal social services involvement particularly with the issue of accommodation.

Introduction

1. Between March 1990 and August 1991 Mr Coombe (aged nineteen) was convicted for the first time, had his first contact with the mental health services and probation, was investigated for the possibility of epilepsy, subsequently received a serious head injury arising from an assault and underwent inpatient investigations into the possibility of brain injury as a result. He left his mother's home, moved to private hostel accommodation and then to Portland near Weymouth. His capacity for fabrication and fantasy was increasingly noted.

Offending

2. In March 1990 Mr Coombe was charged with offences of begging, theft and criminal damage. A probation officer completed a report for the court from which it appears that Mr Coombe was drunk in company with three acquaintances when he approached people using a public park in Bournemouth and asked them for money. The criminal damage (breaking into a garage) and theft offence occurred in Poole on the same day.

3. The probation officer mentioned that Mrs Coombe had told him that her son was *'hyperactive and suffered from a lack of physical co-ordination and concentration'*. While Mr Coombe gave an accurate account of his family background on this occasion the probation officer commented on his claim that he had a friend, living abroad, who was a *'master criminal'* involved in serious crimes including murders. Mr Coombe had told him that this friend contacted him when he needed various jobs doing and that he, Mr Coombe, wanted to become very wealthy through crime. He claimed that he could make his mother cry at will and induce his stepmother to *'break down'*.

4. According to the probation report Mr Coombe had run away from his mother's home about a year previously, going to London from where his mother collected him. Now apparently *'at the end of her tether'* she arranged for him to stay with his father for month. On his return she would not have him back and he went to stay at Dorset Lodge,

a probation hostel, and then at various hotels and bedsits between July 1989 and February 1990. He also spent some time in local "squats".

5. In view of the fantasies he had expressed, and other worrying remarks by Mr Coombe, the probation officer recommended that a psychiatric report be obtained before the court took any further action.

First contact with mental health services

6. Dr Sudhir Rastogi, consultant psychiatrist from St Ann's, submitted a report to the court dated 26 April 1990 in which he briefly noted Mr Coombe's background, including his habit of telling lies, and concluded that there was no evidence that he had any kind of mental illness:

> *'... he suffers from predominantly sociopathic type of personality disorder, and deeply ingrained immature and maladaptive patterns of behaviour, probably caused by the break up of his parents' marriage'*

7. He made no recommendations to the court as to disposal and Mr Coombe was given a twelve month conditional discharge and ordered to pay compensation.

8. A clinical note of his interview with Mr Coombe made on 19 April gave a brief account of his recent offending. He claimed that he had two half brothers, from his mother's "third marriage", aged four and five, that he had ambitions to become an international criminal and wanted to set up a business to export stolen goods. Dr Rastogi observed that he had difficulty in separating fact from fantasy.

9. Mr Coombe went on to tell Dr Rastogi that he had been offending since the age of 10 1/2 years, that he had drunk heavily in the past but had never taken illicit drugs apart from sniffing glue for a while. He was apparently obsessed with gangster films.

Investigations for epilepsy

10. Also in April, Mr Coombe's GP had written to Dr C.J.K Ellis at the neurology clinic at Poole General Hospital asking if they would investigate the possibility of epileptiform episodes in the context of reports from him of brief momentary losses of vision. The GP advised that it was extremely difficult to obtain an accurate picture of the symptoms because of Mr Coombe's difficulty in expressing himself.

11. Dr Ellis saw him on 17 September 1990 and in a letter back to Mr Coombe's GP, written the same day, stated that Mr Coombe was *'intellectually rather slow and vague'*. He could not fix on any obvious explanation for the reported symptoms and speculated a differential diagnosis of epilepsy, migraine or a structural brain lesion. A MRI brain scan and an EEG were arranged. These were never undertaken due to the occurrence of the assault in November 1990.

Drug and alcohol services

12. From a referral letter dated 12 October 1990 from Mr Coombe's GP to Dr Nas Choudry, consultant psychiatrist and specialist in addictions at St Ann's, dated 12 October it is apparent that he had moved to Dorset Lodge as a *'temporary resident'*. The GP advised Dr Choudry that Mr Coombe apparently had a long history of alcoholism and drug abuse, that he was depressed but not suicidal and there were no psychotic problems. It seems that by this time he had become estranged from his mother and had left home. The GP describes Mr Coombe as unkempt, unshaven, smelling of alcohol and with poor concentration. He asked Dr Choudry if he would assess him *'possibly for detoxification'*. There are no records of any assessment being undertaken at this time. This may also be due to the intervening assault.

Comment

13. Mr Coombe had a tendency to fabricate events and the degree to which he indulged in substance misuse. At one point he advised an assessing doctor that he drank five or six bottles of Bacardi a day. However, there is little evidence that regular and/or heavy substance misuse was a part of his life although he almost certainly took cannabis at least intermittently and drank alcohol regularly.

14. Claiming to drink far too much and seriously misuse substances was probably part of his wider fantasy that he was outside the law, an international criminal involved in serious thefts and *'taking out'* other criminals.

15. We consider that the difficulties encountered within the family home were normal in the context of a troubled adolescent. Mrs Coombe did all that was possible for a mother to do to contain and help Mr Coombe.

Assault: November 1990

16. On 17 November 1990 Mr Coombe was seriously assaulted in the Weymouth area. He was by then living in Portland, where he shared a bedsit with a man who had found him in bed and suffering from what he thought was an *'asthmatic attack'*. An ambulance was called and Mr Coombe was immediately moved to Weymouth and District Hospital where he where he was placed on a ventilator.

17. Because he was noted to be only partly conscious with symptoms of possible neurological trauma he was transferred immediately to the Wessex Neurological Centre at Southampton General Hospital under the care of Professor J Pickard. Here he was noted to have obvious bruising around the eyes, to be irritable and, with no spontaneous eye opening. He was making incomprehensible sounds. However, the usual haematological, and biochemical investigations showed him to be within normal limits.

18. He improved slowly over the next three days and as he did not require any further specialist care at this unit he was transferred back to Weymouth and District Hospital on 20 November 1990. On transfer it was noted that a pioneering computer programme of the time gave him a 92% chance of a moderately good prognosis.

19. By 11 December 1990 Mr Coombe was well enough to be discharged home. He had indicated that he wanted to go to his friend's accommodation in Portland that he had shared prior to the assault. As this flat only had one bedroom and his friend had offered to look after him, a junior hospital doctor involved in his outpatient orthopaedic care wrote to the borough council on 10 January 1991 asking if they could provide this man with a two bedroomed flat to enable him to do this. On 30 January 1991 the director of public health at the health authority supported this application.

20. An A&E consultant reviewed Mr Coombe on 7 February 1991 and advised his GP that he had made '*an excellent recovery*' although he was still suffering from some tiredness in the evenings:

> *'On testing his memory and intellectual ability today it is, I think, back to where it was prior to the head injury'.*

21. He did not attend appointments with Dr Ellis on 18 March or 24 June 1991.

22. On 22 May 1991 the police requested a medical report from his then GP in connection with proceedings against the two men who had been charged with his assault. He wrote back to the police on 10 June saying that he had examined Mr Coombe the previous week and found that he still suffered from *'extremely poor memory.... his speech is slurred and hesitant and he tells me that he thinks his ability to think is slowed up'*. Mr Coombe also still complained to his GP of transient problems with visual disturbance, especially at night.

Comment

23. This is an important part of Mr Coombe's history. It is not clear, from the evidence at this time, what the implications might be of this kind of brain injury on his future behaviour. The conclusions of subsequent assessments have been that this injury is unlikely to have made any significant difference to his future behaviour, though there may have been some effect (see chapter 1).

24. In February 1994 Dr Ianotti, senior lecturer and honourary consultant neurosurgeon at the Wessex Neurological Centre prepared a report for the Criminal Injuries Compensation Board in connection with Mr Coombe's claim for compensation for injuries received in the 1990 assault. He concluded that it was probable that Mr Coombe had pre-existing problems, such as learning difficulties, but the head injury added to his difficulties. This conclusion does not detract from the other assessments referred to above.

25. Another difficulty in drawing firm conclusions from this event is that the severity of his injury is not clear from the notes of the first three days following the assault. The level of his coma remains unclear and there is no information about his post-traumatic amnesia or other aspects of his mental state although that would have been more apparent subsequently.

26. On the balance of probabilities, the expert instructed by the Inquiry takes the view that Mr Coombe was of previous low ability and may well have had pre-existing problems with attention or impulsiveness. He probably sustained some degree of brain injury in 1990 and this was probably severe enough to have some further adverse and permanent effect on the control of his behaviour. However these were not extreme changes relative to most others in the population of those who have been brain injured.

27. We accept on the basis of the above, that any difference made to Mr Coombe's behaviour and functioning after the head injury was marginal.

Accommodation

28. During this period Mr Coombe moved several times. GP records, other health service records and the probation report indicates that he had at least six addresses during this time, two in Portland and four in the Bournemouth/Poole area. It seems he finally moved away from the family home in Corfe Mullen sometime around April or June 1990.

29. After that he lived in a mixture of rented hotel and bed-sit accommodation until he moved to Stillwaters, a privately operated, supported accommodation facility in Poole. There were issues surrounding his accommodation on discharge from Weymouth and District Hospital.

30. He moved away from the Portland area shortly after his friend obtained medical approval for his housing application. So far as we are aware nothing came of the bid for him to be looked after by his friend.

31. We know that he was at Stillwaters, a private residential care home in Poole, in August 1991 and had probably moved, or been moved, there some time before then.

Comment

32. It may be surprising that in view of the accommodation issues pre-discharge from Weymouth hospital he was not, as far as we know, referred to social services for assistance with this. Certainly after the head injury and at least in the short term while its aftermath was addressed, Mr Coombe's vulnerability indicated a need for support and help with finding suitable accommodation.

Chapter 3

SOCIAL SERVICES INVOLVEMENT: 1992 to 1993

Summary:

Contact with social services (Dorset) took place on an unclear and ad hoc basis. There was no attempt to understand Mr Coombe's recent history involving contact with the criminal justice system and, more importantly, his head injury. There was an absence of any assessment or planning in relation to his needs as a vulnerable person. There was more evidence of fantasising and overall his presentation appears to have been consistent with later periods in his life.

There was a lack of clarity, including poor record keeping, around his contact with social services services. He lived in two supported care homes in Poole in this period: Still Waters and Bridge Corner House. Mr Coombe did not present or experience any great crisis at this time.

Introduction

1. This (aged twenty-one) was Mr Coombe's most sustained period of contact with social services. We include it here for two reasons. Firstly, it provides the only real opportunity to consider the actions of social services with regard to his needs and secondly, it gives some indication of his behaviour and lifestyle after the head injury in 1990. Records for this period are, however, sparse and there are none surviving from the two supported care homes in Poole: Stillwaters and Bridge Corner House.

2. Mr Coombe had moved to, or been moved, to Stillwaters in 1991. After a brief period of homelessness and a succession of private living arrangements he moved to another supported care home, Bridge Corner House. Both homes quickly became aware early on of his tendency to fantasise and at least one of them reported their concerns about this to social services. There was no offending during this period.

Stillwaters

3. The first note we have seen of contact by Mr Coombe with social services was on 11 December 1990 when a computer record indicates that he referred himself. This was coded as a request for *'support'*. Nothing further about this contact is known.

4. In 1991 social services maintained a liaison role with Stillwaters, a private residential care home in Poole. From July 1991 this was undertaken by a social worker with the rehabilitation team at the Poole north office, Mrs Audrey Rumney. She briefly mentions Mr Coombe in her file on the home on 13 August 1991.

5. The joint proprietor of the home has advised us that Mr Coombe was at Stillwaters for between one to two years during the 1990s and that he was placed there by social services. There is nothing in the social services records available to us that specifies

even approximately when he might have been placed there, or even if he was placed there (by them). All we can say with certainty is that he was there between August 1991 and November 1992.

6. In a statement to us, a member of staff at Stillwaters described Mr Coombe as:

'a somewhat awkward person, easily led - (liable to) get in with a bad crowd'

7. Another care worker at the home stated that Mr Coombe was *'a lovely person'* but one who wanted constant attention from the all -female staff. She did not recall that he drank to excess or that he abused drugs.

8. Mrs Rumney's role was that of liaison with Stillwaters and Mr Coombe was not a client of hers. Nevertheless she took on the role of duty social worker to him in respect of a claim made against him by the driver of a car in front of which he had walked and collided with, causing some minor damage to the car. She dealt with the defence and counterclaim as the duty social worker was off sick. The outcome of this claim is not clear.

9. A reference was made, in a later social services referral, to the case having been closed to Mrs Rumney on 13 January 1993 although it is not clear from earlier records that the case was ever formally opened to her. A later social services emergency duty team referral states that the case was closed to Mrs Rumney in March 1993.

10. Mr Coombe visited social services on 10 March 1993 having left Stillwaters on 24 November 1992, describing it as *'like a prison'*. He produced a summons for non payment of community charge and a bailiff's notice. social services arranged for Mr Coombe to visit the town hall and discuss this problem directly with the staff there. It was noted that he was of *'no fixed abode'* (even though a Bournemouth address was recorded) and might come to their attention again. The duty worker noted that Mr Coombe *'lacks ability to cope with life on his own'*. No further action was taken.

Bridge Corner House: June 1993

11. From the general practitioner's notes, social services records, and correspondence with his solicitor it seems he had at least four different addresses between leaving Stillwaters in November 1992 and moving to Bridge Corner House in June 1993. It would appear that he moved from Poole to Bournemouth sometime late February or early March 1993. Once he went to Bournemouth he moved out of the social services area covered by Mrs Rumney.

12. In May 1993, solicitors acting for Mr Coombe in relation to a claim for criminal injuries compensation arising out of the assault in November 1990 noted that Mr Coombe was acting strangely.

13. The solicitors asked his then GP in June 1993 to comment on his medical circumstances in the context of a legal aid application. The GP observed that Mr Coombe was not able to represent himself in any legal case; he had learning difficulties as a child, had difficulty in expressing himself, and had suffered a brain injury as a result of the assault.

14. On 25 June 1993, Mr Coombe moved into Bridge Corner House, Poole, a facility for homeless men and probation referrals, operated by Stonham Housing Association. He registered his name as *'Luke Palmer'* and on 28 June a staff member contacted the social services emergency duty team to say that he had now revealed his real name, was experiencing some guilt over being discovered and had a *'mental illness propensity'*. While this was being contained, she wished to alert social services in case of any deterioration.

15. A member of staff at Bridge Corner House reported to us in her statement that Mr Coombe claimed to have been found in Bournemouth by his brother, that his parents had died when young and that his elder brother had brought him up, that they had lived as travellers and that he had never gone to school. She describes him as having been:
'a very persistent liar .... aggressive to those he considered weaker than himself .... a strange boy ..... hard to get close to'

16. A referral to social services was made on 29 June 1993 stating that Mr Coombe was threatening to kill himself if he could not stay at Bridge Corner House. However, there is nothing on record that confirms he was actually asked to leave, even after his *'Luke Palmer'* alias had been exposed, although reference is made at one point to a staff member there asking him whether he had a home to go to. It could be speculated that this comment may have prompted his reaction.

17. In view of the move back to Poole from Bournemouth, the team manager in Bournemouth wrote to his opposite number in Poole on 6 July 1993 passing the papers back (although they did not arrive before the case was closed) with a request from Bridge Corner House that someone be identified to work with Mr Coombe to identify *'appropriate community options'* for him. As a result the case was allocated, this time formally, to Mrs Rumney on 12 July 1993.

18. Mrs Rumney completed a summary of her involvement with Mr Coombe until 20 July on which date the case was closed. On 12 July she had been notified by Bridge Corner House that he wanted to leave there. She arranged to visit on 20 July, and when she arrived staff wanted guidance about Mr Coombe's *'child-like behaviour'*. Mr Coombe himself did not keep his appointment although Mrs Rumney wrote that he said he was now settled and wanted to stay. It was agreed that Mr Coombe or the project staff at Bridge Corner House would contact her if he required social work support. She agreed with her supervisor to close the case.

Comment

19. **With regard to the actions of social services we have found that record keeping was inadequate, and there was a lack of clarity over its role and both how and what services were to be provided. The administrative arrangements for case opening, allocation and closure also seemed confused and inconsistent.**

20. **There was no curiosity expressed as to where Mr Coombe had come from, what his history might be, whether he was vulnerable from a social care or a housing need aspect or indeed as a result of the 1990 head injury. It is not clear what the aims and objectives of the contact with Mr Coombe were at this stage. He was offered**

help with the litigation against him, but as a clearly vulnerable individual, he had wider needs, including stable accommodation, which were not addressed.

21. The NHS and Community Care Act 1990 came into force on 1 April 1993. However, no community care assessment was done under that Act after the case had been formally allocated to Mrs Rumney in July 1993, or before, so no consideration was ever given to any specific needs Mr Coombe might have under this legislation.

22. While it might reasonably be expected that not all the arrangements for implementing the above Act were *'up and running'* at this time, we would expect there to be some indication in the records that an assessment had been performed, whether formally under the Act or not.

23. Our expert advice is that by this time in Mr Coombe's life there was enough evidence that he was vulnerable:

- **He had experienced periods of homelessness and difficulties in managing his tenancy when he had accommodation.**
- **He had difficulties in his concentration, memory span, the ability to express himself and a general *'strangeness'* all of which had had been noticed by various professionals he had been in touch with.**
- **He had a history of substance misuse and offending.**
- **He could not sustain any accommodation for very long.**

24. In addition there was the head injury. The threshold for deciding whether someone may be in need of community care services is very low. Mr Coombe would have easily passed that threshold.

25. There was more evidence of a rich fantasy life during this time. We (and subsequent services) are hampered by a lack of an assessment at this time, which if it had been done should have taken account of the fantasy life and child like behaviour and would have provided a useful bench mark against which to judge Mr Coombe's future presentation.

26. Mrs Rumney has advised us that she did not receive any training to implement the NHS and Community Care Act 1990 until November 1993, three months after her involvement with Mr Coombe ceased, and that the polices and procedures relating to the implementation of the Act at the time of her involvement were 'less than comprehensive'. She also says that she agreed all her actions in respect of Mr Coombe with her team manager, and in any case she had doubts whether Mr Coombe would have co-operated sufficiently to undertake any assessment of his needs at this time.

27. Our criticisms here are aimed at social services generally and not at individual officers. They are supplementary to our findings in the Shane Bath Inquiry

28. In spite of Mr Coombe's unsettled way of life there was no great crisis over these years and no contact with the criminal justice system. There was no health service involvement throughout this period apart from GP consultations. We have seen no medical records from the secondary health care services for this time.

Chapter 4

1993 PROBATION ORDER

CFT, CAT and PSYCHIATRIC ASSESSMENT

Summary:

Following further minor offending Mr Coombe was assessed by the CFT, CAT and a psychiatrist at the request of probation. These were speedy and appropriate assessments of the kind that the CFT in particular was initially set up to do. There was, however, a failure to appreciate the limitations in the assessment services it offered, especially for more complex cases.

The probation order was not successful and Mr Coombe proved difficult to motivate and manage, compounded by his going to Cumbria towards the end of 1994. In spite of these problems, revocation of the order was planned and not successfully aborted after his "absconding" to Cumbria. We are critical, here and elsewhere (see chapters 8 and 13), of the apparently mechanistic adherence to national minimum standards of reporting whereby there was a reduction in reporting after a set period but apparently without due regard to the individual presentation of the offender at the time.

We are also critical of the lack of any risk assessment.

There was more evidence of his fantasising and vulnerability.

RECOMMENDATION 1:

The probation service should review the approach to the supervision of those probation clients assessed as presenting a low risk to themselves and others, and review the way in which national standards are applied to such cases.

Introduction

1. On 31 August 1993 (aged twenty two) Mr Coombe was arrested and charged with theft from motor vehicles. This was his first contact with the criminal justice agencies since his conditional discharge for criminal damage and theft in September 1990 and head injury in November of that same year (see chapter 2).

2. Mr Coombe was seen to smash the windows of two cars in an NCP car park, and was arrested by two members of the public and detained until the police arrived. He was found to be in possession of a torch taken from a third car.

3. The probation pre-sentence report prepared in October 1993 for a hearing on 29 October stated that he had been under the influence of drugs and alcohol at the time of his arrest. This was confirmed by the custody record that showed that he had been too drunk for his rights to be read to him and was left in a cell to sleep. He was interviewed on 1

September 1993 at which time he admitted the offences. There was no appropriate adult present. He was granted police bail later that morning.

4. The recommendation to the court was for a full CFT assessment. This was due to Mr Coombe's inebriated state on arrest and also because of his distracted behaviour during his interview with the probation officer who noted that he was unable to maintain a coherent conversation. It was the probation officer's stated opinion that he *"was unfit to be sentenced"* in the absence of such an assessment.

5. This was early in the life of the CFT and was a straightforward probation referral for assessment from court of the type that the team was originally intended to provide. Contact at this time was minimal and appropriate.

6. Mr Coombe was made the subject of an eighteen month probation order by the Bournemouth Magistrates Court in December 1993, to be supervised by Sarah Allsop.

7. Ms Allsop made strenuous efforts on his behalf and, in spite of the difficulties he posed, a plan was made to revoke the probation order in November 1994. Unfortunately, by this time he had absconded to Cumbria and although she attempted to prevent the order from being revoked, this went ahead apparently by some administrative error.

8. During this period, Mr Coombe received an award of compensation from the Criminal Injuries Compensation Board for his head injury in the region of £10,000. To his annoyance, the family took control of his access to this money.

Assessments

9. The formal referral to the CFT took place on 29 October 1993. The next court date was 10 December. Mr Coombe missed an appointment with Dr Grace Leung, chartered clinical psychologist, on 22 November and saw her, and her assistant June Copeland, on 2 December. He had seen John Swire-Cunningham CPN with the CFT on 25 November. We have also seen the manuscript notes of these meetings together with psychometric test results.

10. By 6 December there were reports available from Dr Leung, Mr Swire-Cunningham, Grace Higgins from the Community Alcohol Team and Dr Robert Franklin, consultant psychiatrist. On 7 December there was a multi-disciplinary meeting of the CFT at St Ann's hospital with attendance from all the report writers except Ms Higgins, whose report was read out in her absence.

11. The meeting concluded that Mr Coombe needed stable accommodation, and

> *"perhaps a Probation Order with Day Centre activity. Treatment could be offered but only on a voluntary basis. Possibility of memory learning with Dr Leung next year."*

Dr Leung noted that he was good at mental arithmetic.

12. Dr Franklin had Dr Rastogi's report and the probation report from 1990 available to him. In his report he was unable to offer any assistance to the court in the absence of a full assessment of the head injury. He did not find Mr Coombe to be suffering from any form of mental illness. Mr Coombe's concentration and attention were good when he saw him. He concluded that there is:

> *"evidence that he was developing a personality disorder of the sociopathic type before the head injury of 1990, though his head injury can only have complicated the case."*

His conclusion was much the same as Dr Rastogi's in 1990.

13. Mr Coombe provided an accurate history of his family background to Mr Swire-Cunningham and of a type which he gave fairly consistently throughout his contact with services. This included his unhappiness over his parents divorce, his abuse of solvents and continued use of cannabis. He denied any alcohol problems, but admitted to being easily provoked when he drank vodka. He recalled seeing a child psychiatrist and expressed his own difficulties as relating to poor coordination, poor memory and concentration. Mr Swire-Cunningham recorded that Mr Coombe appeared to him to be mildly elated and unable to grasp that he was to be punished for his offences.

14. Dr Leung noted the head injury and a below average IQ, amongst other things. There is a manuscript addition to the report which is not dated and reads *"Significant difference in verbal and spatial functioning due to his head injury"*. The basis of this opinion is not clear, although it appears to fit in with the earlier educational guidance assessment in 1986 (see chapter 1).

15. Dr Leung concluded that he had:

> *"a mild memory deficit which may be a result of his head injury.*
> *a. He needs to control his drinking so that he will not react impulsively or re-offend.*
> *b. Anger management may be an asset to help him re-adjust to community living.*
> *c. Housing and financial stability can help stop re-offending.*
> *d. Some form of voluntary or day centre may help to motivate and mature him, teaching him some responsibility."*

16. Ms Higgins had difficulty interviewing him due to his limited concentration and *"he tended to flit from the question or subject under discussion"*. She was able to identify, however, that he had no alcohol dependency although he had had times when he drank excessively. He seemed to be more involved in cannabis. He did not feel in need of any help with a drink problem, which he did not think he had, and this was confirmed by his landlord. Mr Coombe had moved out of Bridge Corner House in November 1993 and into a private residential facility house run by an ex-policeman and his wife.

Comment

17. **This evidence appears to indicate a consistency in Mr Coombe's presentation over the years before and after the head injury. There was, at this time, a finding of a significant difference in verbal and spatial functioning. Dr Leung's assessment does not fall into the category of a full assessment of his head injury, but it is probably reasonably accurate in its conclusion.**

18. **Her interpretation of the Stait Trait Anger Expression Inventory (STAXI) which records that:**

"He has poor control of his anger which tends to be of an impulsive nature. He tends to misperceive situations, or over reacts under the influence of alcohol and drugs",

seems accurate with hindsight following the murder, although it was unconnected with his offending and other behaviour at this time.

19. **The CFT made no formal recommendations for treatment or follow up, save for voluntary treatment, and the recommendation for a probation order was made to help Mr Coombe establish stability and to encourage some form of social contact to help him mature. A secondary aim was to monitor his drug and alcohol use. An eighteen month order was recommended and although may seem longer than appropriate for this level of offence, the intention appears to have been to attempt to make a real difference to his life.**

20. **These assessments were made quickly and were not intended to be in depth. There was not the time to do more before Mr Coombe was due back in court. We know that the CFT had recently been set up and were providing a much needed and free assessment service to the courts. For this kind of offender i.e. low risk, it worked well. Difficulties arose as a result of the lack of forensic expertise and the standardised treatment options used, which left the team unable to assess more complex forensic cases and behavioural problems. This was compounded by the fact that this crucial limitation was not sufficiently understood by those responsible for the service, including higher management (see chapter 12 para. 60, Concluding Comments, chapter 19).**

21. **What is noteworthy, however, is that this is a well-documented assessment compiled with some speed to comply with the court time-table. This was a proper multi-disciplinary meeting, one of the only such meetings we have encountered in the CFT (or at St Ann's Hospital) during our investigations.**

22. **The only question we raise is whether the head injury deserved more attention at this point. Again, our view, is that given the features of this case, for example, minor offending and low risk, the constraints within which these services operate and the time and resources involved in such investigations, the lack of a further referral for neuro-psychological assessment is probably justifiable.**

Course of probation order

23. Sarah Allsop was assigned to Mr Coombe's case on 14 December 1993. Her initial view was that behavioural problems were *"evident"*, he had no sense of fear, no conscience, was impulsive, and *"feels he can offend as and when he wishes"*.

24. In her December review, she noted that although he presented a veneer of coping, he was in fact fairly isolated, with few friends. He had given her a litany of previous offences and behaviour involving the abuse of drugs and alcohol, saying that he had made *"hundreds of thousands of pounds"* from his offending *"but has nothing to show for it"*. She challenged him saying that he *"exaggerates in order to appear 'one of the lads' "*. The plan was to establish an honest relationship and for weekly reporting.

25. By early January 1994 Mr Coombe had moved out of his accommodation. The landlord had left a message with Ms Allsop to this effect and that he felt that Mr Coombe was at risk by doing so. Mr Coombe failed to attend his probation appointment on 7 January 1994 for which he was sent a first warning and by 19 January he was warned that he would be "breached" if he did not attend on 24 January. He attended.

26. Ms Allsop tried to discourage him from moving accommodation again *"3 addresses in a month is not good enough"*. He wanted to enrol on a mechanics course which she considered to be unrealistic and a referral was made to the employment and training office.

27. He had told her details of one of his supposed offences, a burglary, in which he carried an air pistol and a machete which he said he would have used, and possibly killed with, if he had been challenged at the time. She has recorded her own view in relation to the latter threat as *"I can believe this"*. He had also said that he no longer wanted to offend and realised the risks involved.

28. There are details of Ms Allsop's attempts to find him a job and to discuss his sexual history. She also counselled him against the company he was keeping with another client, a high risk offender. In March 1994 he turned up to see her in new clothes which he said he had bought from money he had saved up from his "Giro". This she did not believe and told him so. He said he had not been offending and, later, that he had been "sniffing gas".

29. The quarterly review in March 1994 recorded that despite a *"dodgy"* start when Mr Coombe received a final warning, he appeared to have settled into the routine of reporting. Again she noted that although he presented as socially skilled, *"this belies his lack of skill at dealing with life"*. He functioned well when it came to organising accommodation, but her concerns lay more with his social functioning. She noted that he attended at "discos" which were frequented by younger people and that he did not have the skills to successfully interact with people of his own age who are not deviant. *"In particular, it is likely he could be easily led astray"*. Reporting was reduced to fortnightly.

30. In March 1994 he was arrested and charged with criminal damage to a shop door. The value was less than £2000 and he was fined £120 in April 1994.

31. The June 1994 quarterly review indicates that Mr Coombe's contact with his mother had reduced and that he was not well motivated to address his problems which made the order difficult to manage. He remained a vulnerable young man in respect of whom it was difficult to separate fact from fiction.

32. Contact with his mother had revealed that he was due a sum of money (about £10,000) from the CICB for his 1990 head injury and which the family would invest for him. Later in August 1994 there was apparently a disagreement with his mother over who would have control of the money and she lost contact with him then until November 1994.

33. Ms Allsop's concerns were unchanged from her previous review. Reporting was reduced to monthly and she was to continue to challenge his views and attitudes and to encourage compliance with "the norms in society". By August 1994, and in spite of the problems recorded in June and March, there was discussion regarding an application for revocation of the Probation Order.

34. On 19 September 1994, Ms Allsop's record is more promising and noted the potential of a place at Poole College, that he felt settled in his accommodation, and that he was maturing and managing his money. He was no longer trying to get control of his CICB money nor using drugs. She records *"sensible conversation"*. She noted that He said that he had re-made contact with his mother, and this is unlikely to have been true.

35. The revocation application was listed for 5 October 1994 and Mr Coombe was given a copy of the summons. He failed to attend court for this and the matter was adjourned to 2 November 1994.

36. In consultation with her supervisor, it was decided that she would try for a warrant with bail. The plan was that when he did attend, the application would be changed to one for a conditional discharge. On 2 November she noted that she had advised the court clerk that the application for revocation was withdrawn. On 9 November a warrant without bail was issued by Bournemouth Magistrates' Court.

37. Mr Coombe had gone to Cumbria in about early October 1994 for reasons which are still not known. This seems illogical given that his probation order was on course for revocation. Ms Allsop made efforts to find him through the Housing Benefits Agency, but they were *"unable to forward address to me - breach in confidentiality"*.

38. On 10 November 1994 Ms Allsop received a telephone call from Gary Kirby, of Melbreak House, Ulverston, Cumbria telling her that Mr Coombe had been staying there since 19 October 1994 under the name of "Mark Wilder" and had only just revealed his true name. They were planning to take him to a GP because he seemed mentally ill. This appeared to refer to his fabricating stories (see chapter 5).

39. On 12 November 1994 the probation order was revoked by the Bournemouth Magistrates' Court.

40. In her closing summary Ms Allsop refers to Mr Coombe's variable motivation and that he is a person with

> *"some degree of mental health problems (not identified) and some distorted learning ability.....although he has good literacy skills he does, I consider, have, have some distorted thinking which is demonstrated in him having problems in forming and maintaining relationships."*

She considered, however, that his response to the Order was reasonable.

41. The police records show that Mr Coombe attended the police station in Cumbria of his own accord and was accompanied by Mr Kirby. No appropriate adult was present. Once back in Dorset he was medically examined for his fitness to be detained. No symptoms are described except for asthma and respiratory infection. He was prescribed antibiotics.

Comment

42. **Ms Allsop's note keeping was good and thorough. Our expert advice on this period of probation is that, in formal terms, her approach was within the national standards of the day. The criticism we have received from the expert is that while there was a clear identification of the problems to be tackled, the way in which this was to be achieved was less clear, and particularly in relation to reducing his offending behaviour.**

43. **We have been advised that the recommendations made by Dr Leung were more robust than the probation plans and that, in view of the CFT offer of voluntary treatment, there should have been an attempt to jointly manage these problems with the assistance of the health services. This was particularly relevant in view of Ms Allsop's observation that there were unidentified mental health needs. It was acknowledged, however, that Dr Franklin's report may have been reassuring in this regard. We do not criticise the failure to involve the CFT. Mr Coombe was not presenting with symptoms of mental illness, but we accept that there were worrying undercurrents relating to Mr Coombe's mental health needs.**

44. **Our conclusion is that Ms Allsop's notes demonstrate a thoughtful and energetic approach to a difficult and wayward client whose co-operation was fragile. We think her efforts in keeping him in stable accommodation, obtaining employment and training (even if acknowledged to be unrealistic), and encouraging him to stay away from unsuitable companions are to be credited. We also think that her assessments were insightful.**

45. **Our main criticisms relate to the lack of a formal risk assessment and the apparently mechanistic adherence to national standards of reporting leading to an overly swift move to revocation. Dorset was, by this time, already operating a "High Risk" conference procedure. It is not our view, nor that of our expert evidence, that Mr Coombe warranted such a conference. It is clear to us that the details of the offence which he related to Ms Allsop in January 1994 were fabricated although clearly there were aspects of his personality which made her believe that he was capable of violence and, for ease of future reference, more**

should have been made of such as a note in a quarterly summary and not just the case records. This should have meant that anybody referring back to these notes at a later date would have been in a position to factor this into any subsequent assessment.

46. It is a feature of service provision as a whole that once a person is regarded as "low risk", as Mr Coombe was, then resources are allocated accordingly. However, if this results in simply adhering to the requirements expected of national standards, e.g. reporting and an automatic reduction in contact every three months, this rather defeats the purpose of a probation order and makes it of little more than nominal significance. It would fail to address such things as offending behaviour and the individual needs of the offender. (See also chapters 8, 13 and 18)

47. The revocation of the probation order is baffling and likely to be due to a court error. This was a Saturday sitting of the court and Ms Allsop is unable to explain why the revocation took place. It had been her intention that a conditional discharge should replace the Probation Order due to his breach of the order. Had this taken place, then Mr Coombe would effectively still have been released from supervision and been free to return to Cumbria as in fact he did do.

RECOMMENDATION 1:

The probation service should review the approach to the supervision of those probation clients assessed as presenting a low risk to themselves and others, and review the way in which national standards are applied to such cases.

Chapter 5

CUMBRIA 1994 to 1995

ALLEGATIONS OF INDECENT ASSAULT ON A CHILD

Summary:

An important issue arose around the sharing of information regarding an unproved allegation of indecent assault on a child. The information should have been shared by the police with at least social services in Dorset because of the potential child care issues and also the probation service because Mr Coombe was known to have been a former client. However, this alleged incident was not predictive of the subsequent murder; the circumstances were wholly different.

The issue of unproved allegations also arises in the McMahon inquiry. See chapter 13 and chapter 15 para. 37.

RECOMMENDATION 2:

Local agencies, including the police, coming into contact with known service users should devise a standardised procedure for sharing information relating to arrests, charges, convictions, and particularly allegations of violence and indecency.

Introduction

1. Mr Coombe (age twenty three) left the Dorset area sometime in October 1994 and moved up to Cumbria without informing his probation officer Sarah Allsop (chapter 4). It is not known why he left at a time when his probation order was to be revoked. He was admitted to a hostel in Ulverston where he registered himself under the alias of "Mark Wilder". However, his real name and origins quickly became known and the probation service in Bournemouth was made aware of his whereabouts. A warrant for his arrest was issued for breach of bail and he was brought back to Bournemouth. Probably because of an administrative error his probation order was revoked and he journeyed northwards again.

2. He met a woman in Cumbria and moved in with her. This woman's eight year old daughter subsequently moved to be with her father in Lancashire where she made allegations that Mr Coombe had sexually abused her. The allegations were investigated and Mr Coombe was interviewed later by Cumbria police in Dorset about them. The charges were later not proceeded with because of insufficient evidence. The incident was referred to the Lancashire social services for a decision on whether the little girl should be placed on the "at risk" register. This was considered but she was not placed on the register. At this time, Mr Coombe was back in Dorset.

1994: Melbreak House

3. The social services duty officer in Dorset received a telephone call from *'a hostel in Alveston (sic), Cumbria'* on Friday, 4 November 1994 expressing great concern about Mr Coombe's mental state. They were told that no *'real information'* was held there and the main file was at the Bournemouth Central office. It was suggested he telephone on Monday as it was *'now 16.10 and the office was closed'*. The hostel explained that he had used the alias *'Mark Wilder'* on arrival but shortly afterwards had admitted to staff he was Mr Coombe.

4. On Monday, 7 November 1994, someone on behalf of the duty team manager at social services telephoned Bridge Corner House asking them to contact the hostel in Cumbria *'with regard to passing on information about Simon'*.

5. On 10 November Ms Allsop had a telephone call from Mr Kirby, assistant manager in Cumbria to say that Mr Coombe was now at Melbreak House in Ulverston, having arrived there on 19 October using the pseudonym of *'Mark Wilder'*.

6. Melbreak House was privately owned but was, at that time, also supported by a local church charity. Mr Kirby informed Ms Allsop that he believed Mr Coombe to be mentally disordered, he had been telling *'all sorts of stories'* and they were about to take him to a GP in the hope of getting him referred to a psychiatrist. He thought Mr Coombe was running away from something *'major'*.

7. Ms Allsop advised Mr Kirby that a warrant had been taken out on 9 November (for breach of probation) and that Mr Coombe must report to a police station and *'deal with the consequences'*. She noted that a warrant had been forwarded to Ulverston and that she was awaiting contact from the probation service in Barrow- in- Furness.

8. Mr Kirby's memory of Mr Coombe was of someone who was tidy in his person, generally clean, who kept himself to himself, who was liable to mood swings but helpful around the house. He recalled no behavioural problems but could never understand what really happened to make him leave Dorset, he had made enquiries of somewhere he had stayed there (a *'halfway house'* he thought) but could obtain no information *'due to confidentiality'*. After disclosing his real name Mr Coombe referred to *'Mark Wilder'* as another person rather than an alias. Mr Kirby advised us that individual residents were left to follow up any referrals made to medical or social services themselves.

1995: Allegations of sexual abuse

9. Although Mr Coombe's precise movements after release from custody in Dorset on 12 November 1994 are unknown, he did eventually return to Cumbria and there is a suggestion that he may have had some contact with his father who lives in Cheshire.

10. Once back in Cumbria, he entered into a relationship with a woman who was separated from her husband and bringing up her two young children, a girl and a boy, on her own.

11. There is evidence that his fantastical stories were also persisting at this time. He would say that he was going away on "business" and he would often say that he had met

famous people such as the film star Sharon Stone. He also referred to his brother who was "well off" and would look after him.

12. Much later in 1995 he was interviewed in connection with the alleged offence of indecent assault on the little girl, an allegation she made after moving to live with her father in Lancashire. We refer to her as "Anna", not her real name.

13. On 18 May 1995 in an interview with police (in the presence of a social worker), Anna claimed that Mr Coombe had touched her vagina with his fingers and with his penis. A medical examination revealed no physical sign of sexual abuse.

14. This (and other matters raised by Anna unconnected with Mr Coombe) were followed up by Lancashire social services, and a child protection conference was held on 19 May 1995 to consider principally the specific allegations against Mr Coombe in the context of "at risk" registration. Such registration was decided against.

15. Mr Coombe was interviewed by Cumbria police in Dorset in September 1995. Dorset police were, therefore, aware of these allegations relating to a person within their jurisdiction and who had been subject to a probation order the year before. On 11 October 1995, the decision was made by Cumbria police that there was insufficient evidence to proceed against Mr Coombe.

16. Mr Coombe completely denied this allegation of indecency. No "Appropriate Adult" was required during this interview and the transcript and tape demonstrate that he coped exceedingly well with a stressful situation and answered convincingly the questions put to him.

Comment

17. **This was a serious allegation even if not proceeded with by the police. There were obvious child protection issues around the actual child involved which were dealt with in Lancashire, but there were potentially future child protection issues surrounding Mr Coombe and his known whereabouts which were not acted upon.**

18. **Neither Lancashire social services nor the Cumbria nor Dorset police passed any information about these allegations to social or probation services in Dorset. Dorset police did carry this information on their intelligence system.**

19. **Mr Harry Capron, (currently policy development officer with Bournemouth social services) told us that he would expect such information, even in relation to unproved allegations, to be shared with them by outside agencies including the police. There was also broad agreement among witnesses (Cumbria police and Dorset probation service) that, in this case, transmission of the information would have been justified as it was important in considering the level of risk to others. Prosecutions are not proceeded with for many different reasons and allegations may be part of a consistent pattern of challenging and worrying behaviours (as with Mr McMahon, see chapter 15).**

20. **In this case, the child protection issue alone would have justified disclosure to at least social services. The impact of that information on later assessments, for**

example, in 1997 while at St Ann's Hospital, may arguably have been relevant to the "sexually inappropriate" behaviour on the ward. It was, however, quite different in character to this subsequent behaviour and this incident, either on its own or taken with the sexually inappropriate behaviour, was not, in our view, predictive of the murder of Michelle Lock. It would, however, undoubtedly have been valuable in obtaining a complete picture of the individual and his risk to others.

21. **Knowledge of the events in Cumbria might have encouraged local agencies involved in his care and treatment, to explore the issues surrounding Mr Coombe's sexual behaviour while an inpatient at St Ann's hospital later on 1997. It is improbable that this would have led to a significantly higher rating of his risk level or to a probation High Risk conference when he was next under probation supervision because the circumstances surrounding the allegations against him, in the wider context of Anna's family's general problems, did not suggest that Mr Coombe was a man who escaped prosecution only on a technicality. The decision not to proceed with the prosecution does not seem unreasonable when the facts are examined now. Also, it was not part of a pattern of offending nor did it fit in with any previous behaviour nor any violence.**

22. **If the allegation had been of an indecent assault on an adult female, there would be a clear relevance to the subsequent behaviour, yet, unless staff at St Ann's, or the probation service specifically requested information held by the police of this kind (as opposed to a list of convictions), it is unlikely to have been available.**

23. **If the situation is to change, consideration needs to be given to whether there should be any obligation on the police to disclose unproved allegations to mental health and probation services, where there is known contact, and if so, what criteria are to be laid down to achieve this on a proportionate, fair and lawful basis.**

24. **This case (and that of Mr McMahon) is illustrative of a category of cases where the threshold for disclosure had easily been crossed and they were both known to be probation clients. There were clear future child protection issues around the allegations made against Mr Coombe which warranted disclosure at least to social services in Dorset.**

RECOMMENDATION 2:

Local agencies, including the police, coming into contact with known service users should jointly devise a standardised procedure criteria for sharing information relating to arrests, charges, convictions and particularly allegations of violence and indecency.

Chapter 6

1996 OFFENCES

REMAND IN PRISON (1996) AND TRANSFER (JANUARY 1997) TO ST ANN'S HOSPITAL, POOLE UNDER MENTAL HEALTH ACT 1983: JANUARY 1997

Summary:

Mr Coombe had been arrested and charged with two sets of offences, (1) theft of a vehicle in Southampton in October 1995 and (2) burglary of commercial premises in Bournemouth in July 1996. He was remanded in custody on 24 September 1996 for failing to answer to bail in respect of both offences. In January 1997 he was transferred to St Ann's Hospital under section 35 MHA.

The evidence of Mr Coombe's presenting mental state which prompted admission under the MHA has been difficult to determine. Use of the MHA was also imprecise.

Additionally, there is a need for information sharing between the prison service and local hospital services on transfer.

Once again (as with the Shane Bath Inquiry) we have experienced significant delays and problems in locating and obtaining prison records.

RECOMMENDATION 3:

The Home Office should:

a) Issue an instruction for the immediate introduction of a discharge summary which should always accompany a prisoner who is transferred from prison to hospital. This should incorporate summaries of symptoms or behaviour noted on normal wing location and relevant adjudications for infringements of prison discipline. In addition, the copies of any prison medical notes should always be passed on.

b) Conduct a major overhaul of the way in which prison records are stored and transmitted with the aim of ensuring that all records are maintained together, are readily identifiable (including periods on remand) and available to relevant agencies.

Introduction

1. Mr Coombe (aged twenty five) had been arrested and charged with two sets of offences, the first in October 1995 (theft of a vehicle in Southampton) and the second in

July 1996 (burglary of commercial premises in Bournemouth jointly with another person) and remanded in custody on 24 September 1996 for failing to answer to bail in respect of both offences in August 1996. He pleaded not guilty to the Southampton offences and was convicted after a trial in November 1996. The court adjourned for a pre-sentence report and a psychiatric report. He remained in prison until 23 January 1997 when he was transferred to St Ann's Hospital under section 35 MHA.

2. During 1996 he had moved address on a minimum of three occasions and on at least one occasion was of no fixed abode. He lived in low rent areas where he usually occupied bed and breakfast accommodation for those dependent on income support and housing benefit. His family had indicated their concerns for him to his solicitors. It was felt that he needed professional help *"before something terrible happens"*. At this time, this was undoubtedly an understandable expression of concern for Mr Coombe's own vulnerability.

3. Psychiatric and/or CFT assessments were requested at this time by Mr Coombe's solicitors, the court and the probation service. Mr Coombe's vulnerability was very apparent during this period of his life. There are frequent references to his immaturity, impaired memory, low level of intelligence, lack of co-ordination, confusion, suggestibility and anxiety. Possible psychological problems were noted but his precise presentation has been difficult to ascertain. He was in clear need of assessment.

4. The Appropriate Adult who saw Mr Coombe in July 1996 recorded that he

> *"...appeared to become preoccupied by irrelevant issues not related to situation in hand i.e. which shirt was in rucksack and that couldn't knock door down. Mr Coombe was able to quote his NI no. could sign his name with no assistance."*

This is consistent with his presentation in 1993 which prompted a referral to the CFT.

5. The court probation officer, Ms Rachel Newman, had put in her notes

> *"Said he does not have a drink problem? Please note I felt uncomfortable in his presence - please tell me if concerned and I'll expand".*

There is no note that she was ever asked to do this.

6. While in prison he was assessed by Mr Rob Taylor, duty probation officer who wrote two reports (December 1996 and January 1997), Dr Rowton-Lee (December 1996) who advised in-patient assessment and by Studland Ward nursing staff. Dr Rowton-Lee had been asked to see Mr Coombe in July 1996 but did not in fact see him until November. The delay was in part caused by Mr Coombe absconding to Bath in the interim, but he was in custody by 24 September 1996.

7. Mr Taylor had real concerns over Mr Coombe's levels of anxiety during his first interview with him in 1996, such that he brought this to the attention of prison staff resulting, he said, in Mr Coombe being moved to a location in which he could be monitored more closely. This was Mr Coombe's first ever period in custody.

Prison records and communication

8. There are only minimal records available from H. M. Prisons Dorchester and Winchester for this period. There are a handful of entries in the continuous medical record. We obtained separate disclosure of a Governor's adjudication into the slashing of an inmate by Mr Coombe. It was found that he had done so at the request of the other inmate. We were told that the police decided not to prosecute due to the consensual nature of the incident. The "slashing" is referred to within the subsequent hospital records but treated as one of Mr Coombe's fabrications. It was never verified and nursing staff told us that they generally had difficulty getting information from the prison. Thus Mr Coombe's ability to perform this act at the request of another prisoner was never considered during his in-patient treatment. There is no information routinely provided to hospital staff.

9. Prison records were, as ever, extremely difficult to trace and obtain. As with Mr McMahon we were left without complete records.

Comment

10. A discharge summary should always accompany a prisoner who is transferred from prison to hospital. This should incorporate summaries of symptoms or behaviour noted on normal wing location and relevant adjudications for infringements of prison discipline. In addition, the copies of any prison medical notes should always be passed on.

RECOMMENDATION 3:

The Home Office should:

a) Issue an instruction for the immediate introduction of a discharge summary which should always accompany a prisoner who is transferred from prison to hospital. This should incorporate summaries of symptoms or behaviour noted on normal wing location and relevant adjudications for infringements of prison discipline. In addition, copies of any prison medical notes should always be passed on.

b) Conduct a major overhaul of the way in which prison records are stored and transmitted with the aim of ensuring that all records are maintained together, are readily identifiable (including periods on remand) and available to relevant agencies.

Dr Rowton-Lee's assessment of Mr Coombe in prison

11. Mr Coombe was examined at H.M. Prison Dorchester by Dr Rowton-Lee on 28 November and 19 December 1996. His hand written notes indicate that Mr Coombe told him that he was drinking three pints of beer, four to five times a week. He said that he had tried LSD, a long time ago and smoked cannabis every few months. He had said that

he *"felt different"* after the assault in 1990 and Dr Rowton-Lee records his impression as *"Transient depressive episodes.....R frontal headaches all the time"*. This is not included in the court report.

12. There is a fax front sheet that indicates that the Dr Rowton-Lee received 24 pages of historical information held by the Trust on Mr Coombe on 28 November. It is not possible to reconstruct precisely what was sent but it appears to have included most of the following, which appear in the file after the fax cover sheet: the discharge summary from Wessex Neurological Centre and x-ray report (November 1990), referral letter (second) from Mr Coombe's solicitors Sharman and Company, Mr Taylor's first report, prosecution statements for the offence committed in July and record of interview, reports of Dr Iannotti (Wessex Neurological Centre) to the CICB in 1994, and of Dr Rastogi in April 1990, and of the, probation officer (1990), as well as the educational guidance report (1986).

13. What does not appear above are the 1993 assessment reports by the CFT, Grace Higgins and Dr Robert Franklin. With the subsequent introduction of integrated records within the Trust, all forensic service records should now be accessible as a matter of course.

14. The solicitor's referral letter records Mr Taylor's anxiety in relation to Mr Coombe's mental state and asks that all general matters be addressed including how easily led and suggestible he might be. It states:

> *"It appears that he wants to please people and fit in somewhere. It is hard to describe quite what is not right about him mentally. I note that after he was convicted of theft at Southampton Crown Court he immediately admitted to us that he had done it and that it was all his idea. His co-accused in that matter was a man called H who is endlessly stealing vehicles. H was convicted at an earlier trial. Coombe tried to make out that he had taught H what to do and Coombe himself as "Mr Big". I am sure that is not right."*

This fits in with the subsequent impression of nursing staff at St Ann's when his fantasies and sexual behaviour were considered to be an attempt on his part to be "one of the lads" caused by his lack of maturity.

15. In his report of 30 December Dr Rowton-Lee set out a fairly full and accurate history although he noted that it was difficult to separate fact from fantasy in Mr Coombe's own account:

> *"On the face of it there appears to be a mental state disturbance which is either a residual psychological consequence of insecurity and instability following the separation of his parents when he was a boy and he developed dysfunctional patterns of behaviour marked by failure of concentration, over-activity and an absence of development of social judgment, or a degree of this compounded by a head injury some six years ago. There appears to be a possible substance abuse problem. It is not clear what the extent of this is...*
>
> *The previous hospital record will need to be investigated. I recommend a multi-disciplinary assessment by the Community Forensic Team to include a full psychological assessment, further exploration of the past and current social*

factors, to exclude significant head injury, to establish the extent of the alcohol and substance abuse, and to explore realistic options as to what can be achieved at best in the future, and the risk of repetitive, recidivist, criminal behaviour..... This appears to be a complicated case and I am not yet in a position to make full recommendations. It may be appropriate to consider a Section 35 Assessment Order under the 1983 Mental Health Act in due course."

16. The history recorded in the nursing assessment report, notes matters very similar to those contained in other reports. There are the usual fabrications as well, including his twins Philip and Helen, stealing over 100 cars, shooting dead six policemen in San Francisco, several armed robberies here and abroad and slashing another inmate with a razor blade requiring 27 stitches. The latter was, of course, true although the number of stitches may be exaggerated. The nurses supported the admission to Studland Ward.

Comment

17. **In making a section 35 MHA order, the Court had simply to be satisfied that there was *"reason to suspect that...[Mr Coombe]...is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment;..."* (section 35(3)(a)). The Code of Practice to the MHA advises that the medical report should contain a statement as to whether the patient is suffering from a specified form of mental disorder and identifying its relevance to the alleged offence.**

18. **Dr Rowton-Lee's report does not explicitly identify the "mental state disturbance" as possibly being a "mental illness" or any other of the disorders identified in that section. "Mental illness" is stated in the section 35 form submitted to the court together with the report. While Dr Rowton-Lee's report does not conform strictly to the advice in the Code of Practice, it is clear that there was no need for him to reach a firm diagnosis prior to admission for assessment under this section. We do not criticise the use of this section to admit Mr Coombe to hospital. It offered a good opportunity for assessment in a structured environment in which he could be detained.**

Chapter 7

ST ANN'S HOSPITAL, POOLE

IN PATIENT PERIOD JANUARY TO JUNE 1997

TWO PROBATION ORDERS

Summary:

We have a catalogue of criticisms of this in-patient period. Much time, effort and resources were devoted to Mr Coombe with very little focus or direction. Psychiatric and CFT assessments were of particularly poor quality. CFT record keeping was non-existent. The sentencing and discharge processes were hasty and unplanned. CPA was apparent in name only and multi-disciplinary work was uncoordinated.

In addition there was never any proper diagnosis or formulation of Mr Coombe's problems.

Praise is due to the nursing staff on Studland and Branksome wards who worked hard at dealing with the behavioural problems presented by Mr Coombe and others. Praise is also due to the occupational therapist whose input to ward notes was steady and reliable.

In March 1997, Mr Coombe was subject to a section 38 MHA interim hospital order and in June 1997, two probation orders were made. He was discharged from hospital to Dorset Lodge on 19 June 1997.

Although there was no formal risk assessment conducted, Mr Coombe's risk to others remained low.

RECOMMENDATION 4:

The Trust, in liaison with other agencies, should arrange for an independent review of the Dorset Forensic Service, in the light of the numerous failings of the CFT identified. This should include record keeping, report writing and multi-disciplinary work.

RECOMMENDATION 5:

The Trust should institute a system of regular internal reviews of the practices and procedures within the Dorset Forensic Service with the aim of ensuring that acceptable standards of communication and assessment are maintained.

Introduction

1. Simon Coombe (now aged twenty six years old)) was admitted under section 35 of the Mental Health Act 1983 (MHA) to Studland Ward, the locked ward at St Ann's Hospital, Poole, from H.M. Prison Dorchester on 23 January 1997 into the care of Dr Martyn

Rowton Lee, consultant pyschiatrist, having spent the immediately preceding five days at H.M. Prison Winchester whilst on remand from Southampton Crown Court.

2. On 14 March 1997 he was remanded back to St Ann's under section 38 MHA. He was moved to Sandbanks ward and then to Branksome ward in April, from where he was discharged to Dorset Lodge on 19 June 1997 having been sentenced by Bournemouth Magistrates' Court and Southampton Crown Court to two probation orders, to run concurrently for a period of two years, one with an attached condition of treatment.

3. Mr Coombe was admitted to Studland ward on 23 January 1997. He was later transferred via Sandbanks ward on 20 March to Branksome ward on 9 April until his discharge on 19 June 1997. We have focused particularly on his time on Studland and Branksome being the two longest ward periods.

4. At this time Studland ward was still a low secure, six bedded, psychiatric intensive care unit. Dr Martyn Rowton-Lee was responsible for these beds and he conducted a ward round once a week. Dr Hashim Mohammed, associate specialist, was on the ward on most mornings of the week. The ward carried a difficult patient group of acutely disturbed patients and forensic patients, including those diverted from custody, whether police cells or prison, or those who were behaviourally difficult on open wards and requiring more secure provision.

5. We have heard evidence of a philanthropic approach pursued by Dr Rowton-Lee to admission to this ward (and generally) and one which was not necessarily based on any precise diagnosis of mental disorder or assessment of treatability. This led to the regular admission of difficult young male patients with behavioural problems.

6. Branksome ward was an open ward, with about 31 patients at any one time under the care of three consultant psychiatrists including Dr Rowton-Lee. The transitionary period at Sandbanks ward appears to have resulted from the need for Mr Coombe's bed on Studland ward to be vacated and the unavailability of a bed on Branksome ward. Dr Rowton-Lee did not have any beds on Sandbanks ward in the normal course, but "borrowed" one from another consultant at this time.

7. On Branksome ward, the nursing staff (Michelle Hopkins and Phil Rowe of the CFT) had established through their own initiative, a relapse prevention group that Mr Coombe attended. This was because of a perceived need to offer something to the group of undiagnosed young males, often transferred from prison, who could be behaviourally difficult on this ward. This initiative was apparently unknown to either Dr Rowton-Lee or Dr Grace Leung of the CFT.

8. There were three nursing shifts on all wards. On Studland, there were four to five staff on the ward per shift with the same on Branksome. It is clear that there was a much greater concentration of attention on patients on Studland. The evidence has been that the patients on Branksome had a variety of diagnoses including, for example, personality disorder, addiction, psychosis and depression. They were demanding and not a day went by without incidents, such as self-harming or aggression.

9. Mr Coombe was assessed and/or treated by the nursing staff, an occupational therapist, the CFT, a neuropsychologist, the Branksome ward relapse group and the multi-disciplinary team during ward rounds. He was also prescribed medication. In February 1997 the section 35 order was extended and subsequently changed to a section 38 interim hospital order on 14 March.

10. At the time of his admission to Studland Ward there were five matters to be investigated:
a) the extent of any learning disability
b) the impact of his head injury on his behaviour
c) any mental disorder
d) drug/alcohol abuse
e) fantasies and confabulation of events.

From the moment he arrived on the ward there was an additional feature which required analysis and which was recorded on an almost daily basis by nursing and occupational therapy staff as his "sexually inappropriate" behaviour towards females.

11. During this in-patient period, there was no considered assessment of what was causing the fantasies and sexually inappropriate behaviour; the latter was attributed to his immaturity and dealt with by nursing staff. Mr Coombe did engage in 1:1 anger management therapy and, after his move to Branksome ward in April 1997, a personal effectiveness group programme with the CFT as well as a relapse prevention group. There had been no probation officer assigned to Mr Coombe after his admission to St Ann's or until after his discharge in June and precise social services involvement is difficult to discern.

Ward assessment and behaviour

12. Mr Coombe continued to express fantasies involving past criminal activities and violence and he admitted to fabrication and attention seeking. For example, he talked of having twins living in Alaska.

13. The main feature of Mr Coombe's behaviour during his time on Studland and Branksome wards, in addition to the fantasies, was what is noted as his *"inappropriate behaviour with females"*. This was noted during his occupational therapy sessions which were also entered on his nursing notes. Through nursing summaries, these features of his behaviour are reflected in the multidisciplinary team plans.

14. The sexually inappropriate behaviour is documented in the notes from the first day of admission to Studland ward and continued up to the time of his discharge. Examples of the fantasies and inappropriate behaviour are as follows:

- "asking personal questions of female staff"
- "claimed to have stabbed a person to death when aged 11"
- "deviating to sexually orientated topics in discussion group"
- "inappropriate comments to female members of staff"
- "inappropriate with care assistant and sexual comments"
- "States it is often a joke"
- "inappropriate with drunken female patient"
- "bragging about acts of violence in the past"
- "over familiar with fellow patients visitor and attacked by patient as a result"

- "confronted about inappropriate sexual comments to student nurse and actions towards patients".
- "Simon felt that this was amusing and just a bit of fun";
- "continues to be regressive in his interactions with females"
- "spending much of his time with a female patient."

15. "Inappropriate" is the word used by the nursing staff in recording this behaviour. It is clear, however, that it was never threatening to either staff or patients. Yet as an illustration of a lack of proper boundaries, it required more thought at multi-disciplinary level. The nurses felt that they were often left to deal with difficult behaviours by themselves.

16. Other presenting features included a self-reported anger management problem, although no real evidence of this was ever elicited. Mr Coombe was referred to the CFT for, and received, 1:1 anger management therapy from Andrew Derry, psychology assistant (see below).

17. Although one of the first care plans on Studland ward describes a mild depression, subsequently, and with the weekly administration of the Beck depression inventory, this did not re-emerge.

18. On 19 February 1997, chlorpromazine, an antipsychotic, was prescribed to calm down his excitability on the ward. By 5 March, the dose was 50 milligrams, three times a day. A nursing summary indicates that there had been no noticeable change since medication was commenced, yet medication was continued until just before discharge. The nursing staff were unable to understand the logic of this prescription and there is evidence that it was not unusual in the context of a lack of mental illness for such a prescription to be made by Dr Rowton-Lee.

19. There was a full telephone discussion with Mr Coombe's father in Cheshire on 28 January, although there was never a proper discussion with his mother who lived locally and visited weekly. She was likely to have had far more recent information to offer. There is a note that she should be spoken to and she did bring in some reports. There is a ward round note for 19 April which notes an interview with her. There is nothing of substance recorded and no other note of any conversation with her. She told us that this was the only time she was spoken to during this admission. She had asked to see Dr Rowton-Lee. She found the ward round very intimidating because of the number of people present. She was unable to identify who they were. She did not think that her contribution lasted for more than five minutes.

20. The nursing notes record contact with Dr Nick Moffat, chartered clinical psychologist based at Poole hospital, when he attended to assess Mr Coombe. There are, otherwise, about ten references to the CFT that we have been able to find. Of these, some refer to Mr Coombe having attended personal effectiveness groups, the first contact being with Mr Derry on 7 February. None of the entries provide firm evidence of any feedback from the CFT groups. There is a ward round entry on 12 March: "awaiting psychology report".

Comment

21. The nursing notes are good and show that a considerable amount of effort was put into assessing Mr Coombe by the nursing staff. This appears to have occurred, in the main, in isolation from the CFT. This is illustrated by the fact that it was the nursing staff who tried to address his lack of boundaries, fabrications and sexually inappropriate behaviour.

22. We heard evidence from three nurses who cared for Mr Coombe over this period, two from Studland and one from Branksome ward. We have taken written evidence from others. We were impressed by the nurses we interviewed; they were thoughtful and intelligent. The demanding and often thankless nature of their jobs cannot be overstated.

23. A significant omission is a proper risk assessment. Michelle Hopkins completed a risk form on 25 March 1997. It is a confusing document and she said that these assessments had then only recently been introduced.

24. In the same way that the use of CPA was a paper exercise conducted without rigour and thought during this admission, so this risk assessment was merely such an exercise. This is in no way a criticism of Ms Hopkins who really was doing her best. We identified in the Shane Bath report the need for a return to core principles so that staff and clinicians understand the fundamental requirements of an assessment without adhering to an over prescriptive and formulaic approach. This is relevant here also. Risk assessment is an essential area of practice demanding skill, understanding and confidence.

The Community Forensic Team: initial assessment

25. Our findings in the Shane Bath report, on the setting up and functioning of this team, have been echoed and reinforced by the evidence in relation to Mr Coombe. This was mainly to do with the lack of forensic expertise, leadership and a lack of definition of the service offered.

26. Mr Coombe was referred to the CFT for full assessment by Dr Rowton-Lee and the probation officer Mr Taylor. There is a referral form for assessment dated 23 January 1997 completed by Dr Rowton-Lee which includes in the section relating to relevant information:

> *old head injury, memory impairment and motor inco-ordination, confabulation and lies, two current offences, possible alcohol/drug problem, very muddled history with no clear supporting history.*

27. The CFT's role fell essentially into its court diversionary function but Mr Coombe was to be assessed while an in-patient under a section of the MHA. Unlike in 1993 when the aim was to provide a speedy assessment for the court, this provided an opportunity for a more in depth assessment of Mr Coombe's problems. The purpose of its assessments was ultimately to assist probation and/or Dr Rowton-Lee in their recommendations to the court regarding sentence.

28. The only written report from the CFT is an assessment report completed on 11 February 1997. It was signed by Mr Rowe, Mr Derry, psychology assistant since December 1996 and a recent psychology graduate, as well as Dr Grace Leung, consultant clinical psychologist. Mr Derry (now Dr Derry) is a qualified clinical psychologist currently working in forensic psychology at a Medium Secure Unit.

29. The nursing records indicate only that Mr Coombe was seen by Mr Derry on 7 February 1997. The CFT attendance records notes that he was seen on 4 February. Mr Derry has told us that he would have seen Mr Coombe to conduct a psychological interview and complete psychometric tests about three times. It was his role to administer tests determined by Dr Leung. He was totally inexperienced at this point and could have no real clinical opinions of his own. Nevertheless, he said that as assistant to Dr Leung he ran treatment sessions for patients, initially under her direct supervision, but rapidly, and probably even by the time he started seeing Mr Coombe at the end of February for 1:1 anger management sessions, he was conducting these on his own.

30. Mr Rowe had qualified as a registered mental nurse in 1979 and had spent six years as a staff nurse at Broadmoor Special Hospital between 1979 and 1985. He has worked at St Ann's since 1990. He was seconded from the hospital to the CFT in November 1996 at F grade; and it was his first community based post. His role was primarily one of liaison between the team and the hospital wards and in particular Studland and Branksome wards.

31. This initial report was a collaborative effort, with Mr Rowe completing the history and background, Mr Derry providing the psychometric test results and the whole being interpreted by Dr Leung. The conclusions drawn repeat Mr Coombe's assertion that he had an unbalanced childhood since his parents divorce, his low IQ and the need for neurological investigations. Further it was concluded that:

> *"he may be confabulating. He has a need to be recognised. He has little insight into his offending behaviour and has not shown maturation into accepting responsibility. He has little motivation and insight for change, therefore prognosis for change is guarded. He has claimed that he would benefit from help in dealing with his anger. If Mr Coombe is willing to co-operate, the Community Forensic Team is prepared to offer him anger management therapy to help him deal with his anger."*

32. Background and history were taken from Mr Coombe himself. The interview with Mr Coombe's father had by this time been completed and noted by the nurses (28 January 1997). There would have been ample opportunity also to consult with Mrs Coombe who was a regular visitor to the hospital as well as Mr Coombe's GP. In terms of ward liaison, one might have expected this to have come to Mr Rowe's attention. It is also not clear to what extent the earlier CFT assessment in 1993 was accessed or used at this time.

33. The psychometric testing showed no signs of depression. Mr Derry told us that there were signs of psychotic or delusional thinking which did not necessarily indicate a psychotic disorder. It may be that this resulted from the psychometric test results which indicated that Mr Coombe may have been exaggerating his answers making the results invalid, but that the scores suggested slight delusional and psychotic thinking patterns. Our forensic psychology expert pointed out that this test result was in fact invalid

because only 400 out of 567 items had been answered. This was not noted in the report and although Dr Leung stated that it was her standard practice to score all items on this test, we have seen evidence elsewhere that this was not an isolated occurrence.

34. Dr Leung's evidence was that insofar as diagnosis was relevant to the psychological process, her working diagnosis, which was not noted anywhere, was of a personality disorder.

35. Mr Rowe told us that he did not think that Mr Coombe had an anger problem, and there is support for his view in the nursing records, yet he did not feel able to challenge Dr Leung's conclusion that Mr Coombe required anger management.

36. The CFT's subsequent involvement with Mr Coombe has been difficult to determine with precision. The chaotic approach of Dr Leung was not assisted by the failure of others, in this instance Mr Derry and Mr Martin Koscikiewicz, trainee psychologist, to keep any notes of sessions with Mr Coombe or to provide any assessment for the sentencing process. Mr Derry was unqualified at this time and the responsibility for notes rested with Dr Leung. He told us that he did have notes of his meetings, and left these in Dorset when he finished his contract there at the end of 1997. He did not himself incorporate his notes into the main file and he recognises that he should have done so.

37. Evidence of chaos is obtained firstly in the lack of notes and secondly, the inability to determine precisely when Mr Coombe was seen by the CFT and how often. The CFT appointments record shows no meetings with Mr Derry at all. We have concluded that Mr Derry probably did see Mr Coombe for individual sessions, supervised by Dr Leung between 28 February and 29 April. The nursing notes mention a CFT group on 21 April, and it is known that at least on one occasion (6 May) Mr Coombe pretended he was going to his personal effectiveness group when it was not being held that day.

Anger management

38. After the murder of Michelle Lock, notes of six sessions of individual anger management were put into the main file by Dr Leung. These, she says, were her own notes which she had not placed in the file before. However, it is her view that there would have been at least ten such sessions and that she would only have attended five. Her basis for saying this is that a highly structured method was used and would have necessitated more than five sessions. We have found no evidence of this at all.

39. The notes show that on 13 February 1997, Mr Coombe had been disruptive during a group anger management session and been evicted from it. Thereafter, he received individual sessions. Dr Leung assured us that her notes were contemporaneous with the sessions they record.

40. There is a typed chronology on file prepared for the internal Trust inquiry (held immediately after the murder) which does not note any additional sessions. There is another typed document entitled "psychological therapy - Mr Simon Coombe" which summarises the work with Mr Derry and then deals with the personal effectiveness group between 7 May and 9 July. Dr Leung says that this was a summary of work undertaken, produced before the murder but not placed in the file until later.

41. What is clear is that there was no report prepared by Mr Derry or Dr Leung after the anger management therapy was completed and no evidence of any feedback of events during the sessions to the ward by either Mr Derry or Mr Rowe. Mr Derry, whose recollection in the absence of notes was admittedly "vague", said that this was because Mr Coombe was to continue with personal effectiveness and his involvement with the CFT had not ceased. However, even once it did so cease, there was no attempt to consolidate the results of these different sessions in a final report.

42. Mr Derry did not appear familiar with the allegations of sexual inappropriateness on the ward. He did recall going to the ward with Dr Leung on one occasion when he says she asked Mr Coombe very bluntly, and in a way which was embarrassing to Mr Coombe, about whether he masturbated. He believes that this was at the request of ward staff and intended to address the sexually inappropriate behaviour.

43. Even if there had been any analysis of Mr Coombe's tendency to fantasise and act inappropriately, this never found its way into notes available to the multi-disciplinary team. Mr Rowe, whose liaison role should have resulted in this information being shared with the CFT, was of the view that the behaviour exhibited by Mr Coombe in this respect was not of a serious or worrying nature. Although initially he told us that he was unaware of "sexually inappropriate" behaviour, it became apparent that this behaviour had not come to his attention in those terms.

44. Mr Rowe kept his own notes of ward rounds and Branksome ward groups. These show that he regularly attended at ward rounds and probably missed no more than three meetings. He notes the failed anger management group session on 13 February and some of the individual work with Mr Derry but without details of the contents of those sessions.

Personal effectiveness programme

45. A similar problem emerges in relation to the personal effectiveness programme with Martin Koscikiewicz. There are no contemporaneous notes of these meetings at all, but the nursing notes and Mr Rowe refer to them as being ongoing. There is again no evidence of feedback from these sessions to the ward. There is one reference on 11 May in the nursing notes to some "acting out" behaviour mentioned by Mr Rowe. Mr Rowe has made no separate note of this, but on 4 June, records from the personal effectiveness group: *"acts out" a little".*

46. The only notes of these sessions are in the summary prepared by Dr Leung but not placed in the main file until after the murder. The entry for 4 June 1997 is fuller than the rest and indicates that Mr Coombe was exhibiting attention-seeking behaviour like *"showing off".*

47. This summary indicates that Mr Coombe attended on six out of ten of these sessions. This is mirrored by the CFT appointments record but not by an apparently contemporaneous "register" provided to us by Mr Koscikiewicz which is the only record of an attendance on 18 June. Otherwise the notes suggest that his last attendance was on 11 June and that, as soon as he was discharged from hospital, he made it known that he would not be attending for further treatment.

48. We think it likely that Mr Coombe failed to attend on 18 June. This is confirmed by the extraordinarily brief and uninformative "interim report on treatment" provided on 19 June 1997 to Dr Rowton-Lee. This noted that Mr Coombe had by this time attended six sessions and missed one. It states in list form that cognitive therapies were started on depression, anxiety and effectiveness, but that obsession, anger and grief were "N/A". The progress report stated *"Has some problem with attendance plus despite some attention seeking he did contribute to the working of the group"*. It is signed by Mr Koscikiewicz.

49. There is then a report on which the word "interim" has been deleted and substituted with "final". It is undated and unsigned and in manuscript form. It appears to be addressed to Dr Rowton-Lee. It attempts to put together all the CFT interventions but states erroneously that treatment started on 28 April. This is wrong because if "individual anger management" is the starting point, then 28 February should be the correct date and if "personal effectiveness" is the starting point, then 7 May is the proper date.

50. This "final" report refers to the five individual sessions and one missed session. It goes on to record a total of sessions attended (including group) of eleven and of appointments missed as five.

51. This is clearly intended to summarise the CFT intervention in this case, but remains in an incomplete form in the CFT file. There is no evidence that it was ever sent to Dr Rowton-Lee. However, the substance of the progress report was put into a letter dated 10 July and headed "interim report" by Mr Koscikiewicz. This letter is important as Dr Rowton-Lee said he had no recollection of seeing it and neither did Mr Rowe until after the murder. There is a copy on the Trust file but the date it was received is not stamped onto it. Further it was copied to Mr Taylor at the probation service but he had by this time left the service and there is no copy of the letter on probation records.

Letter of 10 July 1997

52. The undated versions reads:

> *"Has made some progress during group therapy sessions, although responding when challenged his responses have at times been inappropriate. As a result some control has been necessary in managing his acting out behaviour during group sessions. He has tended to maintain his antisocial attitudes in particular those relating to violence and females. Needs CPN support in the community."*

53. In the letter of 10 July the last sentence is omitted. It seems to us that the reference to acting out behaviour may have reached the ward round on or before 4 June. However, the letter offers no explanation for this apparently important conclusion being communicated in a brief letter two weeks after Mr Coombe was discharged.

54. Mr Koscikiewicz told us that he was unaware of the sexually inappropriate behaviour noted by ward staff and would not have read the nursing notes. He told us that he concluded that Mr Coombe had problems with relationships with those in authority, females and aggression.

55. In expanding on the events during the group sessions which led to this conclusion and the final line of the letter of 10 July, Mr Koscikiewicz said to the Inquiry that Mr Coombe's:

> *"attitude towards women and his view of women did become an issue for the group...In as much as he perceived women as objects and that if sexual gratification was what he sought..."I'll just go out and pick a woman up and have her for sex and just dump her out in the morning". He had a totally dysfunctional attitude to females and his view to violence such that it sticks in my mind."*

56. As for the violence, Mr Koscikiewicz said that the group had been discussing how to handle a situation where somebody was "chatting up" your partner. Mr Coombe apparently jumped up and ran around the room:

> *"showing how he would attack the person with a pool cue. Totally lost it actually. Everyone just sat there gob-smacked about his presentation."*

57. By contrast, both Dr Leung and Mr Rowe told us that they think that the letter was unfortunately worded to link "violence" with "females" and this cannot have been intended.

58. Mr Koscikiewicz was sure that he would have discussed these events with either or both of Dr Leung and Mr Rowe. He felt sure that he would have discussed his letter with Dr Leung. Of course, none of this is documented. Mr Koscikiewicz said there was no requirement to keep notes for each patient in the group.

Comment

59. **The result of the CFT intervention in this case is that, over a period of about four months, much time and effort was expended on Mr Coombe. Superficially the records give the impression of significant psychological input above the norm to be expected of a local service such as this. It is clear, however, that assessment imperceptibly changed to treatment. There is no firm evidence of feedback to the nursing staff and no final report or assessment was provided to assist with the sentencing process as originally requested. This was a haphazard process ending with an alarming letter, written without proper consideration, or consultation or follow up.**

60. **It should not have to be said, that there is no value in this level of input without there being some output in terms of contribution to the multi-disciplinary assessment (there was no CFT input to the discharge process either), or to the recommendation to the court. This is evidence of the lack of leadership and evaluation of the work of this team, for which there must be managerial accountability (see Concluding Comments, chapter 19).**

61. **We have heard that the choice of treatments on offer was limited to (1) cognitive therapy, (2) sex offender treatment, (3) anger management and (4) personal effectiveness. Our expert forensic psychologist has criticised the content of (4) and its unsuitability as anything more than a motivational tool to encourage participation in further in depth treatment.**

62. **We have previously commented on the use of unqualified psychology assistants (see Shane Bath). Our concerns regarding the proper training of staff within this team to carry out a forensic role is underlined. Mr Koscikiewicz was a trainee psychologist with no clinical background. He had recently completed a masters degree in legal forensic psychology and, as a result, regarded himself as a qualified psychologist. The Trust, however, had resisted upgrading him and this was clearly a matter of some disappointment to him.**

63. **Dr Leung gave evidence of the heavy work load being carried by the CFT and this is also contained in the CFT steering group minutes. She was the only clinically qualified psychologist on the team and was struggling to cope with the work load. She said the problems she was experiencing were taken to her manager who was Linda Boland at that time. Steps taken to recruit another qualified psychologist had been unsuccessful. Ms Joanna Brook-Tanker, consultant clinical psychologist with significant forensic experience took up her post in November 1997. (See Concluding Comments, chapter 19).**

64. **Record keeping could, and should, have been monitored by the Trust and is likely to have given an indication of the standards of the team. The lack of feedback of sessions to ward rounds and multi-disciplinary meetings could also have been picked up by proper management scrutiny.**

65. **We are aware that there is a new Dorset wide forensic service now in operation. We think it is important that a review is conducted of that service based on our comments and findings. This is the kind of sensitive and difficult service which warrants periodic monitoring of the standards and quality being achieved at least in these basic areas of practice.**

RECOMMENDATION 4:

The Trust, in liaison with other agencies, should arrange for an independent review of the Dorset Forensic Service, in the light of the numerous identified failings of the CFT. This should include record keeping, report writing and multi-disciplinary work.

RECOMMENDATION 5:

The Trust should institute a system of regular internal reviews of the practices and procedures within the Dorset Forensic Service with the aim of ensuring that acceptable standards of communication and assessment are maintained.

Neuropsychological assessment by Dr Nick Moffat.

66. This is dated 11 March 1997. Dr Moffat, chartered clinical psychologist, Brain Injury Team, Poole General Hospital, told us that he was very rushed and conducted his assessment of Mr Coombe one evening, and after Mr Derry had completed some of the psychometric testing for him. He did not have the Wessex neurological material available to him, nor the educational guidance report of 1986. He states that the background is set out in Dr Rowton-Lee's referral letter and the CFT report. Dr Rowton-Lee had summarised the Wessex findings.

67. He concluded that there was no "*obvious or severe problem which can be directly attributable to a previous head injury, and not to his educational and family background.*"

68. Dr Moffat stands by his conclusions having been shown the reports which were not available to him at the time of his assessment.

Ward Rounds

69. It has already been stated that the notes of ward rounds were scanty and rarely noted who was present.

Comment

70. We are left with the impression, which has been confirmed by evidence, that Dr Rowton-Lee operated a medically led team of an old-fashioned variety. There is little evidence of any attempt to draw together the assessments made together in a multi-disciplinary case conference. The most obvious example of this is the lack of any recording of progress from the anger management or personal effectiveness groups run by the CFT. The lack of a diagnosis, or psychiatric or psychological formulation, is further evidence of the lack of a coherent or co-ordinated approach.

Court reports and sentencing

71. There was no sense of urgency in responding to the court with an assessment of Mr Coombe. On 13 February 1997, Dr Rowton-Lee provided a four line report requesting an extension of the section 35 order, which was granted.

72. A section 38 interim hospital order was made on 14 March 1997. The court report was provided by Dr Mohammed. He provides no specific diagnosis, but states that Mr Coombe:

> *"presented with high anxiety levels and "covert depression". He has low self-esteem. He has ideas of hopelessness and worthlessness. He experienced high levels of anger and his behaviour was inappropriate at times".*

There is no reference to the results of the assessment of Dr Moffat or the CFT. The second opinion was provided in a pro forma style by Dr Rowton-Lee. He refers to a long term depression and a *"longstanding mental state disorder which has not responded to out patient treatment"*. There would appear to be no basis for this opinion in the records.

73. On 5 June 1997 Dr Rowton-Lee, in a very brief report, recommended a *"probation order with condition of treatment as an in-patient for the immediate future"* and then discharge with attendance as a *"day patient for the foreseeable future"* in his report to the court. He stated optimistically (judged against the records) that Mr Coombe had made great efforts to co-operate with treatment and especially the cognitive therapy from the CFT. He offered no diagnosis except for:

"Remains a young man with considerable difficulties".

74. Mr Coombe received a two year probation order from Southampton Crown Court on 6 June 1997 in respect of the charge of theft of a vehicle. He received a two year probation order with a condition of treatment from Bournemouth Magistrates Court on 13 June 1997. The orders were to run concurrently.

75. There was no additional probation report available and indeed Mr Coombe had no assigned probation officer involved in his care since the retirement of Mr Taylor in March 1997.

Comment

76. We have commented previously on the need for proper court reports (Shane Bath, chapter 6). For medical reports, a formal diagnosis and an explicit reference to the statutory criteria being applied are necessary, as is a prognosis section which should trigger consideration of risk.

77. The use of section 38 was surprising in the absence of a diagnosis. Section 38 requires the certification of two registered medical practioners that "the offender is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment" and that there is reason to suppose that a hospital order may be appropriate (section 38(1)(a) and (b)). A hospital order (section 37) additionally requires that proposed hospital treatment "is likely to alleviate or prevent a deterioration of his condition" (section 37 (2)(a)(i)).

78. We have already commented on the use of "covert depression" as a diagnosis in chapter 1 and paragraph 86 below. It was expedient to use it to continue Mr Coombe's detention in hospital, but this was an inappropriate and probably unlawful use of the MHA. It would have been more appropriate to make residence in hospital a condition of bail once the section 35 came to an end. The use of the MHA also arose as an issue in the Shane Bath report.

79. It is unclear what treatment the court expected Mr Coombe to receive under this probation order. A probation order with a condition of psychiatric treatment (section 3 and Schedule 1A Powers of Criminal Courts Act 1973, now in the Powers of the Criminal Courts (Sentencing) Act 2000) requires a court to be satisfied, on the evidence of an approved medical practitioner, that the mental condition of the offender is such as requires and is susceptible to treatment, but does not warrant his detention under a hospital order (Schedule 1A(5)(1)). Dr Rowton-Lee's report did not satisfy these requirements.

80. Additionally, from his report the impression was not conveyed that discharge was imminent (19 June). This would have been relevant for the court on 13 June to know about and may have affected the outcome, especially in light of the fact that there was no assigned probation officer at that time to provide details of community provision for Mr Coombe.

Diagnosis and formulation

81. The clinical note on admission to hospital written by Dr Rowton-Lee's senior house officer stated *"For assessment for? personality disorder on background of dysfunctional family"*. This was not in Dr Rowton-Lee's report of December 1996, nor is there any further reference to personality disorder in the records. Dr Leung told us that this was her working formulation which she held in her head. Later Dr Mohammed and Dr Rowton-Lee referred to depression for which there appears to be no basis. The discharge summary makes no reference to a diagnosis.

82. Of the nurses we interviewed, one was unaware of the working diagnosis and another said it was "personality disorder, covert depression and immature personality".

83. A clear omission, in terms of a formulation, is any consideration of the reasons why Mr Coombe was so prone to fantasy and fabrication or why he felt the need to display bravado and sexual prowess in his interactions with females on the ward.

84. Mr Coombe had also said that his offences were drug related. We do have evidence of some alcohol misuse in 1993. During this admission, however, no such problem emerged. He was noted to have admitted to using cannabis in hospital, but all the drug screens for this were negative. A lack of any withdrawal symptoms was also noted at a time when he said he was craving cocaine.

85. Although there is some evidence of a discussion about drug use and offending, there is no evidence of any other investigation of the extent of his actual use. The evidence which does exist suggests that at this time Mr Coombe was either fabricating or exaggerating his drug use.

Comment

86. Dr Mohammed told us that "covert depression" meant an "underlying depression". He acknowledged that this was a term favoured by Dr Rowton-Lee and indeed we have come across it in all three inquiries, but it is not referred to anywhere in the literature or text books. Dr Mohammed was loyal to Dr Rowton-Lee on this issue and defended the diagnosis of depression at this time in his interview with the Inquiry panel.

87. It should not need saying that for Mr Coombe to be discharged from hospital after six months with no diagnosis or formulation of his presenting difficulties is totally unacceptable. We emphasise again the waste of resources that this represents and the evidence suggests that this was not an isolated case.

88. The recommendations we have made in chapter 8 relating to the need for a proper complaints system through which consultant failures can be addressed by staff, together with the comments relating to the need for equal partnerships within multi-disciplinary teams also apply here. It should also assist, for example, with the concerns expressed to us by nursing staff over the prescription of medication to Mr Coombe with no apparent clinical indication for the same (paragraph 18 above).

CPA and discharge

89. Within two weeks of the court report of 5 June 1997 from Dr Rowton-Lee, and five days of the probation order with a condition of treatment was being made, plans were made to discharge Mr Coombe. He was discharged a day later.

90. There was a ward round on 18 June 1997 with Dr Rowton-Lee at which it was concluded that Mr Coombe required close supervision and was not to go to independent accommodation. He was to await a place at Dorset Lodge, a probation hostel, with a structured programme. The CFT social worker, Vic Trimble, managed to get him a place there for the next day.

91. Mr Rowe was present at the meeting and the clinical note states that the key worker in the community is to be *"Victor or Phil"*. Mr Trimble does not appear to have been present at this meeting because the nursing note reads *"CFT V Trimball to be informed by Phil Rowe"*. Mr Rowe told us that on subsequent discussion with Mr Trimble the role of community key worker fell to him i.e. Mr Rowe

92. The CPA form (A) is dated 19 June 1997 and was not filled in by Michelle Hopkins who was not at work on that day. He was discharged on level 1. The significant background information recorded includes the two offences, the head injury in 1990, hyperactive behaviour as a child, and the difficulties following his parents divorce. Under "Special precautions/risk factors" appears:

> *"no violence in Simon's history but he has reported shooting 6 police men in San Francisco and 1 in France, armed robbery in the past. No evidence of this. Abuse of illicit drug use reduces Simon's' behaviour to non-compliance with society's rules".*

"Specific indicators of relapse" are:

> *"as there has been no evidence of mental illness unable to identify specific factors to cause relapse of anti-social behaviour. Drug and alcohol abuse relate to increased antisocial behaviour".*

The plan was for a *"Full range of services to be made available"*.

93. The probation service was not involved in this discharge process.

94. The treatment plan in CPA form (B) was primarily for monitoring of mental state by Mr Rowe and a first appointment was set up for 24 June, secondly, to continue with personal effectiveness at St Ann's and thirdly, to establish a structured day. In relation to the latter,

Michelle Hopkins had made a referral to out -patients occupational therapy. All these are recorded as needs which are met, yet it is clear that Mr Coombe had already defaulted on the personal effectiveness sessions by this date and never in fact returned to them. Dr Rowton-Lee told us that it was intended that occupational therapy would form the treatment under the probation order. He was not on any medication at this time.

95. Mr Coombe attended occupational therapy between 14 and 30 July (on seven days) and then stopped. He did not accede to any other form of treatment after his discharge from hospital. In occupational therapy, his mood was described as bright and he was sociable. He was also demanding, lacking in motivation and easily distracted.

96. The discharge summary was dated 8 July 1997 and addressed to Mr Coombe's general practitioner. It was written by Dr Rowton-Lee's senior house officer. It incorrectly records the discharge date as 25 June. His presenting complaint was said to include a *"previous history of car theft and commercial burglary"*. He was said only to have been seen by Dr Choudry in the past. This is also a clear error as Mr Coombe had been seen in 1989 and 1993 by Drs Rastogi and Franklin.

97. On mental state examination, it was recorded that *"it was felt at first that he was probably suffering from a personality disorder on the background of a dysfunctional family"*.

There was no indication of what the diagnosis on discharge might have been.

98. As for treatment and progress, occupational therapy and CFT were mentioned but no results of assessments. There was no mention of the sexually inappropriate behaviour on the wards but it was recorded that his behaviour was at times childish and disruptive. There was no mention of the section 38 order. The probation order was mentioned and the condition of treatment was outlined very generally as *"he has to see the CFT and be involved with the hospital"*. There was nothing about risk or relapse factors or indeed prognosis. The GP received the CPA form on 24 June.

Comment

99. It is not possible to tell who was present at the 18 June meeting, which was not a specific discharge planning meeting. There is no evidence that Mr Rowe provided any feed back from the CFT groups and no other member of the CFT is referred to. It was erroneously noted that Mr Coombe was still attending personal effectiveness although he had ceased to do so on 11 June. This cannot have been as a result of the "interim" report of Mr Koscikiewicz, which was provided the next day. Altogether this was a very peremptory and unsatisfactory discharge meeting.

100. We would expect to see a full list of attendees invited in advance to a specifically designated discharge meeting. There should have been full verbal or written feedback from all those involved in assessing and treating Mr Coombe, resulting in the preparation of a detailed care plan being the result. It goes without saying that the subsequent filling in of a CPA form, in the manner described above, does not conform to expectations over the proper process to be undertaken. It did not reflect what was in the ward round note for the previous day and the plan for a "full range of services" is highly uninformative. Of the three elements of the treatment plan set

out, one (personal effectiveness) had already failed and another (occupational therapy) failed by the end of July without being addressed.

101. We have already commented on the importance of proper discharge summaries (Shane Bath para. 31.11 and App. H).

Social services

102. There are references to Vic Trimble, CFT social worker in the records. These do not indicate, however, that he ever saw or assessed Mr Coombe prior to discharge when he arranged accommodation at Creek House (part of Dorset Lodge).

103. The social services records are very sparse indeed, consisting of one short note and a telephone message. There is no evidence of the case being opened to Mr Trimble. He expressed surprise to us that there are so few records now available. He assured us that he saw Mr Coombe five or six times and kept a contact sheet summarising each client contact. He also stated that he had completed a community care assessment using the departmental format. A search has been made for these documents to no avail.

104. As well as not being available on the social services records, the community care assessment is also not to be found on the files of any other agencies involved in Mr Coombe's care and in particular, St Ann's or the CFT. We have also not found any reference to such an assessment in any of the documents available to us. We have, therefore, been unable to verify Mr Trimble's claims.

Comment

105. Throughout these inquiries we have found that social services record keeping, and not simply within the CFT, was very poor. We have commented on this further in the McMahon report at chapter 14.

Chapter 8

AFTER CARE, AND COMMUNITY LIVING AND PROBATION

PROBATION

JUNE 1997 TO APRIL 1998

Health and Probation Services

Summary:

The initial allocation of a probation officer following sentencing on 6 June 1997, and discharge from hospital on 19 June 1997, was not carried out within national standards.

Thereafter, there were serious communication and leadership problems between the probation and health service over the management of the probation order with a condition of treatment. This resulted in the probation service receiving no proper summary of the period of in-patient care and no progress report from Dr Rowton-Lee in relation to the condition of treatment.

Probation and health worked in isolation and Phil Rowe, CFT nurse, conducted a CPA review in October 1997 on his own. Hence, there is evidence that the CPA was being imperfectly used and multi-agency collaboration was at a low level.

We have perceived an inequality in the partnerships within the multi-agency relationship. Again we are critical of the strict adherence to national minimal standards of probation reporting in this case.

Mr Coombe remained a low risk of harm to others.

RECOMMENDATION 6:

The probation service should set guidelines for probation officers in maintaining contact with the lead clinician responsible for offenders referred for inpatient assessment prior to sentencing. This should include advice on ensuring that there is an up to date report for the court and involvement in discharge planning.

RECOMMENDATION 7:

The Trust should take the lead in including the probation service in the operation of the CPA and hospital discharge process.

RECOMMENDATION 8:

There should be an agreed joint agency protocol for prosecuting failures in multi –disciplinary working and a complaints procedure. This should involve chief executives and emphasise the need for equal partnerships within multi-disciplinary/agency work.

Summary continued

RECOMMENDATION 9:

Joint health and probation service guidance should be developed on the management of probation orders with a condition of treatment. This should include clearly identified roles for each service together with an identified treatment plan, a timetable of appointment and provision for joint reviews.

Introduction

1. This chapter concerns itself with Mr Coombe's care and treatment in the community and covers the period following discharge from St Ann's Hospital, on 19 June 1997, to Dorset Lodge, and his subsequent move to a flat in Holdenhurst Road on 9 or 10 October (the evidence as to the exact date is contradictory) and the period leading up to his move to Wimborne Road, Kinson on 9 February 1998. Dorset Lodge is a 16 bed hostel situated in Bournemouth providing accommodation and support for homeless men and women aged 18 and over, including residents on bail, statutory licence and probation orders.

2. Although a probation order had first been made on 6 June 1997, no probation officer had been appointed by the time that Mr Coombe left St Ann's. The condition of treatment (made on 13 June) was ultimately fulfilled by supervision in the community by Mr Rowe from the CFT, who had become the key worker, and out-patient appointments with Dr Rowton-Lee. These health service appointments are deemed to be satisfactory for the purposes of compliance with probation national standards on reporting, presumably to avoid duplication of effort.

3. Mr Coombe had stopped attending the CFT personal effectiveness group prior to discharge from St Ann's and subsequently failed to attend at occupational therapy. He also failed to co-operate with the Dorset Lodge Outreach programme.

4. Mr Coombe was supervised by three probation officers in this period. Tina Ridge, based in Poole was appointed on 26 June 1997. Tariq Hyatt, a Bournemouth based officer, took over on 11 July. The final transfer to Judy Parsons was in early November 1997 and was due to Mr Hyatt's leaving Dorset by November, after Mr Coombe had moved to independent living at Holdenhurst Road. He moved from weekly to fortnightly reporting in October and by January was being seen monthly.

5. The Dorset Lodge records are no longer available and were destroyed prior to the murder of Michelle Lock. The log book entries have not been located. However, the evidence available from the hostel manager is that Mr Coombe paid his rent on time, maintained his room well and was willing to do his duties around the hostel. Mr Rowe had noted that he was a management problem and was angry with an ex-resident, but we have been unable to obtain any elaboration of this entry.

6. There were no real concerns over Mr Coombe's mental health over this period and he was doing well selling the Big Issue. Mr Rowe did, however, communicate his concerns over Mr Coombe's vulnerability in independent accommodation at Holdenhurst Road to

Dr Rowton-Lee and Ms Parsons. There was evidence that he was being exploited by a drug taking group of younger people. There was also an incident when a young man died in his flat through an overdose. Mr Coombe called an ambulance and gave evidence at the subsequent inquest.

7. Although Mr Coombe was not implicated in any of this activity, it did eventually lead to his being evicted from Holdenhurst Road in early January 1998 and there was a flurry of activity by probation and CFT around this time regarding his accommodation. By the middle of February, and with the help of his mother, he had moved into 1579A Wimborne Road, Kinson where his neighbour was Michelle Lock.

8. There had been a hiatus in CFT contact from 22 January to 24 March 1998. He had missed an appointment in late January and Mr Rowe had been on sick leave in early February when Mr Swire-Cunningham had covered for him. He had changed from seeing Mr Rowe fortnightly to monthly, shortly after he moved to Holdenhurst Road and had been seeing Dr Rowton-Lee monthly.

9. Throughout this period Mr Coombe was considered to present a low risk of harm to others.

Allocation of probation officer on discharge from St Ann's

10. Rob Taylor, the probation officer who had prepared two pre-sentence reports in December 1996 and January 1997, retired in March 1997. He had written to the court duty officer at Bournemouth Magistrates' Court on 3 March to say that he was leaving the service, that Mr Coombe was an inpatient and it was still unclear what kind of treatment he might be offered. Therefore, it was not possible for him to offer any sentencing proposals. He suggested that the case be transferred to the Court East Team, that is, the team covering the Bournemouth area. Nothing seems to have transpired from this and no action took place until just before his discharge in June.

11. We heard from Margaret Harris, senior probation officer in Bournemouth, that a probation officer is not appointed until after the court has sentenced the individual to a probation order. National standards for the probation service at the time required that someone should be seen within five working days of an order being made but if they are resident at somewhere like St Ann's then they should be seen within five working days of leaving there i.e. by 24 June.

12. In any case, Ms Harris told us that she would have expected that a probation officer was appointed prior to discharge. The first she heard about Mr Coombe was a telephone call from Michelle Hopkins, his primary nurse at St Ann's, on 16 June warning her that he was about to be discharged. As a result, Ms Harris wrote to her opposite number in Poole, Alan Yelling, *'hoping'* he would accept him., The rationale being that his address prior to this had been *'NFA Poole'*. Mr Yelling made a hand-written note on this memo from Ms Harris to the effect that the case had been *'around the houses'* since 6 June when the first probation order had been made.

13. In response, Tina Ridge was appointed as the supervising probation officer on 26 June 1997. She made telephone contact with Branksome ward on 30 June and established that Mr Coombe was at Dorset Lodge. She first saw him on 7 July.

14. Ms Ridge does not remember her face to face contact with Mr Coombe. The only information she had on allocation was that available in the two pre-sentence reports of Mr Taylor and a telephone message from Michelle Hopkins prior to the allocation. She requested a copy of Dr Rowton-Lee's brief court report, which was never received, a list of previous convictions and a summary of evidence for the offences from the police. On 3 July a copy of the CPA dated 19 June was received from St Ann's.

15. On 8 July 1997 Ms Ridge contacted Martin Koscikiewicz and was told that Mr Coombe had dropped out of anger management but was attending the personal effectiveness programme. He actually attended his last session of the latter on 11 June. There is no evidence that he had dropped out of the former.

Comment

16. **There was clear confusion over the allocation of a probation officer at this time resulting in a failure to see Mr Coombe within the prescribed national standards. He was seen twelve days outside the required time and there was no up to date probation report available to the court.**

17. **Our expert advice is that, in this case, it was primarily the responsibility of the probation service, as officers of the court, to have ensured that enough of a watching brief was kept over Mr Coombe's progress through the courts to have appointed an officer early enough after the making a probation order to have been linked with his discharge plans. The limited role of a probation officer while an offender is an in -patient, is provided for by statute (Schedule 1A(5)(5) Powers of the Criminal Courts Act 1973, now in Powers of the Criminal Courts (Sentencing) Act 2000)**

18. **However, there is a clear responsibility on the part of the health service to have initiated an early approach to the probation service, especially as the recommendation for a probation order (in the second court case heard on 13 June) came from the health service and in pursuance of the objective of multi-agency working. We do know and Ms Harris acknowledged that she had heard from Ms Hopkins, Mr Coombe's primary nurse on 16 June. At that time it was not known, however, that discharge was imminent.**

RECOMMENDATION 6:

The probation service should set guidelines for probation officers in maintaining contact with the lead clinician responsible for offenders referred for inpatient assessment prior to sentencing. This should include advice on ensuring that there is an up to date report for the court and involvement in discharge planning.

RECOMMENDATION 7:

The Trust should take the lead in including the probation service in the operation of the CPA and hospital discharge process.

Supervision and monitoring in the community: Dorset Lodge

19. Probation record entries for the period from July 1997 are very brief and lacking in detail. Mr Coombe failed to attend only one out of eleven supervision sessions with Mr Hyatt who had written his supervision plan in Mr Coombe's absence, although it is noted that he had been consulted about it. The plan was to attend for treatment with Dr Rowton-Lee, address offending behaviour through *"supervision of cognitive programme"* until the end of the order and to report to his probation officer.

20. Dr Rowton-Lee saw Mr Coombe on four occasions as an outpatient between his discharge from St Ann's on 19 June 1997 and his leaving Dorset Lodge on 9 or 10 October 1997. He could not recall receiving a notification from the occupational therapy department on 4 August that Mr Coombe was not going to attend future sessions and was unaware that this programme did not go ahead for as long as was planned. He had also stopped attending the personal effectiveness courses run by Mr Koscikewicz and again, Dr Rowton-Lee was not aware of this.

21. Dr Rowton-Lee knew that Mr Coombe wanted to move out of Dorset Lodge and into independent accommodation and as early as 30 July 1997 was content for probation and Dorset Lodge to decide the issue. This was reflected in a letter of 4 August he wrote to the CFT (copied to Dorset Lodge), that he would support such a move subject to their views. He also recorded that Mr Coombe had talked enthusiastically about his efforts to live a cleaner life and had been encouraged to take an Outreach course in further education. He concluded that he seemed "better than ever before" but still needed close supervision. He was to offer another appointment in six weeks.

22. We do not know when and if Mr Coombe ever started on the Outreach course, but by the end of October (after he had moved to Holdenhurst Road) Dorset Lodge informed probation that he was no longer attending. Mr Hyatt wrote to him and advised him to attend in his best interests and to keep out of trouble. This was to no avail.

23. There is no record of Dr Rowton-Lee (or indeed Mr Rowe) being informed of this failure, and he could not recall being informed that Mr Coombe did not attend the outreach course there.

24. Mr Rowe saw Mr Coombe on eight occasions between his discharge and his leaving Dorset Lodge. It is apparent from his notes that Mr Coombe was keen to move into independent accommodation from the beginning of his stay there. Dr Rowton-Lee was initially not prepared to support this but had changed his mind by 30 July when he advised that provided his probation officer and Dorset Lodge were happy to support such a move he would not stand in his way. Mr Coombe presented very few problems at Dorset Lodge and appeared well during this time. There were no signs of mental illness.

25. Mr Coombe was selling the Big Issue in this period and seemed to enjoy this work according to the project manager. He was quite successful at it, selling up to 60 copies at a time. His tendency to exaggerate and tell tall stories was noted. The project manager did not feel intimidated by him even though like others, he tried to flirt with female staff although this was discouraged and challenged when it did happen. She suspected that he might have been on medication, but said that if he took illicit drugs he either hid it well or were not the ones she had observed many times in others.

26. The project manager advised us that there were problems in obtaining information from other agencies. Sometimes information was necessary and relevant to their approach to the vendors or staff safety.

Comment

27. Mr Hyatt's reference to *'supervision of cognitive programme'* would seem to refer to the probation services own group programme running on cognitive therapy lines. Judy Parsons, in her written evidence, questioned whether Mr Coombe was a suitable candidate for such an approach and it seems that he never took part in this programme. In fact, according to Ms Parsons, because he would have required a specific condition to be attached to his order and was still in the first six months of his supervision, he would not have been eligible for this programme. This objective was not reviewed, at the end of Mr Hyatt's supervision of Mr Coombe, and his overall plan was never implemented.

28. Mr Hyatt's notes are too brief, for example ' *Simon reported. Next appt at ....'*, a point which he now accepts. Apart from a short note recording the sorting out of a missed appointment with Dr Rowton-Lee and the logging of a telephone call from Dorset Lodge, the dates of reporting are the only activity recorded.

29. It is by no means clear what, if any, involvement Mr Hyatt had with arranging the move from Dorset Lodge to Holdenhurst Rd in October 1997. He thought that Dorset Lodge would provide the support to enable Mr Coombe to make the transition and even be involved in finding the accommodation. He did not record, nor could he recall, the date Mr Coombe moved out of Dorset Lodge.

Supervision and monitoring in the community: Holdenhurst Road to Wimborne Road

30. On 31 October 1997, Mr Hyatt wrote to Dr Rowton-Lee asking for a progress report on Mr Coombe's treatment. There was no response. In his subsequent transfer summary to Judy Parsons he incorrectly stated that Mr Coombe was on medication. There was no hand over meeting and Ms Harris told us that although this was best practice it does not always happen.

31. Ms Parsons worked half time as a probation officer supervising offenders on court orders or prison licences. She thought her own caseload was not exceptional and while she was working hard she did not feel under unacceptable work pressure. She had attended training courses on risk assessment and dangerousness and had some limited experience in mental health work.

32. The information available to her on transfer apart from Mr Hyatt's transfer summary and the probation file consisted of a list of his previous convictions and Dr Rowton-Lee's very short report of 5 June to the court recommending a probation order with a condition of treatment.

33. Ms Parsons agreed with us that this was inadequate information. Dr Rowton-Lee did not reply to Mr Hyatt's request for a progress report on Mr Coombe's treatment, neither had there been a reply to earlier requests for an initial psychiatric report. Both Ms Harris and Ms Parsons stated that this was a general issue so far as Dr Rowton-Lee was concerned. Ms Harris told us that he never responded to requests for progress reports while Ms Parsons said:

> *'There is a gross problem in obtaining information and it is not just in this case. It is quite common not to get very full and complete reports and he does not attend meetings when he is invited to. That is commonly known ....'*

34. Because of the delay in obtaining the progress report from Dr Rowton-Lee, Ms Harris asked her colleague responsible for working with other agencies to follow it up. She explained to us that she had also passed on to him other examples of unacceptable delay in receiving information. Apparently, nothing came of this.

35. We asked Ms Parsons why she was not more forthright in asking for the relevant health service information herself, as the probation order was under the control of the probation officer and there was a condition of treatment. She explained that the general feedback she was getting was that matters were proceeding smoothly and there were no alarm signals that might prompt her to press for the information. She did not believe that the fact it was being dealt with by managers had any influence on whether she proactively followed up the missing information or not.

36. Because of the lack of health service information, she was not in possession of all the relevant facts. She was unaware, for example, of Mr Coombe's sexual inappropriateness on the ward. Ms Parsons assured us that had she been aware of this she would have pursued the psychiatric reports of Dr Rowton-Lee more vigorously:

> *'.. it is a concerning feature. I need to know more ..... I would have highlighted it. I would also make the point that it is a little irresponsible. I am a female, I am seeing him in my own room. I want to know more.'*

37. Ms Parsons was due to see Mr Coombe on five occasions over a period of just under five months, the first time being on 10 November 1997. Under the national standards applicable at the time the reporting requirement shifted to once monthly from January 1998 onwards but reporting to the CPN and the RMO counted as reporting occasions.

38. She advised us that Mr Coombe presented well although he had poor concentration and his emotional range seemed limited. She did not feel uncomfortable in his presence and suggested that he might have a degree of learning disability. She described her initial approach to his problems:

> *'I was just trying to tackle the influence of others upon his behaviour and the dangers of illegal drugs and alcohol. Quite a simplistic "here and now" problem*

solving approach - trying to encourage thinking about solutions to current problems - the main problem he identified was dissatisfaction about his accommodation in that other people were invading his home, not necessarily with his agreement'

39. The difficulties Ms Parsons encountered in motivating Mr Coombe to attend, for example, the Outreach programme run at Dorset Lodge, coincided with him receiving a large social security back payment (around £4,000).

Comment

40. Generally, the approach taken to probation supervision seems to reflect the fact that Mr Coombe was assessed to present a low risk to the public. There was little meaningful effort to engage Mr Coombe or to obtain his compliance with more than reporting requirements. We have commented on what we have found to be a mechanistic approach to national standards of reporting in chapter 4 and also in the McMahon report (chapter 13). See Recommendation 1.

41. Once low risk is established, the categorisation is only really likely to change if the person commits a relevant offence e.g. a crime involving serious violence. We think that it is understandable that low risk cases should attract low resources in this context. Resources are always finite. It should be clearly appreciated (by the public and government alike), that this is unlikely to allow for sensitive or accurate predictions of future dangerousness.

Mr Rowe

42. Between 22 October 1997 and 9 February 1998, Mr Rowe visited the Holdenhurst Road flat on four occasions, finding Mr Coombe at home on two of them. On the first he seemed happy and no problems were expressed.

43. Following a visit on the afternoon of 26 November 1997 he wrote a letter expressing concern over Mr Coombe to Dr Rowton-Lee and copied it to Ms Parsons. He also completed CPA review documentation.

44. That morning he had spoken with Mrs Gibbard, the manager of the flats where Mr Coombe was staying, who informed him that she had no concerns about him. Mr Rowe, reflecting her views wrote:

'he is polite, caring and always pays his rent on time. However she felt that he is being taken advantage of by others. She stated that there are always lots of people in his flat, even when he is not there'.

According to Mr Rowe, she went on to say that Mr Coombe had arrived home one day to find a man dead in his flat who had overdosed on illicit drugs. He had called the ambulance but the man had died before it arrived. Mrs Gibbard did not implicate Mr Coombe in this but was concerned that *'undesirable people'* were keeping him company.

45. Mr Rowe went on in his letter to say that, on visiting Mr Coombe, he had found two couples asleep on the floor. Mr Coombe looked unkempt and tired but denied he had

been using any illicit substances. He said that he had been busy selling the Big Issue and called a halt to the interview because he had to get back to work. Mr Rowe wrote that:

> *'Mr Coombe is very strong willed and insists on his independence. I feel that in an effort to make friends and be liked by others he is at risk of being taken advantage of by more street-wise people.'*

46. While Mr Coombe had no signs or symptoms of mental illness Mr Rowe asked Dr Rowton-Lee, if he would be able to *'point out the error of his ways'*. In his copy of this letter to Ms Parsons, he enclosed a copy of the CPA review form.

47. Mr Rowe told us that he wrote this letter because of his concerns about Mr Coombe's vulnerability, his ability to live independently and the risk of him re-offending. The fatal overdose of the man in his flat was the trigger for the letter although he had wider concerns about Mr Coombe's vulnerability to exploitation by others.

48. While noting and briefly summarising the letter in her notes, Ms Parsons made no comment about it and did not speak to Mr Rowe about his concerns. Mr Coombe was moved on to monthly reporting ten days before this letter and that remained the frequency of visiting for the rest of his supervision. On 15 December Mr Coombe reported to her. On this occasion he seemed more focused. He acknowledged that he had been used by people and claimed only to have one welcome friend staying. He had given up selling Big Issue because he was fed up and wanted to avoid others who were blaming him for the death of the man in his flat. He had been burgled twice in his flat and his CD player taken. He was staying at his mother's over Christmas. She noted his next appointments with Dr Rowton-Lee and Phil Rowe. The next day Mr Rowe telephoned Mrs Gibbard who said that Mr Coombe was well and presented no problems.

CPA review

49. In his clinical record Mr Rowe wrote that he did the CPA review paperwork during his visit on 26 November. Mr Coombe assured Mr Rowe that he was not taking any drugs but was suffering the after effects of a late night. Mr Rowe picked up that Mr Coombe was not attending the outreach programme.

50. Under "problems, needs and goals" Mr Rowe noted in the CPA review that Mr Coombe had attended anger management and personal effectiveness therapy sessions under the CFT, that he, the CPN (Mr Rowe), had monitored his mental health, that he was not on medication and had outpatient appointments with Dr Rowton-Lee. He registered risk factors in Mr Coombe's *'occasional physically aggressive outbursts'*, his vulnerability as a past victim of physical abuse, his having misused alcohol and drugs in the past (but not at present) and having had an admission in the last two years.

51. Dr Rowton-Lee had written to Mr Coombe's GP on 15 December 1997 to advise that his team were continuing to monitor him. In Dr Rowton-Lee's view, he was doing very well, and keeping himself out of trouble, and he was expressing an interest in going to college. However, he was allowing his *'druggy'* friends to take advantage of him but seemed not to be persuaded by them to take drugs. This letter was copied to, among others, Mr Rowe and Steve Moores, senior occupational therapist.

52. Dr Rowton-Lee had made an unexplained referral to Mr Moores at about the same time. Mr Moores cannot recall ever seeing the letter of 15 December. He had no indication that the referral was urgent and so placed Mr Coombe on his waiting list. He never saw Mr Coombe.

Early 1998

53. On 19 January Mr Coombe reported to Ms Parsons that he had been served with a "notice to quit" his flat in Holdenhurst Road. He had contacted Dorset Lodge where there were no vacancies (Ms Parsons checked this). She arranged for him to go to the YMCA. In her three monthly review she noted Mr Rowe's concerns about his vulnerability in independent living.

54. Ms Parsons went on to write that he wanted to go his own way and preferred the way of life offered by selling the Big Issue. She felt that he needed supported accommodation and would discuss a referral to the Carr Gomm Society, which offered this. His risk of re-offending was scored at 2 out of a scale of 9 and his risk of serious harm to the public as 1 out of 9.

55. Ms Parsons spoke to Martin Koscikiewicz at the CFT because she only had a report from last June 1997 from Dr Rowton-Lee to go on and wanted to know whether there was a mental health diagnosis. Mr Koscikiewicz advised her that there was not. The YMCA telephoned to say that they were prepared to offer Mr Coombe a place from the next Monday (26 January) but had concerns that he had not been open about his previous convictions.

56. The next day, the 20 January 1998, Ms Parsons contacted the Carr Gomm Society to see if a referral there might be possible but was advised of a problem in having sufficient vacancies. On 22 January Mr Rowe visited Mr Coombe at home and was told by him that he had to leave his flat. Mrs Gibbard has explained to us that she felt she had to issue a notice to quit because although Mr Coombe had been warned on several occasions about people staying overnight and the problems they caused, for example, loud music, disruptive behaviour and general noise, this pattern of behaviour continued. She wrote to us:

> *'I do know that on several occasions Simon did not stay in the flat when his friends were there because I believe he knew there would be trouble and really he didn't want to be involved.'*

57. Mr Coombe did not turn up at the YMCA on 26 January to take up his bed but they agreed to hold the vacancy until Wednesday lunchtime. Ms Parsons tried to contact Mr Coombe via both the Big Issue office in Blandford and Mr Rowe. Mr Rowe telephoned the next day and left a message that he had not seen him. Mr Rowe telephoned Ms Parson's secretary on 29 January and was told about Mr Coombe not turning up to claim his bed at the YMCA. He noted that *'Probation does not have an address for Simon'*.

58. John Swire-Cunningham, CPN with the CFT, was standing in for Mr Rowe who was on leave, when he called to see Mr Coombe in his flat on 5 February 1998. He found no-one at home but spoke with a *'management representative'* at the flats who advised him

about Mr Coombe's problem with visitors. He was advised that he was under notice to quit. He requested that Mr Coombe see him on 9 February at 11am. He did not turn up.

59. On 6 February Mr Swire-Cunningham telephoned Ms Parsons and left a message saying that Mr Coombe's accommodation was under threat and they needed to confer. This was followed by a message via Martin Koscikiewicz on the 9 February requesting the same.

60. According to Mrs Gibbard, Mr Coombe left his flat at Holdenhurst Rd on 9 February 1998.

Comment

61. **We have on the whole been impressed by the quality of the probation officers we have interviewed. Theirs is a difficult job, made more difficult by the lack of support and information from their health partners.**

62. **The difficulties in communication, with consultants, for example, indicate an inequality between members of a multi-agency/disciplinary team. We think this is wholly unjustified and improper. Multi-agency/disciplinary work requires an acknowledgement of the equal partnerships between participants. It is imperative that problems in the process can be addressed swiftly by all and at a senior managerial or chief executive level if necessary.**

63. **The probation officers involved with this order never had any direct contact with Dr Rowton-Lee or Mr Rowe. They were copied into correspondence but no more. Requests for progress reports from Dr Rowton-Lee went unanswered. In addition, the information provided by Mr Koscikiewicz to Ms Ridge in July was inaccurate and his letter of 10 July is not on the probation file. We heard complaints of a lack of co-operation from Dr Rowton-Lee in this and other cases which were referred up to senior management with no result.**

64. **Mr Coombe's vulnerability was heightened at the time of his leaving Holdenhurst Road, and it is unfortunate that there was a reduction in his reporting obligations at this time. Given the limited contact between health and probation during this order, it has been difficult to determine how probation monitored how often Mr Coombe was seeing health services in order to know that he was keeping to his reporting requirements. It is necessary, in these situations, for the probation officer holding the order to take the initiative to set up a timetable for reporting between all concerned, so that there is no room for error or guess work.**

65. **It seems that Mr Coombe was probably in fact being seen more often that national standards required, taking into account his appointments with Mr Rowe, but this is unclear.**

66. **There is a need for jointly agreed procedures on the running of probation orders with a condition of treatment. We think that a natural starting point for such a procedure is the CPA model.**

RECOMMENDATION 8:

There should be an agreed joint agency protocol for prosecuting failures in multi –disciplinary working and a complaints procedure. This should involve chief executives and emphasise the need for equal partnerships within multi-disciplinary/agency work.

RECOMMENDATION 9:

Joint health and probation service guidance should be developed on the management of probation orders with a condition of treatment. This should include clearly identified roles for each service together with an identified treatment plan, a timetable of appointment and provision for joint reviews.

Chapter 9

APRIL 1998

THE MURDER OF MICHELLE LOCK

Summary:

Mr Coombe moved to a flat in Wimborne Road, Kinson in February 1998. He was seen by Judy Parsons, Phil Rowe and Dr Rowton-Lee.

There was no known cause for concern.

The murder of Michelle Lock was not predictable.

Introduction

1. Mr Coombe moved to a flat in Wimborne Road in February 1998. Judy Parsons, Dr Rowton-Lee and Phil Rowe were once more in contact. He seemed settled here and very happy with his flat.

2. Mr Coombe did not know Michelle Lock and had never held a conversation with her. She was simply his neighbour and he had observed her. She had recounted to her family that she found him *"creepy"* and one evening he had stared into her flat through the window. She was a single woman and clearly a lively and attractive person, who had lived in the locality all her life and was known to many people. Unsurprisingly her family has been devastated by her murder, but are eager to try and understand what precisely happened. We thank them for their co-operation.

Contact with services leading up to the murder on 1 April 1998

3. Mr Swire-Cunningham, the CPN who had been standing in for Phil Rowe while he was on leave, wrote to Mr Coombe on 9 February 1998 to say that he had tried to contact him but without success. He therefore offered him an appointment at Holdenhurst Road for 13 February. However, Mr Coombe had left that address by this time.

4. Ms Parsons received a telephone call from a member of staff at the YMCA on 12 February saying that Mr Coombe was there but was leaving the next day and had left no forwarding address. Mr Coombe contacted Ms Parson's office on 18 February from the night shelter when she was on leave asking when his next appointment was. She was on leave and on her return, she tried to contact him at the night shelter but without success.

5. She found out his new address on 4 March via a filed copy of a letter from the clinic secretary to Dr Rowton-Lee, copied to her and received on 25 February. The next day Mr Coombe himself called at the probation office to notify them of his new address.

6. His last appointment with Dr Rowton-Lee before the murder was on 16 March when a slight depression was noted, but otherwise his mental state was recorded as *"not too bad"*. Mr Rowe saw him on 24 March and noted that he was bright and cheerful. No problems were identified but he would continue to see Mr Coombe at his home address in a supportive role. A further appointment was made for 6 April 1998. His last recorded appointment with Ms Parsons was on 17 March 1998 and she noted that he was more focused and coherent than before.

7. He also reported to Ms Parsons on 17 March that his mother had helped him to find a new flat in Wimborne Road.

8. Having originally been requested by Dr Rowton –Lee to see Mr Coombe in December 1997, Stephen Moores, community occupational therapist, offered another appointment to Mr Coombe on 17 March, this time for 8 April 1998. Of course, this date was after the murder so he never saw Mr Coombe at all.

9. On 18 March 1998, Mr Coombe presented himself to the A&E department at Poole General Hospital. He claimed to have been hit on the head with a stool by a girlfriend and complained about some blurring of vision. No permanent damage seems to have been caused and he was discharged.

10. Mr Rowe told us that Mr Coombe was keen to see him:

'He was really happy with his flat and was over the moon really, quite proud of it and quite eager for me to come and see him'

The murder of Michelle Lock

11. The account of the murder given by Mr Coombe has varied over time. Initially he said that she consented to sexual intercourse, he left his flat and when he returned later, he found the door open and Michelle Lock dead. Mr Coombe went to St Ann's Hospital after killing Ms Lock and CFT staff took him to his solicitors and called for an ambulance to go to Wimborne Road.

12. On 24 March 1999 Mr Coombe pleaded guilty to her murder at Winchester Crown Court and was sentenced to life imprisonment. What is set out below is taken from the court transcript.

13. On 1 April, Ms Lock had spent the afternoon in a public house where she was a well-known customer. She returned to her flat, a short walk away, at close to 8 p.m. She was seen on the external staircase to her flat, which was above a parade of shops talking and laughing with Mr Coombe.

14. Later he went out to buy some cans of lager and these were found unopened in the refrigerator in his flat after the murder. What happened between this time and midnight is known only to Mr Coombe. It is clear that he killed her and DNA testing showed that he had had sexual intercourse with her. The Judge did not accept that this was consensual. She had been repeatedly hit over the head with a pipe cutter resulting in fatal injuries. She had also been hit with an ashtray. It is not clear, whether the sexual intercourse took place before or after she was hit.

15. The police took a witness statement after the murder from a young woman in which she claimed to have had her wrist fractured by Mr Coombe in his flat during the early part of 1998. She alleged that Mr Coombe had grabbed her by the wrists because she accidentally slammed the door after he had told her to leave the flat. She was with other friends in the flat at the time. They also gave witness statements to the police after the murder in which they confirmed the basic details of this incident.

16. However, neither Ms Parsons nor Mr Rowe were aware of this incident prior to the inquiry, nor could they have found out about it as the alleged victim did not report the injury to the police at the time. She also said that she had told medical staff treating her that the injury was as a result of falling from a horse.

17. A psychiatric report commissioned by Mr Coombe's defence from Dr A Payne, consultant forensic psychiatrist at Broadmoor Special Hospital, concluded that his mental state was satisfactory on arrest and there was no evidence of any mental illness, or psychopathic disorder within the MHA. He was found not to be suffering from any abnormality of mind within the Homicide Act 1957.

Chapter 10

SIMON COOMBE

CONCLUSION

and

EXECUTIVE SUMMARY

Introduction

1. Mr Coombe's main contact with services was with the community forensic team (1993 and 1997-1998), probation service (1993 and 1997-1998) and social services (1992 and 1997). These periods of contact overlap closely with those of Mr McMahon.

2. The key features of his presentation were that
   - he had no diagnosis of mental illness, or severe mental illness, but a mild learning disability
   - his history of offending was minor and contained no violence and
   - he presented a low risk of serious harm to others.

3. Additionally, he was a vulnerable and immature person open to exploitation by others and seeking out the company of younger people. There is a possibility that he has some degree of organic brain disorder, although the evidence of this is inconclusive and any impact this may have on his functioning has not been possible to determine, except to say that it is likely to be minimal. While he was undoubtedly a user of illegal drugs and alcohol, evidence of any long term abuse of these substances was based on unreliable self-report. Mr Coombe has created and used a fantasy life consistently since his early childhood. The causes of this have yet to be understood. Behaviour termed "sexually inappropriate" on the wards at St Ann's was also never assessed, but ascribed to his immaturity by nursing staff.

4. Insofar as there is such a thing Mr Coombe was not a *'typical case'* for the mental health services. He was noted to be *'odd'* rather than mentally ill. Moreover, his behaviour did not generally cause great concern to those caring for him; the risk level to him and others was judged to be low and he did not fit any neat diagnostic or service defined categories of need. Those assessing him were unable to come to any definitive opinion about his care and treatment needs. The inability to do so should have been explicitly identified and recorded, thereby demonstrating defensible practices even where the outcome (murder) is the worst imaginable (see Shane Bath report, Chapter 33).

5. We have found evidence of, and commented on, the themes recurring in the many previous homicide inquiry reports published over the years. These include:

   a) **information sharing** (Cumbria incident and prison records) and **gathering** (early history checking),

b) **inter-agency** and **inter-disciplinary communication** (in-patient period and follow up),

c) use of **CPA** and **multi-disciplinary work** (St Ann's in-patient period and discharge)

d) poverty of **assessments: health, social care needs** and **risk,**

e) poor **record keeping** (CFT and social services).

6. These findings reinforce our conclusions in the Shane Bath report regarding the need for mental health services and practitioners to be able to demonstrate their commitment to the "core principles" of information gathering, inter-agency communication and multi-disciplinary work from which good practice should naturally flow (Shane Bath, Chapter 33).

7. Rather than revisit all of these we would like to focus on the following aspects of service provision in 1997 and 1998 for special consideration below:

a) Health, social care and probation assessments

b) Risk assessment

8. The key period of care for Mr Coombe was during his in-patient stay at St Ann's from January to June 1997, and thereafter in the community, pursuant to two probation orders, one with a condition of treatment, to run for two years.

9. We have additionally had the opportunity to consider the role of the probation service in assessing and managing mentally disordered offenders. The conclusions in this chapter aim to focus on the issues specific to Mr Coombe. Those issues applicable more generally to both reports are considered separately in chapter 18, Risk Assessments and chapter 19, Concluding Comments.

Needs assessment, diagnosis and care planning

10. Mr Coombe was not adequately or sufficiently assessed or followed up by the health, social or probation services:-

Health Service

11. Mr Coombe was assessed by Dr Rowton-Lee, ward nursing staff, the CFT and by the CPN.

a) **Dr Rowton-Lee** took an adequate initial history while Mr Coombe was in prison at the end of 1996 and rightly wished to reserve his opinion about Mr Coombe until he had been assessed in hospital. However, at no time after his admission to St Ann's in January 1997 did Dr Rowton-Lee make an appropriate formulation of Mr Coombe's mental health problems nor did he suggest a working diagnosis.

Nursing staff attempted to fill out risk assessment and CPA forms as required by Trust policy, but this process was not actively supported nor encouraged by Dr Rowton-Lee. His lax attitude to multi-agency work is also apparent in the poor ward round notes and the failure to conduct and record a proper discharge meeting.

As the lead clinician, and the one responsible for the referral to the CFT, he failed to consolidate the results of the assessment undertaken by that team during the in-patient period and, in particular, discharged Mr Coombe from hospital without any feedback from the CFT. In our view, this was not simply a failure of reasonable clinical practice, but also a failure of his obligation to the court because Mr Coombe was being assessed under a section of the MHA. We think that the court was mislead into making a condition of treatment, because there was never any treatment available or envisaged for Mr Coombe beyond monitoring and supervision, which he would have received under a probation order in any event.

By 30 July 1997, he had abdicated the responsibility for the decision to allow Mr Coombe to move into independent accommodation to both Dorset Lodge and the probation service. We accept that the probation service found him unapproachable and had difficulty gaining input from him.

b) We heard evidence during the Shane Bath Inquiry that Dr Rowton-Lee was holding a large workload. He was also the Medical Director of the Trust at this time, accountable only to the Chief Executive. The evidence we have gathered supports the conclusion that Dr Rowton-Lee's idiosyncratic practices, including the regular admission or transfer from the criminal justice system to St Ann's of untreatable and behaviourally difficult male patients with no discernible mental illness, were of long standing. We think that there should be procedures in place enabling staff at all levels to bring the problematic and unsafe practices (to public and staff) of senior clinicians to the attention of the Chief Executive. This should be complementary to the "whistle-blowing" policy.

c) **The nursing staff** noted Mr Coombe's behaviour on the ward in considerable detail and attempted to deal with his "sexually inappropriate" behaviour without any clinical and/or CFT input. They put a good deal of effort into noting his day to day behaviours and, by their own initiative, established a group (together with Mr Rowe of the CFT) on Branksome ward to deal with the difficult patient group referred to above and regularly admitted by Dr Rowton-Lee. There is little evidence that their efforts were fruitful or properly considered in a multi-disciplinary context.

d) **The CFT** assessed him in 1993 and 1997. Dr Leung's initial assessment in 1993 was adequate but there were no formal recommendations for treatment or follow up. The number of assessments the team was required to do made anything but a basic assessment difficult. Even taking that into account this, and later assessments by the CFT, were cursory and superficial. The chaotic way in which the team was managed, organised and administered meant that proper records were not kept of assessments and treatment interventions. The treatments that were provided to Mr Coombe by the CFT did not always prove relevant to his needs. Again these did not feed into a multi-disciplinary forum and were ultimately a waste of effort and resources. The CFT was

effectively disbanded in 1999 and a new county-wide forensic service has been set up under the leadership of Dr Simon Beer, consultant forensic psychiatrist.

e) Phil Rowe, the CPN mainly involved with Mr Coombe, assessed him but did not take into consideration information held by the probation service. He never had any face to face contact with the probation officer in charge of the order to which Mr Coombe was subject. He was new to the community and liaison role which he was fulfilling at this time.

Social Services

12. Our overall conclusion is that case recording in social services for all three inquiries was generally poor. This is especially true in this case. Standards of social services recording were very poor compared to those in other agencies. Additionally, the role of social services within the CFT was unclear and difficult to determine.

13. Social services involvement in the CFT commenced three years after the team was established and the two social workers concerned, covering the Bournemouth (Victor Trimble in this case) and Poole areas, were not in post until early 1997. The recruitment of the social workers at the time was undertaken solely by social services (we understand that this has now changed and appointments are made on a joint agency basis).

14. There was a lack of shared understanding between the agencies as to the social work role within the CFT that may have contributed to the difficulty we have found in determining the extent and nature of the social work input into this case

Probation Service

15. Overall, we have been impressed with the quality of individual probation officers we have interviewed. There were clear difficulties, however, over liaison with health, and in particular, Dr Rowton-Lee, which were being addressed by senior managers. We have identified an inequality in the multi-agency working system, whereby there is no effective mechanism for bringing about changes in non-compliance by lead clinicians of the requirements of CPA and multi-agency work. This type of hierarchical functioning, where consultants, through their independent working methods, effectively thwart the good working practices of other members of a team, is unacceptable in current practice.

16. Also we are aware that the Dorset probation service, seen as being over-funded for its needs by comparison with other areas, had been operating against a reducing cash limit since 1993 and that the period of Mr Coombe's supervision in 1997 coincided with a ten per cent reduction in the probation budget. We have taken account of this in judging the performance of this service.

Risk assessment

Risk factors

17. The killing of Michelle Lock was an event which caused everybody we took evidence from total surprise. He was not a man about whom there was great concern so far as risk to others was concerned.

18. It might be argued that there were parts of Mr Coombe's history that should have given rise to more concern about his risk to others, and would have done had they been better assessed during his in-patient period in 1997:

a) Sexually inappropriate behaviour at St Ann's. Mr Coombe's behaviour in relation to females while an inpatient at St Ann's Hospital during 1997 should have been considered and might have given rise to concern about potential risk to others. Nursing staff often noted that he tried ineptly to 'chat women up' on the ward, that he made sexual remarks to patients and staff, inappropriately made advances to women on the ward etc. These behaviours did not cause undue concern, however, to staff. In their view, it was more a case of immaturity on his part than evidence of a predatory approach to females. It was more that he lacked the social skills to develop relationships with women than that he was trying to hurt them. No person we received evidence from felt uneasy in his presence although Rachel Newman, probation officer, reported at the time that she did not feel comfortable with him during a contact for a pre-sentence report request. She was unable to elaborate on this further.

b) This was a new feature of his presentation judged by what was known of his past and we are highly critical of the fact that its cause(s) were left unassessed by the multi-disciplinary clinical team. We are left wondering what the point was of him being in hospital if the most obvious, and potentially concerning, behaviour was not properly addressed.

c) Had it been addressed by the CFT, we are not confident that the result would have been anything more than to say it was caused by immaturity. We note that no one reported being intimidated by it and yet it was enduring. We think that a "proper" assessment would have entailed far more than the CFT was able to provide. It becomes overly speculative to consider what referrals might have been made to deal with it adequately, had the need to do so been recognised, and what difference it might have made to his behaviour.

d) When considered together with the letter of Mr Koscikiewicz (see below), it may be argued that a worrying picture was emerging of potential sexual offending. We think that this is an understandable but retrospective view following the murder. There are several difficulties with the letter of 10 July 1997, which are discussed to below.

e) **Letter of 10 July from Martin Koscikiewicz.** There is an indication about violence and females that occurs in a letter to Dr Rowton-Lee from CFT assistant psychologist, Martin Koscikiewicz, dated 10 July 1997. Mr Koscikiewicz stated in the letter that:

> *'He has tended to maintain his anti-social attitudes in particular those relating to violence and females'*

f) Neither Dr Rowton-Lee nor Phil Rowe could recall seeing this letter before the Inquiry. Dr Rowton-Lee said that if he had seen it he would have sought further details of what it meant. He was not sure what difference this would have made *'because he was constantly acting out, boasting'*. Mr Rowe said that even if he

had seen the letter his actions would not have been any different because his assessment of Mr Coombe's risk had begun when he took over his care in the community and he did not have any concerns about his risk to others or self harm.

g) In our view, had the contents of this letter been pursued with Mr Koscikiewicz and Mr Coombe, it is unlikely to have made a difference to the way in which Mr Coombe was followed up in the community. This is because it was an isolated reference by a trainee psychologist and was based on no properly documented event or events. Further, if Mr Koscikiewicz's subsequent elaboration of this event had been known, it is likely to have been seen as no more than added evidence of immaturity and bravado and is unlikely to have altered Mr Coombe's risk rating. It is also unclear precisely when the letter reached the Trust files. The important issue is that there should have been evidence that it was communicated swiftly to the correct agencies, followed by a discussion of its impact on the CPA and arrangements made for follow up in the community.

h) Any decision by Dr Rowton-Lee not to have extended the period of in-patient treatment on the basis of the letter could not be said to be unreasonable and it seems unlikely that he would have extended the in-patient treatment. Further, given that Mr Coombe had ceased attending the personal effectiveness group, and occupational therapy shortly after that, there is unlikely to have been any extra benefit to him from such a course of action. Also, once the section 38 MHA order came to an end there was nothing by which to hold Mr Coombe in hospital.

i) If more had been made of the letter, the options in the community were still limited and it is unlikely that he would have had closer monitoring in the community than he in fact received. Even if it had, there was no evidence, for example, at Dorset Lodge, of any difficulties with Mr Coombe and women. The Big Issue manager, who provided us with the most reliable information of his functioning in the wider community, did not identify any concerns in this regard either. There was no indication that he required assessment for further detention in hospital and, short of that, there was little that could be done to prevent Mr Coombe from meeting and socialising with others, including women.

j) **The alleged wrist fracture** to the teenage girl in early 1998 was another potential risk factor but this was not known to either of the professionals then in contact with him nor the police. It could not therefore have been taken into account.

k) **Illicit drugs and alcohol.** Mr Coombe often claimed to be taking, or to have taken, many illicit substances. He also said that he had abused alcohol severely. It was very unusual, however, for anyone in contact with him to observe him as having possibly drunk excess alcohol or as being under the influence of drugs. While he undoubtedly did at times drink, take cannabis and, possibly, occasionally take amphetamines, there are few indications over the course of his care and treatment that his behaviour was affected significantly by any substances. There is no evidence that he was under the influence of drugs or alcohol at the time of the murder of Michelle Lock.

Was the murder of Michelle Lock avoidable?

18. We have made a number of specific criticisms of the services as they operated at the time in relation to professional and management practices. Looking back over what happened, we can see that Mr Coombe could have been better assessed, a wider picture could have been obtained of his needs and the risks he posed to others, the care planning process and inter-agency communication could have been more robust and free-flowing.

19. However, the management of very few cases would avoid some level of criticism if looked at after the event and in such detail as we have done in this case. No human service is perfect and no-one working within the mental health services should pretend that their own practice at all times would survive such a level of scrutiny.

21. As we have stated, the level of risk that Mr Coombe presented to others should have been, but was not, assessed properly. However, had he been subject to a formal risk assessment at the time, including the use of actuarial tools, it would not have signified a high level of risk. It would have shown that he was a low risk to others.

22. We therefore conclude that he did not represent a significant risk to others prior to the killing. This was a tragic killing but not one that could reasonably have been predicted by anyone.

Chronology

SIMON COOMBE

1971 - 1988

30 January 1971	Born in Munster, Germany
1978	Family move to East Dorset. Mr Coombe attends Beaucroft School, Wimborne.
17 September 1981	Poole Hospital - minor orthopaedic problem re toes.
03 May 1986	Seen by educational psychologist.
09 September 1988	Poole Hospital, - Dept of Child and Adolescent Psychiatry Child Development Centre. Referred by GP re mother's concerns.

1989 - 1991

05 December 1989	Police arrest Mr Coombe + 3 Others, - theft from shop window - charged
21 March 1990	Probation report regarding December offences above
10 April 1990	GP: investigation of epileptiform episodes
19 April 1990	First known to Dorset HealthCare NHS Trust, - psychiatric report requested by court re Begging, criminal damage etc - Seen by Dr Rastogi
26 April 1990	Court report of Dr Rastogi
27 April 1990	Poole Magistrates Court - re theft - sentence deferred
17 September 1990	Neurological report on possible epilepsy - Dr Ellis
18 September 1990	Criminal Damage x2 Poole Magistrates Court. 12 month Conditional Discharge
12 October 1990	GP: Request to Dr Choudry. Assess for detox.
17 November 1990	Serious assault, - head injuries, - initially to Weymouth Hospital, - transferred to Southampton - Neurological Unit. Discharge on 20/11/90 to Weymouth and District Hospital. Prof. Pickard reports "diffuse head injury"
10 December 1990	Home to friend's flat, Portland.
13 August 1991	Mr Coombe at Stillwaters - sheltered accommodation.

1992

03 April 1992	GP: Referral to neurologist re "vacancy" episodes
09 July 1992	GP: letter from Poole Hospital neurologist - New referral to Dr Ellis re amnesic episodes.
13 July 1992	Social services LOCI form shows support at request of local authority
06 August 1992	Poole Hospital - EEG / clinical neurophysiology report to Dr Ellis at Weymouth Hospital
22 August 1992	Minor Road Traffic Accident - Mr Coombe walked in front of car
08 October 1992	Mr Coombe received County Court claim forms. Dealt with by A Rumney [S/W].
24 November 1992	Left Still Waters accommodation

1993

10 March 1993	Mr Coombe visits to Dorset Social Services re County Court Summons re unpaid Community Charge
28 June 1993	Emergency referral to Dorset Social Services from Liz Brown at Bridge Corner House. Mr Coombe there as "Luke Palmer".
31 August 1993	Police - arrest Mr Coombe re breaking windows on two cars - charged
04 October 1993	Police - arrest Mr Coombe re alleged shoplifting - no charge.
25 October 1993	Pre Sentence Report.
11 November 1993	Probation referral to CFT.
06 December 1993	Psychiatric nursing report by John S-Cunningham Psychological assessment by Dr G Leung. Dorset Healthcare Community Alcohol Team. Grace Higgins Psychiatric report from Dr Robert Franklin. Assessment at request of Bournemouth Magistrates Court.
07 December 1993	Multi-disciplinary meeting at St Ann's.
10 December 1993	Bournemouth Magistrates Court - Theft from vehicle and attempted theft from vehicle x 2 - Probation 18 months

1994

15 February 1994	Report of Dr Iannotti (Neurosurgeon at Southampton Hospital) to CICB.

03 March 1994	Probation quarterly summary and supervision plan (Mar - May) by S Allsop.
14 March 1994	Police - Charge Mr Coombe re criminal damage.
25 April 1994	Bournemouth Magistrates Court - Criminal Damage - Fine + costs
04 May 1994	To YMCA
11 June 1994	Poole Hospital - Appendectomy
15 June 1994	Probation quarterly summary and supervision plan
02 July 1994	Police request Appropriate Adult - Mr Coombe at Bournemouth Police Station - suspicion of burglary. M Wainwright to attend.
26 July 1994	Mr Coombe has interview at employment office.
19 September 1994	Poole College awaiting reference from school - no offer made.
04 November 1994	Mr Coombe in Cumbria [Melbreak House] using alias "Mark Wilder" - Cumbria Social Services contact Bournemouth Social Services
10 November 1994	Mr Coombe held in custody in Cumbria re warrant from Bournemouth for Breach of Probation Order. Transfer to Dorset Police.
11 November 1994	Medical exam - fit to detain
12 November 1994	Probation Order Revoked at Bournemouth Magistrates Court.

1995

01 May 1995	Allegation of sexual abuse of /indecency with female aged 7 in Cumbria [Not substantiated - not proceeded with by Police]
09 October 1995	Police arrest Mr Coombe re Theft of vehicle - Subsequent Probation order 6.6.97

1996

27 March 1996	Police - Mr Coombe charged with allowing himself to be carried in stolen car - not subsequently proceeded with.
02 July 1996	Police request Appropriate Adult - Mr Coombe + another charged with burglary - Miss Wainwright. Psychiatric report requested from Dr Rowton–Lee.
24 September 1996	HMP Dorchester - detained re failing to surrender to bail August 1996
16 October 1996	Pre -Sentence Report completed by Rachel Kidner (Newman).

28 November 1996	Dr Rowton-Lee examines Mr Coombe at Dorchester Prison *"Transient depressive episodes.."*
09 December 1996	Adjudication at HMP Dorchester. Mr Coombe admits cutting other prisoner's arm - prisoner requested Mr Coombe to do it
30 December 1996	Report of Dr Rowton-Lee recommending admission to St Ann's

1997

08 January 1997	Nursing assessment at HMP Dorchester
17 January 1997	Southampton Crown Court - Remand to St Ann's for reports - S.35 MHA
18 January 1997	Transfer from HMP Dorchester to HMP Winchester.
23 January 1997	Admitted to St Ann's under Section 35 MHA
11 February 1997	CFT report signed by Phil Rowe, Andrew Derry and Dr G Leung.
13 February 1997	Dr Rowton-Lee's - Court report requesting extension of S. 35 order.
28 February 1997	Psychological therapy with Dr Leung and Andrew Derry
03 March 1997	Referral to Social Services by Dr Rowton-Lee requesting assessment addressing poor social relationship and employment rehabilitation.
04 March 1997	Commenced weekly psychology sessions until 29 April 1997. Mr Coombe interviewed by Nick Moffat - report 11/3/97
11 March 1997	Poole Hospital, - Report of Nick Moffat - Chartered Clinical Psychologist
5-12 March 1997	Social Worker Vic Trimble to see Mr Coombe this week .week.
13 March 1997	Court report by Dr Mohammed Dr Rowton-Lee certifies on S 38 form that Mr Coombe is suffering from mental illness within MHA.
14 March 1997	Interim Hospital Order S 38 for 12 weeks to 6 June 1997.6.97
20 March 1997	Sandbanks ward, St Ann's. Admission at CPA level 2
21 March 1997	Contract between Mr Coombe and CFT.
25 March 1997	Adult risk assessment screening form: medium risk of self- harm and physical aggression to others.

05 April 1997	Left ward without permission, returned by himself. AWOL procedure followed, Police advised. Walked to Southampton and back.
28 April 1997	Dr G Leung invites Mr Coombe to Coping with Moods and Personal Effectiveness Group on 7/5/ May 1997 for 10 weeks.
06 May 1997	Self- referral to Bournemouth Social Services re Benefits.
07 May 1997	Personal effectiveness group commenced (Dr.Leung and M Koscikiewicz)
28 May 1997	Social Worker Vic Trimble to liaise with probation over court records.
05 June 1997	Court report of Dr Rowton-Lee. Mr Coombe needs to remain in hospital to progress further but not under section of MHA. *"Remains a young man with considerable difficulties".* No diagnosis
06 June 1997	Southampton Crown Court re theft of vehicle - 2 years probation + treatment under Dr Rowton-Lee.
09 June 1997	Mr Coombe visits Bournemouth Social Services about income support
13 June 1997	Bournemouth Magistrates Court re Burglary. Probation 2 years + treatment by Dr Rowton-Lee. Concurrently with the sentence 6 June 1997.
18 June 1997	SW Vic Trimble contacts Creek House, will - to accept Simon from 19 June.
19 June 1997	Discharged from St Ann's CPA review Interim report of CFT by Martin Koscikiewicz.
08 July 1997	Mr Coombe reported for breach of Probation Order
09 July 1997	Personal effectiveness sessions end. Probation Officer - case transferred to T Hyatt
10 July 1997	Letter to Dr Rowton-Lee from Martin Koscikiewicz - Reports Mr Coombe's antisocial attitudes still maintained.
09 October 1997	Mr Coombe moves to flat 142 Holdenhurst Road.
31 October 1997	Probation service request interim progress report from Dr Rowton-Lee
05 November 1997	Case transferred to Probation Officer Judy Parsons.
14 November 1997	Burglary at Mr Coombe's flat at 142 Holdenhurst Rd

19 November 1997	Death of young man from drug overdose at Mr Coombe's flat at 142 Holdenhurst Rd.
26 November 1997	CPA review by Phil Rowe CPN
24 December 1997	Letter to Mr Coombe from Occupational Therapist, Steve Moores. No immediate appointment possible.

1998

01 January 1998	Mr Coombe leaves flat at 142 Holdenhurst Road. Goes to YMCA 29 January 1998.
12 February 1998	Mr Coombe 'telephone call to Dr Rowton-Lee - cannot attend outpatient clinic 16/2/ February 1998. New address provided in Kinson.
13 February 1998	Leaves YMCA - moves into flat 1579A, Wimborne Road, Kinson
10 March 1998	Letter to Mr Coombe from Steve Moores, community O.T. - appointment for 30 March 1998 (later postponed to 8 April 1998).
16 March 1998	Sees Dr Rowton-Lee at Kings Park Hospital - next appointment listed for 18 May 1998
17 March 1998	Mr Coombe - Routine Probation appointment
18 March 1998	Poole Hospital - A&E minor head injury - hit by stool during altercation at Mr Coombe's flat.
24 March 1998	Seen by Phil Rowe, CPN.
01 April 1998	Killed Michelle Lock at Wimborne Road, Kinson, Bournemouth.
02 April 1998	Mr Coombe attends St Ann's Hospital, - Mr Koscikiewicz takes Mr Coombe to solicitor's office, - solicitor calls Police, - Mr Coombe arrested for murder.

1999

24 March 1999	Mr Coombe pleads guilty to murder of Michelle Lock - sentenced to Life Imprisonment.

Chapter 11

DAVID GARY McMAHON
(d.o.b. 23 February 1965)

CHILDHOOD AND HISTORY PRIOR TO DORSET

Summary:

The main features of Mr McMahon's early life in Belfast involved:

- **Sectarian Violence**
- **Divorced parents**
- **Alcoholic father**
- **Early offending: age 14**
- **Paramilitary activity**
- **Punishment shooting 1986**

In 1986 he fled Belfast for England. He described living a life in which he was constantly looking over his shoulder for fear of reprisals from the IRA or other Irish groups.

He was convicted of GBH in 1990 in Leicester resulting in an eighteen month sentence of imprisonment. On his release he was admitted informally to Leicester General Hospital, apparently suffering from a psychotic episode. This was his first and only contact with mental health services prior to his contact with Dorset services in 1993.

Introduction

1. This chapter aims to provide the background information that would have been available to services assessing David McMahon. The information was provided by Mr McMahon himself (though not any details of his paramilitary activities), and largely confirmed by his mother. Other sources include records from Belfast City Hospital, Trust records and police information gathered by the Inquiry.

2. We are grateful to Mrs McMahon for her assistance and forebearance in answering questions about events which to her are clearly difficult and emotional.

Early life: Belfast

3. David Gary McMahon was born into a Protestant family living in North Belfast, Northern Ireland in 1965. He was known as Gary. He is now 37 years old and by the time he was three years old in 1968, the "Troubles" had begun in Northern Ireland and dominated the lives of all those living in its midst.

4. Mr McMahon is the third of four children. His eldest brother died shortly after birth and he has an older sister and younger brother still living in Belfast. His father, now deceased, had an unbroken work record of which Mrs McMahon is justly proud. Family

life was unremarkable for Belfast at this time, whether Protestant or Catholic. They lived in a close supportive community, strained daily by the sectarian violence surrounding it. Mr McMahon's parents divorced when he was aged about seven.

5. Mr McMahon recalls being good at mathematics and sport at school (we do not have school records). By the time he was in secondary school and in about 1977, he told us that they were *"practically living in a 'no-go' area, so school was not really a top issue"*. In fact from the age of about five or six, he and his friends would play truant from school and go looking for *"adventure"*.

6. Playing truant was a way of life but there were also times when the children were unable to go to school because, for example, the British Army had occupied the school to use it as a base, or because the teachers were on strike. His mother recounted that he was a much-liked child who got on well with people, including his teachers. He had a cheeky sense of humour and was always loving and thoughtful towards her. She never associated him with anger or aggression and trusted him implicitly.

7. His first recorded criminal offence was in 1979, aged 14, for using threatening words and behaviour to the RUC, and between 1979 and 1983 his offences in Belfast included using threatening words and behaviour (x 3), common assault (x 4), burglary and obstructing police. From about this age many young boys are likely to have become involved in paramilitary activities. Even if they were not, family and friends quite often were, and violence and intimidation were commonly experienced or witnessed.

8. Mr McMahon told us that he witnessed atrocities on a regular, and probably weekly, basis from a very young age. It was a highly politicised childhood; he was told how to behave and what to do by his peers. You could not be seen talking to the police or to Catholics for fear of punishment. If you were too young for punishment, family members would be targeted. Later he remembered being in pubs when gunmen would burst in and shoot selected people dead. He described realising that he had been living in a war zone only after he left Belfast in 1986, when he learnt that life outside Northern Ireland was entirely different.

9. This was the height of the conflict in Northern Ireland. It was a time of internment, super grasses, Bobby Sands and hunger strikers.

10. The first that his mother knew of his involvement with the Loyalist paramilitaries was when her door was kicked in by gunmen looking for Mr McMahon. The force used is described to have taken the door off its hinges. Mr McMahon clearly took care not to tell his mother what he was doing. This was at a time (1982) when a close friend of Mr McMahon's, whom we refer in this report to as "Y", and who was intimately associated with Loyalist paramilitary activities, was imprisoned and at which time Mr McMahon fled to Scotland. He was also in London for a brief spell in 1985 prior to returning to Belfast.

11. Mr McMahon spent his time with Mr Y and was "under his wing". Mrs McMahon saw little of her son. On Y's release from prison after about two years, he sent word that Mr McMahon was to return to Belfast.

12. In 1986 Y was murdered. This is reported as having a profound effect on Mr McMahon who went "off the rails" for a time. Probably as a result of his behaviour, he was subjected to a punishment shooting in October 1986 on the Shankill Road. We have been able to confirm that three masked gunmen shot him a total of three times in the thighs, having dragged him up an alleyway. He was also clubbed around the head requiring sutures above his left eye. He was treated at Belfast City Hospital and has been left with a bullet fragment in his right leg. As soon as he recovered sufficiently from his injuries, and for fear of his life, he fled to Scotland and then to England where he has remained, travelling around the country and arriving in Dorset in about 1992.

13. The Belfast hospital notes catalogue the injuries Mr McMahon suffered and that, perhaps unsurprisingly, he was *"distressed +++"*.

14. At times, Mr McMahon has reported to mental health services that he witnessed the death of Y, who he also described as his brother. It is clear that he did not witness this killing, but certainly considered his friendship to be like that of a brother. Mr McMahon was tearful when he spoke to us of Y's death and told us that his *"world fell apart"* when he was killed. He has also reported being shot by the IRA on this occasion.

15. There was little work available in Belfast at this time. Mr McMahon recalls some Youth Training Schemes he participated in involving cars, joinery, bricklaying and the like. We know nothing of any girlfriends or other relationships before he left for England.

16. The only other matter of note is that Mr McMahon was born with a congenital abnormality, which was operated on several times when he was a young boy. His mother recalls numerous operations, which were ultimately unsuccessful. There is no mention of this condition in his records after 1985.

After Belfast

17. Mr McMahon left for Scotland by ferry and still on crutches. He sought medical attention to have his stitches removed. He told us that there were death threats made against him and he feared for his life. He travelled to London and back to Scotland and then around the country so that he could not be kept track of.

18. Our investigations show him to have been in Southampton, Hastings, Chester, Aberdeen, Leicester, Ipswich, Lowestoft, and Croydon. He arrived in Bournemouth in about mid 1992.

19. Mr McMahon told us that he became a very private person to protect his security. He carried, and still carries, images in his head of when he was shot. There were constant reminders of Northern Ireland in the news that triggered emotional responses in him. For a long time, he was unable to sleep and he thought too much every time he lay down saying: *"My head was going ten to the dozen"*. He recalled walking into housing estates in Manchester, or Birmingham or London which looked the same as areas of the Shankill or Crumlin Road. On one occasion in London, he said that he *"freaked out"* and *"everything started coming back to me"* when he got lost and found himself in a place which *"looked like a blueprint of where things had happened in Ireland"* i.e. the shooting on Shankill Road.

20. In Southampton in 1988 a GP noted alcohol dependency. Mr McMahon told us that alcohol was not a problem for him. He liked a drink and did get drunk, but had no dependency. He did engage in binge drinking. He said it was the only way to get into a particular Salvation Army Hostel and he managed to convince the doctor that he had a drink problem. He described it as *"ducking and diving"* while living a *"nomadic"* life. Later it was thought that alcohol did play a large part in his offending behaviour and he was referred to the Community Alcohol Team (CAT) in Dorset in 1993 (see below). There is no evidence that the offences of GBH and ABH (1990 and 1993) were committed while under the influence of alcohol or drugs. Later offences in 1993 included driving whilst under the influence of alcohol which instigated the CAT referral.

Leicester 1990: GBH, prison and psychiatric admission to hospital

21. In February 1989, Mr McMahon received an absolute discharge for possession of an offensive weapon in a public place. In March 1989 he received 14 days in prison for two offences of actual bodily harm when he assaulted a warden at a night shelter by grabbing his throat, causing bruising, and then head butted a second man in the face.

22. On 8 February 1990, Mr McMahon was imprisoned for 15 months and 6 months consecutively, for offences of grievous bodily harm and actual bodily harm respectively. The former involved Mr McMahon punching and kicking a man into unconsciousness, resulting in fractured ribs and a collapsed lung. He explained to us that it had occurred because he felt the man was trying to intimidate him by using the names of known paramilitaries. The latter was when he accosted a man and his girlfriend in a lift and punched the man about the head. This was a seemingly unprovoked attack.

23. On 30 August 1990, and shortly after being released from prison, Mr McMahon sought admission to Leicester General Hospital because of feelings of paranoia that he was being followed and fear that he might kill someone. He describes having panic attacks and not sleeping for days on end.

24. He was diagnosed as suffering from a paranoid psychosis and remained in hospital until 7 September 1990. He was briefly placed under a section 5(2) MHA to prevent him from leaving hospital and until a section 2 assessment could be made. His responsible medical officer was concerned that he should be detained because he had been aggressive and had been in a fight a few days previously. Mr McMahon became very disturbed and violent at this time requiring seclusion, six staff to restrain him and sedation. He was later apologetic for his behaviour. Subsequently he was assessed by social workers not to fulfil the criteria for a section 2 MHA detention and was discharged.

25. A summary of this in-patient period was provided to Dr Rowton-Lee at St Ann's Hospital in 1993. We have obtained the social worker's assessments separately. Neither the probation nor the prison records for this period are now available.

26. The social worker's notes are full and impressive. They record a history that is consistent with that described by Mr McMahon about this period. He indicated his willingness to remain in hospital voluntarily and the social worker's view was that compulsory admission could not be justified:

27. The responsible medical officer was unhappy with this decision, being of the view that Mr McMahon was a serious risk to himself if allowed his liberty. A second social work assessment was arranged because his behaviour was said to have deteriorated. The probation officer had provided information that Mr McMahon had a "volatile, violent personality". Mr McMahon expressed his anger at the re-assessment in a collected way. The decision not to section him was confirmed for a second time by a social worker. He was discharged to attend out-patients, which he failed to do. He effectively disappeared from the Leicester services at this time. The next record available is from Dorset in 1993.

Comment

28. **Mr McMahon's background and upbringing in Belfast were essential features which required verification and understanding for any assessment, whether psychiatric, psychological or probation to be meaningful. Although he consistently provided the essential components of this information to those who assessed him in Dorset and the probation officer, Sheila Shepherd, attempted to discuss his experiences with him, there was little focus on this aspect of him.**

29. **One of the main functions of gathering information for an assessment of an individual, must be to formulate an understanding of a person's background and culture. This is equally true of a person who was born and brought up in the United Kingdom, as of a person of a different ethnicity or origin. The answers to the questions "who is this person?", "where are they from?" and "what has formed them?" are likely to encourage more reliable assessments, not just of risk, but also of need and treatment. We think that it is ultimately the more individualised and thoughtful approach that is likely to produce positive and defensible outcomes to service intervention.**

Chapter 12

1993

COMMUNITY FORENSIC TEAM, COMMUNITY ALCOHOL TEAM, PSYCHIATRIC ASSESSMENTS AND PROBATION ORDER

Summary:

Speedy assessments were provided for the court by Dr Grace Leung, Dr Rowton-Lee and Grace Higgins. The unacknowledged limitations operating on this service meant, however, that these assessments were superficial and failed to deal with two important features of Mr McMahon's presentation: personality disorder and PTSD. (See also Coombe chapter 4 and and Concluding Comments, chapter 19.)

Reports provided little practical advice and guidance to assist with the sentencing process. The probation efforts were overall good but suffered from an over-reliance on Mr McMahon's own statements. There was no communication with the Leicester Probation Service.

Reports also need to be explicit on any limitations operating on the conclusions expressed, for example, the quality of the factual information available.

We also comment on probation High Risk conference criteria, the lack of any risk assessment and the content of court reports.

RECOMMENDATION 10:

The Probation Service must ensure that all staff understand the vital importance of independent verification of the facts of an offence, and of any incidence of violence, with first hand information and especially of the need to avoid over-reliance on self-report by the offender in question. Where it has not been possible to do this the fact that the details have not been confirmed must be noted in the record.

Introduction

1. This was the period during which Mr McMahon had his first contact with Dorset services. He was seen on this occasion by probation, health, community forensic team (CFT) and the community alcohol team (CAT). He was sentenced on 13 August 1993 to 4 months imprisonment for offences committed in 1992/93 although the probation officer had recommended a probation order, with a condition that he attend for treatment for his alcohol problem, for which he was referred to the Sedman Unit (Dr Choudry) at this time. He later received a two year probation order, with a condition to attend anger management sessions, on 18 April 1994 for an attack on his neighbour. It is this order that then was carried through, following a renewal for breach in 1996, up to March 1998, three months prior to the murder of William Bodle.

2. Mr McMahon had been charged with actual bodily harm (ABH) against his then girlfriend in November 1992. This new charge was discontinued on 19 April 1993 and a week later he was charged with ABH on his next door neighbour who tried to intervene when he heard Mr McMahon and his girlfriend arguing in the flat below.

3. In summary, the police alleged that Mr McMahon punched the man in the face injuring his nose. He was struck several more times before being able to return to his flat. He was attacked by Mr McMahon a second time when he attempted to leave the building to call the police. Mr McMahon denied punching this man more than once.

4. Prior to this, Mr McMahon had been charged with various offences between September 1992 and February 1993. These included an assault on a policeman (described as minor), two offences of driving under the influence of alcohol and criminal damage to a glass door. This represented a gap in his offending since late 1989 and the GBH/ABH offences for which he served a 21 months sentence in 1990.

5. The important background information at this time, related to his convictions for GBH and ABH in 1990, the psychiatric in-patient period in Leicester and his experiences in Northern Ireland. All of this was available to those assessing Mr McMahon at this time.

6. The assessment by Dr Rowton-Lee appears to have focused on the existence of mental illness and he noted "lingering" symptoms of PTSD. This was not followed up by the CFT, who concurred with the CAT that he required residential alcohol rehabilitation. This was rejected by the court. Through his lack of motivation for residential rehabilitation, anger management was eventually offered to him in April 1994.

7. The majority of the Dorset probation records were destroyed, apparently in accordance with policy, on termination of his probation order in March 1998. This included the Part C daily record of contact. What remain are the supervision plans, quarterly reviews, transfer and closing summaries and pre-sentence reports. The lack of Part C's has caused considerable difficulty in filling in the details for the period 1994 to 1997. Without the daily record, it is difficult to assess the quality of the remaining documents.

8. There was no further contact with the CFT or other Trust services until November 1997. Mr McMahon was not considered to have mental health problems in the intervening period.

Probation assessments and reports

9. The court probation officer was Rachel Newman who dealt with both sets of offences. Firstly, the drink driving and criminal damage offences and secondly, the ABH on the neighbour. For reasons that have now been lost, Ms Newman wrote to Patricia Best, senior probation officer SPO stating that she had *"serious concerns about this referral"*.

10. These concerns included: his failure to keep appointments with her, the nature of his previous convictions, and his serious problem with binge drinking, and the GBH where

> *"the victim sustained broken ribs and a punctured lung. He said the victim deserved it as he was robbing his home...[he] says pressure builds up within him*

and he has a "short fuse". (ALCOHOL/VIOLENCE = MAJOR PROBLEMS)".

She mentioned his background in Belfast where he witnessed *"much serious violence"* and the shooting in 1986 of his "brother", as well as being shot himself. He had expressed the wish to have an opportunity to sort out his alcohol problems and she outlined her referrals to the CAT, and for an assessment for suitability for attendance at a probation centre. The court had indicated that it was considering a custodial sentence.

11. Ms Newman recalls writing this letter but no more. Ms Best has no recollection of it, and there is no record of what action was taken as a result because of the destruction of the majority of the probation records. A suggestion that it may have led to a High Risk conference is not supported by any documentation held by the Trust or the police. There is no reference to any such conference at the time of the High Risk conference in December 1997 as one might expect and so we have concluded that there was no such conference at this time.

12. Her pre-sentence report for the 1992/93 offences indicates that she had conducted a joint assessment with a colleague from the Probation Centre - East and that Mr McMahon had also been assessed by Grace Higgins, probation officer attached to the CAT, Bournemouth. He had told her that his girlfriend (the same one he was earlier charged with assaulting) had been admitted to St Ann's and, in an emotional state, he had turned to alcohol for solace. He had said that his relationship with this woman had, up to then, provided him with greater stability in his life resulting in a gap in offending since 1990. As a result of a horrific attack on her by another person, however, her behaviour had become more volatile, a situation with which he could not cope. (This description shares a great deal of similarity with events in 1996/97 surrounding his violent relationship with another woman, Ms B, including the initial period of apparent stability.)

13. He appeared to accept that he had a problem with alcohol that he wanted to address, and that he was sometimes violent in response to certain situations.

14. She considered that his upbringing in North Belfast might have had a bearing on his violence and offending. He had told her that he had grown up in an area of *"violence and segregation"* and that *"my nervous system is shattered"*. His binge drinking caused him to feel more depressed. Ms Newman concluded that if he was motivated, and genuinely wished to work on these problems, the risk of re-offending could be greatly reduced.

15. This is the only pre-sentence report on the Trust records for this period and is incomplete. The surviving probation records contain a completed version that includes a "Conclusion and Proposal" section. She expressed the view that the recurrence of violence on his record was of *"great concern"*. She identified that he presented as a *"complex man with deep rooted problems. In order that a fuller assessment of his personality, problems and motivation to work on them be carried out"* she recommended a referral to the CFT where he would be assessed by a psychiatrist, psychologist and community psychiatric nurse. The ultimate proposal, should he be suitable, was for a probation order with a condition of treatment, with the aim being to reduce the risk of recidivism.

16. Central funding was only required for the psychiatrist's report because the CFT provided a free assessment service.

17. Her subsequent report (9 July 1993) to the court attached the assessments by Dr Rowton-Lee, Dr Grace Leung and Grace Higgins. She summarised their findings that he was not suffering from a mental illness, but seriously abused alcohol to try to cope with life. Alcohol released his excessive anger, resulting in offending. The anger, she said, appeared to have developed as a result of his experiences in Belfast. She recommended a further adjournment to test out Mr McMahon's motivation to attend alcohol rehabilitation as a part of a probation order, as he had failed to keep two appointments with Grace Higgins. She concluded that he was "*very definitely a man in need of considerable help*".

18. In her final report, regarding the 1992/93 offences, for a court hearing on 13 August 1993 she stated that Mr McMahon did not consider that he could realistically cope with a regime of residential alcohol rehabilitation. However, due to the "*considerable risk of future alcohol related offending*" she recommended a probation order with a condition of treatment for his alcohol problem as directed by the probation officer. She had investigated the possibility of the Sedman Unit, run by Dr Choudry, which involved an intensive programme of work and required a GP referral.

19. In spite of this recommendation and a report from Grace Higgins stating that the GP referral to the Sedman Unit had been made, Mr McMahon was sentenced to 4 months in prison. (This did not come to the attention of either Dr Leung or Dr Rowton-Lee). There are no prison records for this period.

20. On 2 November 1993, Ms Newman prepared a pre-sentence report in respect of the ABH on the neighbour. She referred to his many convictions for assault, which appeared to be as a result of alcohol and drug abuse as well as his quick loss of temper. She did state that she was not aware that the circumstances of this assault were similar to previous assaults and Mr McMahon did not recall drink being involved. She concluded, on the basis of what must have been told to her by Mr McMahon, that the assault was influenced by the victim's unacceptable behaviour over a period of time (this was in his proof of evidence). This does not accord with the Dorset police summary of evidence, which recounts two attacks on the neighbour, or Mr McMahon's police interview. He did, however, admit to throwing one punch. Mr McMahon made a habit of minimising his offending behaviour and casting blame onto his victims.

21. Ms Newman noted again that his experiences in Ireland appear to have had a marked effect on his personality. She recommended a twelve month probation order with a condition that he attended an anger management group for a period of eight weeks.

22. On 18 April 1994, the court made a two -year probation order with a condition of attendance at the Don Low Probation Centre's Anger Management Group. At the time this order was made, Mr McMahon was re-arrested on a warrant from Leicester for theft of £1,200 in 1991. A message was left at the Leicester probation office for Dorset to be kept up to date on this. There is nothing further on this matter in the Dorset records. There are no surviving Leicester probation records.

Assessment by Dr Rowton-Lee

23. This report is dated 4 June 1993 and there was a follow up letter on 23 June, following receipt of a summary of the in-patient period in Leicester by fax dated 22 June. Dr Rowton-Lee is likely to have seen the incomplete version of Ms Newman's first report (see above).

24. The defence solicitor's referral letter enclosed a proof of evidence and a list of previous convictions. The solicitor wrote:

> *"I cannot begin to judge whether he is pschyzophrenic(sic) nor whether the shooting incident he describes in 1986 has seriously affected his mental state. That is why I would appreciate your assistance. I know, however, that he seems inwardly to be terribly tense even when he is chatting in a relaxed atmosphere and I think that he is constantly at boiling point. Certainly when he is drunk and when dealt with by the police (for whom he has little or no respect) he can be thoroughly obnoxious and unreasonable. Whether this is just his personality inherently or whether it can be put down to psychological damage I don't know."*

25. Mr McMahon's proof of evidence covers all offences including the assault on the neighbour. Dr Rowton-Lee interviewed Mr McMahon on 28 May 1993 the referral having been made on 24 May.

26. Dr Rowton-Lee's notes of his interview are quite full and Mr McMahon was clearly forthcoming with details of his past in Belfast, and the attack in 1986 that he had said was by the IRA. He had said his *"nerves were shattered"*. He described his father as a chronic alcoholic and that his parents had separated when he was aged seven. Dr Rowton-Lee noted the admission to hospital in 1990 with

> *"what appears to have been a severe depressive illness, complicated by symptoms of anxiety and post-traumatic stress disorder relating back to the attack by the IRA."*

He also noted the conviction for GBH. A history of very heavy drinking is noted but Mr McMahon had denied being drunk at the time of the assault on his neighbour.

27. He found no evidence of schizophrenic illness but noted that he had not seen the Leicester notes at this time. He thought it likely that he had suffered from chronic depressive episodes and there were *"lingering symptoms of post-traumatic stress disorder which has been severe in the past."* Mr McMahon accepted that he had been involved in a violent incident but thought the degree of violence to be justified in the circumstances. Dr Rowton-Lee concluded that although he ought to be held responsible for his violence regardless of intoxication, if he was asking for help it should be provided. Therefore, he was asking for an assessment by the CFT and a psychological assessment. An appointment with the addiction service for counselling had already been arranged.

28. On 23 June, he wrote in addition that he had perused the Leicester notes and that the symptoms at that time were of paranoid psychosis. His impression was of a *"stress induced psychotic episode"* probably due to being tense and anxious, the *"terrifying"*

attack in Belfast being only a year or two earlier.

29. Dr Rowton-Lee had received a short, one paragraph letter dated 22 June 1993 summarising the Leicester in-patient period from Dr C.A. Walker, the consultant responsible for Mr McMahon during that admission. The letter stated his view that a section 2 MHA detention had been appropriate but not supported by the ASW. He considered this to be *"outrageous"*.

30. There are no clinical records from Leicester in the Trust records. Dr Rowton-Lee was shown the copies of those records obtained by the Inquiry and accepts that he had not in fact perused the actual clinical records, but only Dr Walker's summary of them as contained in his letter of 22 June.

31. While he clearly ruled out mental illness, he recounted the *"horrific"* attack in 1986, the possibility of PTSD, violence, depression and alcohol abuse without offering any diagnostic formulation or differential diagnoses. Most obviously he did not refer to any personality problems or offer any risk assessment. The proof of evidence provided by the solicitor set out some of the detail of the 1990 GBH and that Mr McMahon accepted responsibility for *"fracturing the skull of a man"*.

32. Coincidentally, and without reference to the 4 June report, on 17 June 1993 Mr McMahon's GP referred him to Dr Rowton-Lee for help with PTSD. The GP wrote:

"I wonder if he is suffering from a post-traumatic stress disorder. Apparently he has suffered from gun shot injuries himself and witnessed the murder of his brother. Unfortunately, I have very little information on him but he feels unable to return back to work and a normal life since this incident."

Mr McMahon was offered an appointment to see Dr Rowton-Lee on 23 August, but failed to attend (he was in prison by this time). This failure was notified to the GP with no further appointment to be offered unless requested.

33. Dr Rowton-Lee said he could not recall Mr McMahon. Still he told us that he interpreted his task as being to identify whether there was any mental illness, and specifically schizophrenia, and this he did. His explanation of his referral to the CFT was somewhat confused. He had hoped that the CFT would be able to offer Mr McMahon some support but had not expected or intended a full exploration of the PTSD. He also told us that he covered personality disorder by implication in his report and that he did consider that he suffered from a "disordered personality". He would have expected the CFT to assume such a personality as all their clients tended to be so disordered. He was not asked to assess risk and formal risk assessments were not his practice at that time, although they would be today. (Dr Rowton-Lee is now retired but works as a locum for a medium secure unit.)

34. His experience of PTSD stemmed from writing reports on behalf of victims of road traffic accidents. He also had some experience of ex-servicemen (Gulf War veterans) suffering from PTSD. It was his view that the symptoms of PTSD diminished over time and he did not consider that Mr McMahon was demonstrating active symptoms of PTSD when he saw him. He was unaware of any links between PTSD and anger or violence. He did not have the opportunity, and it does not seem to have been part of his practice,

to conduct any research to help with the diagnostic process in what he admitted was an interesting case.

Assessment by CFT: Dr Leung

35. Dr Leung now lives in Hong Kong and the Inquiry Panel is grateful for the efforts she made to assist the Inquiry. We were able to interview her while she was on holiday in the United Kingdom and subsequently she provided supplementary evidence in writing to the Inquiry.

36. The probation referral form noted anger, violence and alcohol as problems suspected to contribute to offending. Her report of 5 July 1993 contained no history section and no indication of the sources of information relied upon. Dr Leung has told us, and we are aware, that the practice at the CFT at this time was for a separate nursing report to set out the history. If one was completed at that time, it is missing from the Trust records. Also missing are minutes of the multi-agency panel assessment meeting on 6 July 1993 at which the reports written, including that of Grace Higgins, would have been available and their authors would have been present.

37. The report is based on the results of five psychometric tests. These indicated a mild to moderate depression (Beck), a below average intelligence (Standard Progressive Matrices), anxiety (Self Evaluation Questionnaire), chronic anger readily expressed with little provocation which is reflected in his offending behaviour (State Trait Anger Inventory), poor concentration, psychomotor slowness and poor visuo-spatial skills (Bexley Maudsley Automated Psychological Screening). The latter scores on the "Little Men" test were reportedly worse than the alcoholic norms.

38. She concluded that he is an anxious person who tends to:

> *"exaggerate his symptoms particularly his "not coming to terms" with being "shot" in Ireland by the IRA.....There is intense anger within himself with poor control. He also abuses alcohol in order to cope with life and his frustrations."*

If motivated to change, she recommended that he would benefit from CAT counselling.

39. Dr Leung did not conduct any tests for PTSD and her conclusion that Mr McMahon was exaggerating these symptoms is unexplained in her report. There was no risk assessment because she told the Inquiry that she was not asked to perform one. She would have carried the possibility of personality disorder in her head and discussed it at the panel assessment meeting for which the minutes are missing.

40. She was under considerable time constraints in providing these (free) assessments and reported that she had been specifically requested not to include a history section by the probation service. We have been unable to confirm this.

41. The psychometric tests on this occasion as others (see Shane Bath and Simon Coombe) were administered by a psychology assistant, June Copeland. We have been told that they formed a part of a standard battery of tests for all patients, although Dr Leung assured us that they were chosen to fit each patient's needs.

42. Also, although she has provided us with times when she would have interviewed Mr McMahon, these are not recorded in the notes, and the evidence from the psychology assistant is that she (the assistant) interviewed, assessed and wrote the report on Mr McMahon which was then checked over by Dr Leung. Precise recollections of this kind may not be accurate after eight years, but it seems reasonable to conclude that there probably were occasions when Dr Leung would not have had the time to interview and assess the patients herself, but would have reviewed the work of her assistants.

CAT assessment: Grace Higgins

43. The Community Alcohol Team is provided by the Trust and Grace Higgins was a probation officer who has since retired. Her report (28 June 1993) summarised Mr McMahon's background and stated that he appeared to have developed the habit of using alcohol to cope with difficult situations and feelings. Although he appeared motivated to change and to work at controlling his drinking, he had missed two appointments by the time this report was written. The team was, therefore, unable to offer any assistance.

44. Further efforts to explore his motivation to enter residential rehabilitation culminated instead in a referral to the Sedman Unit via the GP. The referral letter to Dr Choudry on 5 August mentions the referral to Dr Rowton-Lee for help with PTSD and that Mr McMahon smelt of alcohol when he attended the surgery.

45. The response from the Sedman Unit on 17 August (copied to Grace Higgins) was to the effect that Dr Choudry felt that it would be appropriate to await Dr Rowton-Lee's assessment, as his drinking may resolve once the PTSD is treated. Dr Rowton-Lee was expected to refer him again if he considered it appropriate to do so. Further attendance has to be voluntary and would only be considered exceptionally as a part of court proceedings. This would require a request from the court for a medical report.

COMMENT

Probation

46. **Rachel Newman's efforts to pull together a multi-disciplinary assessment of Mr McMahon's needs on this occasion were good. Her concerns regarding the complexity of this case and the potential for further violent offending are well and thoughtfully expressed in her reports.**

47. **Dorset Probation Service was one of the first in the country to implement High Risk conference procedures; they had been introduced during 1988. Mr McMahon would not have automatically fallen into the "prima facie high risk" category on the basis of his criminal record resulting in a mandatory High Risk conference. A supervising probation officer could call a conference based on his or her "grave concerns". Based on the concerns expressed by Ms Newman in her letter to Ms Best, such a conference could have been justified. It would appear that actual registration of an offender as "high risk" on this basis is difficult without a conviction or evidence of recently escalating violence. There were grounds for**

registering Mr McMahon as "high risk" at this time, but we would not have felt able to criticise a failure to register. There were clear risks of serious harm, but the added requirement of immediacy of the risk was less apparent at this time than later in 1997. The probation High Risk conference criteria and procedures are considered in more detail in chapter 14.

48. The main point of criticism raised by the probation expert instructed by the Inquiry is the failure to obtain the probation records from Leicester. Although the details of the offences in 1990 were known, and indeed elaborated upon by Mr McMahon, a conversation with someone with experience of him around the time of his in-patient admission is likely to have been very useful indeed and may have helped in coming to a decision on whether a High Risk conference was appropriate. It may also have assisted in evaluating the likelihood of his co-operating with a probation order.

49. The 1990 offences of GBH and ABH were serious and an understanding of their nature from a source independent of Mr McMahon was essential and is unlikely to have led to the acceptance of his version of the assault on his neighbour, which he undoubtedly minimised. It was his custom to justify his violence, a factor important in understanding the role played by his personality in his offending.

50. It is so important for the assessment of risk, during this and later periods, that the facts of an offence are not minimised and that any incidence of violence be properly assessed[1].

RECOMMENDATION 10:

The Probation Service must ensure that all staff understand the vital importance of independent verification of the facts of an offence, and of any incidence of violence, with first hand information and especially of the need to avoid over-reliance on self-report by the offender in question. Where it has not been possible to do this the fact that the details have not been confirmed must be noted in the record.

51. Although she felt that, generally, the quality of assessments provided by the CFT was low, Ms Newman told the Inquiry that she did usually derive assistance from them. She was critical of the quality of assessments provided by Dr Rowton-Lee and said that she found it difficult to discuss cases with him, preferring when possible to go to one of the consultant psychiatrists at the Ravenswood Medium Secure Unit. (See also the Coombe report regarding complaints and equality of services, chapter 8 and Recommendation 8).

[1] See the Report into the Care and Treatment of Christopher Clunis, published by Camden and Islington Health Authority (1994).

Psychiatric assessment: Dr Rowton Lee

52. Mr McMahon's solicitor clearly raised issues for consideration surrounding mental illness, the effect of the 1986 shooting on his mental state and whether his problems were due to personality or psychological problems. Ms Newman's first report (the version on the Trust file) also raised the question of the impact of his upbringing on his mental state.

53. In his report Dr Rowton-Lee managed only to catalogue the range of problems exhibited by Mr McMahon. At the least, there should have been a description of the symptoms elicited of the depression and PTSD as well as a risk assessment. He talks of Mr McMahon's *"many problems"* but offers the court no clue as to what kind of "help" he considered may be appropriate.

54. The expert evidence received by the Inquiry is that it is very probable that Mr McMahon does suffer from PTSD and that his uncontrolled anger (as evidenced by the 1990 and 1993 offences) and binge drinking are related to it. As the provider of court reports, if not a trained forensic psychiatrist, Dr Rowton-Lee should have been aware of this likely connection and his admitted lack of knowledge is surprising and worrying. He should have expected and sought some investigation of the PTSD from the CFT. In the view of our expert, early offending (age 14) and PTSD puts an offender into the high risk category. In general one would expect offending to diminish over the years, except where there is a personality disorder coupled with drinking - a volatile mix. This knowledge would have been available in standard texts of the time. As will be seen (below), the Inquiry has been advised that Mr McMahon also probably suffers from a severe personality disorder falling into the category of psychopathic disorder within the MHA.

55. Recognition of a high risk of harm to others at this stage is likely to have led to closer supervision of the probation orders made in 1994 and 1996. A High Risk conference may have been held sooner than December 1997 and led to registration as a high risk offender.

56. One would hope that had Mr McMahon undergone anger management, the complexity of his problems arising from his background and traumatic experiences, might have been revealed in more detail and referred for specialist assessment. The anger management course was inappropriate to address these issues. Indeed, the whole issue of PTSD was rather undermined in this process and this was probably due to the report of Dr Leung in this regard. Ultimately, however, he did not comply with the probation order and breach proceedings were instigated as early as July 1994. It is not reasonable to suggest that detention under the MHA should have been considered at this time based on "lingering symptoms" of PTSD or personality disorder. Compulsory admission with a primary diagnosis of PTSD would, in any event, have been an unusual practice in 1993.

57. One of the common themes running through both these inquiries is the need to provide an assessment of the quality and sources of evidence forming the basis of reports, whether, probation, psychiatric or psychological. This is a valuable exercise for the report writer and, we think, would aid the provision of consistent risk assessments. It would also be of great assistance to those receiving the reports

in terms of evaluating and understanding the conclusion reached and the limitations operating on it. (See chapter 14 and Recommendation 15, and chapter 18 on Risk Assessments).

58. Dr Rowton-Lee's answers to the Inquiry were vague and unhelpful and at points could even be interpreted as disdainful. This may have been influenced by a degree of "inquiry fatigue", in respect of which some sympathy may be just as it is the third homicide inquiry at which he has had to account for his actions. However, this cannot detract from the need to remain properly accountable for one's clinical practice even after retirement. He was after all the lead clinician at this time and a man was later murdered.

Psychological assessment: Dr Leung

59. Like Dr Rowton-Lee, Dr Leung had no forensic training. There are two issues arising here: the quality of assessments and the remit of the CFT. Providing a free court assessment service meant that she was overwhelmed with work and coped with the demand by employing psychology assistants who were usually graduates in psychology with no clinical qualification. Dorset was one of the first local areas to set up a community forensic team but its structure, leadership and remit were not properly thought through.

60. An appreciation of the clinical limitations of the membership of the team in this field should have led to a clear definition of the restrictions within which the service operated. Thus, if the team was unable to assess PTSD or personality disorder, or was limited by the time available, this should have been made explicit and those using the service should have been provided with a clear briefing of what assessments and treatments were available. It seems that a standard battery of tests was generally used in assessments and not necessarily tailored to the needs of the individual. This often led to poor assessments. It seems that instead, corners were cut so that, for example, the psychological assessments did not contain the historical information on the basis of which a person's behaviour might be understood. (see chapter 4 para 20 and Concluding Comments, chapter 19)

61. An example of the problems created by a standard, rather than a case specific, approach is that an important potential specialist referral was missed. The expert forensic psychologist instructed by the Inquiry has noted that according to the Bexley-Maudsley test administered to Mr McMahon, he performed worse than the alcoholic norm on the visuo-spatial test which indicated the need for a neuropsychological examination to determine what organic damage, if any, there was and its cause. (Our expert had never heard of this test and concluded, following brief investigation, that it was probably one that has been out of use for many years). At least the possibility of a future referral or the implications of such a result should have been noted. It may have been a very important method of verifying the extent of Mr McMahon's alcohol abuse. The potential importance of this investigation is increased by the fact that his notes also contain a reference to his having been struck by a baseball bat early in his history. Constraints of time and resources in making such a referral are relevant here (see chapter 4 para 22).

62. **Our forensic psychology expert has assessed Mr McMahon's data actuarially (VRAG) and using the PCL-R (Hare psychopathy checklist). Scoring conservatively i.e. under scoring where there was any doubt surrounding available information and using only data from before the murder, she found him to fall into the category of severe anti-social personality disorder. Documents show that PCL-R was being used in Dorset by Dr Leung. Whilst advice we have received advice has been that it may not have been unreasonable to have missed the extent and severity of his personality disorder, not to perform any testing for PTSD, given the contents of Dr Rowton-Lee's report and also of Ms Newman's, is less easy to justify. Thereafter, to dismiss as exaggerated Mr McMahon's reports of the symptoms of PTSD without further explanation is clinically unacceptable by the standards of a chartered clinical psychologist.**

63. **Equally, the lack of some risk assessment was unjustifiable. We have found a reluctance, then and later in 1997, to deal with an assessment of risk explicitly. There seem to be many possible reasons for this ranging from a lack of expertise to a disapproval of a system of simple classification limited to high, medium or low (see assessment by Joanna Brook-Tanker in November 1997). Such an assessment must be squarely within the remit of the CFT and vital to the probation service in coming to a conclusion about the possible benefits of a probation order and the likelihood of compliance.**

64. **Although this report was seen by the court, it was in fact intended simply to inform the probation service in making recommendations to the court on sentencing and disposal. The kind of practical advice and guidance that the probation service is likely to have found useful would have involved:**

    a) **an evaluation of mental state together with any limitations on the assessment process (this would include the information forming the basis of the evaluation and any missing information),**

    b) **any further assessments or treatments which are necessary prior to a firmer conclusion being drawn,**

    c) **whether or not the CFT are able to provide any such assessments or treatments,**

    d) **any treatments being offered as part of the sentencing process,**

    e) **an evaluation of any link between the offending behaviour and mental state, together with the likely risk of harm to self or to others.**

65. **Dr Leung told us in her defence that her work was much appreciated and she felt that she had made a difference to the lives of many people. This is not an inaccurate statement and it is true that the probation service were grateful for this speedy source of assessment. They did, however, have reservations about the quality of the service.**

Chapter 13

PROBATION ORDER AND SUPERVISION

JANUARY 1996 TO NOVEMBER 1997

Summary:

Mr McMahon was supervised by a relatively inexperienced probation officer during 1996. It is possible to detect signs of manipulation of this officer by Mr McMahon. The Inquiry is concerned at the process for case supervision by senior probation officers and also that for the transfer of cases between probation officers.

The police had information regarding allegations of assault by Mr McMahon but which were never prosecuted. Details of these, which would have been important in evaluating Mr McMahon's motivation and more particularly in assessing any risk to others, were not passed on to the probation service. See chapter 5 and Recommendation 2, and chapter 15, para 37.

However, there was a period of relative stability for Mr McMahon between about March 1996 and January 1997.

His troubled relationship with Ms B was noted. She too was subject to probation supervision. This was a violent relationship between two probation clients and there is no evidence of any communication or liaison between their respective supervising officers.

Local agencies, including the police, coming into contact with known service users should jointly devise a standardised procedure criteria for sharing information relating to arrests, charges, convictions and particularly allegations of violence and indecency.

See recommendation 2 chapter 5

RECOMMENDATION 11:

The Probation Service should prioritise cases for supervision by a senior probation officer cases that have been subject to a transfer between supervising officers.

RECOMMENDATION 12:

The Probation Service should review the training needs of probation officers in relation to the supervision of mentally disordered offenders and particularly those with a personality disorder.

Introduction

1. As before our investigation into this period has been severely hampered by the lack of probation records.

2. The probation order with a condition of anger management on 18 April 1994 was unsuccessful. Following breach proceedings, a further two year probation order, with no conditions attached, was made on 8 March 1996. The Inquiry focused on the supervision of the latter because Mr McMahon had absconded for much of the period up to August 1995.

3. Following the 1994 order, there were further non-violent offences but no convictions, and Mr McMahon failed to attend anger management sessions and appointments with his supervising officer Trevor Hopkins. Over the next three years he was supervised by three probation officers,: Trevor Hopkins (April to August 1994), Sheila Shepherd (August 1994 to May 1996 and from November 1997) and Elaine Phillips (May 1996 to November 1997). There was no contact with him from about August 1994 to August 1995 and breach proceedings were instigated. In that time, he says he went to London, back to Ireland and then returned to England. There is a lack of information about his activities in this period, but no offences show on his record.

4. Our reconstruction of Mr McMahon's behaviour and presentation over this time, relies on the recollections of those officers who had contact with him and the probation summaries. In 1997 there was also some police documentation, sparse social services records, GP and A&E notes available together with CFT notes for late 1997.

5. Broadly, the pattern over this period is a surprisingly successful period of supervision until early 1997 and then a deterioration in his behaviour and mental well being over that year ending with crisis, a probation High Risk conference and a referral to the CFT (see chapter 14). Again unexpectedly, Mr McMahon maintained his co-operation with the probation service throughout and until the order terminated in March 1998, although there was little progress in achieving any real change in him.

6. Supervising and motivating Mr McMahon was a complex task. In retrospect, it is possible to say that he exerted control over, and manipulated, the way in which this order (1996) was run, at least in the first six months of it. There were, additionally, low expectations of him, which resulted in a plan to contain, rather than lose him by challenging him.

7. Importantly, he was not considered to have mental health problems because of the assessments in 1993 and it was not until the latter part of 1997 that Ms Phillips and Ms Shepherd had renewed concerns on those grounds resulting in a referral to the CFT.

8. Mr McMahon's behaviour started to deteriorate from late 1996 after he had moved in with Ms B. He attributed his apparent stability at this time to his relationship with her although this was short lived. Mr McMahon was evicted in January 1997 from Bridge Corner House, supported accommodation in Poole, due to his behaviour. He had been threatening and aggressive. He was said to have been drinking more heavily. He had moved out of Ms B's home due to the stress being caused by the relationship.

9. Ms B was a vulnerable young woman who suffered from an acute manic depressive illness, PTSD and was also subject to a probation order which terminated in January 1998. Her account of this relationship differs materially from Mr McMahon's. The relationship was known to the probation service to be a volatile one with violence from both partners. Mr McMahon usually said that he acted in self-defence against her. From

about July 1997 the police were called out on several occasions to incidents of "domestic violence" at her address. None of these resulted in any prosecution but she was later advised not to allow him in to her home. The most serious assaults occurred in March 1998, firstly when she stabbed Mr McMahon and then, when he retaliated on release from hospital (chapter 15). Sadly, she took her own life in July 1998.

10. The details of this alleged violence and certainly its frequency, were not known to his supervising officers. There is no evidence of any liaison between their respective probation officers.

11. His relationship with her was an important factor in his worsening mental health in the second half of 1997. In July 1997, she took a massive overdose resulting in a coma and about six weeks hospitalisation. She is reported to have been on a life support machine. Mr McMahon was with her daily in hospital and moved into her flat to look after her when she was discharged from hospital.

12. This period was subsequently recognised to have triggered off symptoms of PTSD in Mr McMahon. He said he had found her virtually "dead" and called for an ambulance. The period she spent in hospital was clearly traumatic for him. He probably did save her life and exerted a strong emotional hold over her for this afterwards. With Ms B's own emotional instability and Mr McMahon's deteriorating mental health, the police records demonstrate that the relationship became more violent. These records show call outs to Ms B's address for incidents of "domestic violence" from July 1997.

13. He was not considered to pose a high risk of harm to others until later in 1997 when Ms Shepherd called a High Risk conference due to her concerns. He was not registered High Risk at that time.

Breach of Probation Order of April 1994

14. Sheila Shepherd was a newly qualified probation officer in August 1994 with little formal training relating to mentally disordered offenders. She had previous experience in a probation bail hostel where she had worked for three years.

15. In a statement of facts on 10 January 1996 Ms Shepherd wrote that Mr McMahon had failed to keep four appointments with her and that letters had been returned marked with rude messages saying that he did not reside there. She was, therefore, still to meet him by this date. It is not clear whether the messages were his or not, but Ms Shepherd's recommendation to the court at this time was that the probation order be revoked and Mr McMahon re-sentenced for his original offences.

16. The breach was in court again for sentencing on 8 March 1996. Before this could happen, however, Mr McMahon was arrested and charged with ABH on a man on 25 January 1996. An appropriate adult was requested because the police record showed a previous mental health problem. The appropriate adult noted that he was *"very drunk and violent"* on arrest and had an *"invisible friend"* in the cell with him. He had been seen by a CPN earlier due to his "strange behaviour". His assessment by the court diversion team showed no signs of thought or mood disorder and that he was fit to be interviewed.

17. The appropriate adult note also states that Mr McMahon's version of the event was different to that of the person he is said to have assaulted. He did not deny that an incident happened but maintained that it happened in a different way because he could not clench his left fist due to the recent surgery[2]. In the course of the altercation, Mr McMahon had a finger poked into his right eye. He was released without charge because there were no independent witnesses (a third man had run off) to the assault. The facts were that he had assaulted a man who he believed had stolen property from his flat 18-24 months previously. This incident did not come to the attention of the probation service.

18. Ms Shepherd wrote a pre-sentence report for court on 7 March which was far more positive than her first statement for the court. He blamed his failure to comply with the earlier order on his chaotic lifestyle, and excessive drinking and police harassment which he felt was due to his being Northern Irish and an upcoming Conservative Party Conference in Bournemouth. He felt he had to get away. He went to Ireland to see his parents for a few months, although this was not confirmed by his mother who said to us that she had not seen him since he left Belfast by the time of the murder trial.

19. To us Ms Shepherd added that he had not established a rapport with his earlier probation officer and also had not felt able to go through with group anger management.

20. Ms Shepherd explained in her report that his apparent mental illness on arrest in August, when a psychiatrist was called, was due to his coffee being "spiked" and drug induced. This information had been provided by Mr McMahon. She says that he had settled down since then and also that he had kept their weekly appointments since 17 January and demonstrated a willingness *"to examine his offending, alcohol abuse and inappropriate behaviour"* and *"appears determined to settle down"*....

21. Mr McMahon had impressed upon Ms Shepherd that past alcohol abuse had caused immense problems but that he now appeared able to control his drinking and never drank at home. He no longer associated with his heavy drinking companions. His social evenings consisted of listening to live folk music. She noted that his offending seemed to have slowed down as a result of his changing attitudes and controlled drinking, and that *"although he has led an extremely violent life he now presents as someone who is tired of "fighting", he would now love a quiet life"*.

22. In her analysis, many of his past convictions for assault appeared to be as a result of alcohol and drug abuse and Mr McMahon's quick loss of temper.

23. In her assessment, his risk of violent offending would be significantly reduced if he continued to control his drinking and avoid potentially violent situations. Given the reasons he gave for the breach, she felt able to recommend a further probation order without a condition of treatment, which the court accepted.

24. She had made a home visit that reinforced her impression that Mr McMahon was making an effort to address his problems. It was clean and tidy and, she told us, "orderly". The statement of his landlord to the police following the murder, however, states that he was dirty and drunk much of the time. It is difficult to know how much weight to attach to this post a murder when people's recollections may become less charitable.

[2] This refers to another altercation with a man in December 1995 when Mr McMahon's hand was cut by a knife. He required microsurgery to his left hand

Comment

25. **Mr McMahon's compliance with the reporting requirements of this probation order, the fact that he was able to talk to Ms Shepherd about his experiences in Ireland and the fact that he was able to remain trouble free for some months are perhaps evidence that her optimism for the immediate future was well judged.**

26. **The tone of her report had mellowed considerably in the six weeks since her first report in January 1996. She put forward the option of a further probation order almost entirely on the basis of Mr McMahon's own version of his offending behaviour. Very few steps had been taken to verify what he was saying to her.**

27. **There is a clear likelihood that he was manipulating the situation to his advantage. A week after his first appointment with Ms Shepherd he was arrested and was "quite drunk" which does not accord with him controlling his drinking.**

28. **The other evidence available suggests that he was rather exaggerating his apparent reform and the extent to which he was controlling his drinking. If she had known about the January arrest at the time or, if she had taken into account his recent history of professed determination to change and then non-compliance, she would have been able to evaluate his assertions more realistically. Equally, even if she was able to verify through her own knowledge subsequently, the matters that he had reported, e.g. that he knew about folk music and was a tin whistle player, which suggested a more settled lifestyle at this stage, then her reliance on this information without any formal verification was a naïve and even risky way to proceed.**

29. **We have already commented on the over-reliance on self-reported evidence in relation to the pre-sentence report in 1993. (See Recommendation 10 chapter 12).**

30. **The arrest in January 1996 does not appear to have come to the attention of the probation service. It should have been notified to them by either the police, or social services or the CPN. It would have assisted in the assessment of risk to have known about it and also in assessing the accuracy of Mr McMahon's statements enabling the probation officer to be more sceptical about information provided by him. This was not the last occasion on which information known to the police, and which would have been of assistance to the probation service, was not passed on. This was also the case with the incidents of domestic violence to which the police were called out from July 1997 onwards, and particularly in March 1998 when the most serious of the assaults would appear to have taken place. (See chapter 15) .**

Recommendation 2 (see chapter 5)
Local agencies, including the police, coming into contact with known service users should jointly devise a standardised procedure criteria for sharing information relating to arrests, charges, convictions and particularly allegations of violence and indecency.

31. In her supervision plan, Ms Shepherd identified *that "virtually all his offending is drug + alcohol related"*. No "problems" and "needs" were identified to be addressed during sessions, but the aim was to look at offending behaviour, build a more positive attitude and to use "brief therapy" to help define goals.

32. She explained to us that the risk of re-offending and of harm to others was scored by her as "4" out of a possible "8" (high). She was undecided as to risk and, by initially scoring him at the middle of the scale, gave herself room for movement. The use of this scale was subjective and highly unsophisticated, each officer having their own methods of scoring risk. We are told that actuarial tests have now been introduced which reduce the subjectivity of such an assessment.

33. By the time of her transfer summary in May 1996 Mr McMahon had not re-offended. His compliance with the order had "exceeded expectations" since his last failed probation order. His efforts to change were hampered by his still drinking to excess on occasions and continued harassment by the police. In the latter context, she noted that he stated he had been hospitalised with serious injuries as a result, but we have seen no medical records to support this allegation.

34. She also said that he *"will never change radically since his Irish background was so violent for so long, his behaviour + attitudes are well entrenched".* She stated, and the Inquiry heard evidence, that it was agreed with Elaine Phillips beforehand that

> *"it would not be productive to challenge him too much as he would just stop reporting, his breach would then inevitably end in a custodial sentence, we would then have lost any element of influence. I have agreed that he can report to the duty officer and see his supervising officer at each 3 months stage to discuss supervision plan - this may be that he just continues to report. In my opinion it is better to contain him than lose him and who knows the order may be able to be revoked at the 1/2 way stage".*

35. A transfer was necessitated by Ms Shepherd's move to a court duty officer role. Mr McMahon was very resistant to this change.

36. Ms Shepherd continued to see Mr McMahon on an *ad hoc* basis after the transfer when he would drop in to see her at court and she would report back on these meetings to Ms Phillips. She told us that there was an observable improvement in Mr McMahon such that he spruced up his appearance by cutting his hair, which had been in a pony-tail. He went on holiday abroad in Europe, probably Portugal, and returned looking tanned and healthy.

Comment

37. Due to the lack of part C records, we have no contemporaneous evidence of the contact between Ms Shepherd and Mr McMahon. She told us that he "educated" her about Northern Irish politics and opened up to her about much of what he had experienced and seen, and this is reflected in the summary. It had probably correctly alerted her to the scale of violence involved and the likelihood of its lasting impact on him.

38. Due to Mr McMahon's reluctance to agree to any change in probation officer Ms Shepherd said she had "hand picked" Elaine Phillips as an officer who she felt worked in a manner close to her own. She arranged a three-way introductory meeting to make the transition smoother.

39. The prescriptive nature of this transfer summary is surprising and has been criticised by our probation expert. The recommendation that Mr McMahon was not to be challenged, but contained in preference, effectively meant that apart from complying with reporting requirements no progress was to be made in addressing his offending behaviour or other rehabilitation. It places the receiving officer in a difficult position with the client as well, effectively undermining her authority. Ms Phillips told us that she felt at a disadvantage taking over this order in this way.

40. By prescribed national standards (1995) a change to monthly reporting at this juncture was too early, as three months of the order had yet to elapse. The suggestion that he report to the duty officer monthly and his supervising officer three monthly was designed simply to ensure strict compliance with the order. Ms Phillips' review for August 1996 indicates that monthly reporting started on 8 September 1996, and, she told us, that reporting with her was monthly.

41. Our expert evidence is that this transfer arrangement should have been questioned at supervision by the senior probation officer. It is not clear when, or if, this particular arrangement came to the notice of the supervising officer.

RECOMMENDATION 11:

The Probation Service should prioritise cases that have been subject to a transfer between supervising officers, for supervision by a senior probation officer.

42. Again, it is a possibility that by firmly expressing a reluctance to co-operate with any other probation officer Mr McMahon influenced the transfer arrangements. This must have suited Mr McMahon perfectly as a mode of staying out of prison. It may be that resistance to change is not unusual in offenders, and that by seeking to find another probation officer who worked as she did, Ms Shepherd was showing sensitivity to her client's needs.

43. It is also difficult to unduly criticise any attempt to maintain seeing an offender throughout an order to prevent any further breaches being recorded against him, and getting Mr McMahon to the point of transfer was itself an achievement. Ms Phillips told us, in response to questioning about the merits of simply containing and monitoring, that *"one of the greatest indicators that things are going wrong in an offender's life is his non-compliance"*. Of course, compliance with reporting requirements does not necessarily prevent re-offending and the result was that Mr McMahon was allowed to coast through his probation order without his behaviour being challenged, or any positive attempts at rehabilitation which, after all, is the aim of a probation order.

44. Ms Shepherd told us that Mr McMahon presented a challenge as other officers had been unable to work with him and she felt "flattered " that he had opened up to, and co-operated with, her. This is again a more naïve reflection than one would expect from a, by now more experienced, probation officer and perhaps another

indication that Mr McMahon was manipulating Ms Shepherd into effectively doing his bidding more than she realised.

45. In retrospect, evidence is discernible of the kind of manipulative behaviour more commonly associated in a person with an anti-social personality disorder.

46. It was not Ms Shepherd's role to diagnose a personality disorder and he was not presenting with other mental health problems warranting a referral to health services. She was eighteen months qualified and it should have been part of her training to be alert to the possibility of manipulation by clients whether personality disordered or not, and to be more questioning. Failing that, it should definitely have been picked up and addressed at supervision sessions by the senior practitioner.

RECOMMENDATION 12:

The Probation Service should review the training needs of probation officers in relation to the supervision of mentally disordered offenders and particularly those with a personality disorder.

47. Even though it was stated that "virtually" all his offending was alcohol or drug related, his most serious offences, of GBH and ABH (1990) and ABH (1993), were not, and this conclusion demonstrates that the precise circumstances of these offences were not appreciated. Ms Newman had noted that his offending was not always related to substance or alcohol abuse. This highlights the importance of the facts of a recorded conviction being properly researched and recorded from the outset. (See chapter 12 and Recommendation 10 .)

48. Mr McMahon vehemently denied to the Inquiry that he was an "alcoholic" at any time, but accepted that he did "binge" drink at times of stress and frustration, and that this could lead to offending.

May 1996: transfer of the probation order to Elaine Phillips

49. In August 1996, Mr McMahon was fined £60 for interfering with a vehicle. Ms Phillips wrote a supportive memorandum to the duty court officer emphasising his compliance with the reporting instructions of his order and his previous probation officer felt that he was making efforts to change. This led to a Money Payment Supervision Order (MPSO) in February 1997. She mentions also that on arrest he says that he was "attacked" by six police officers and lost his front teeth. The precise details of this assault were not verified.

50. That an incident occurred is confirmed by the Police Complaints Authority response of February 1997 to Mr McMahon's complaint, which the Inquiry obtained separately from solicitors acting for Mr McMahon. The officer concerned admitted to striking him once

on the jaw in self-defence. Both officers involved deny using excessive force or assaulting him, as do the officers who arrived at the scene subsequently. It was also denied that he was assaulted in the police station cells.

51. Although the medical evidence failed to identify any fracture to his ribs, it was stated that his injuries were consistent with an assault. Faced with the denials of the officers, and no independent witnesses to support either account, the Authority doubted that the injuries were caused by unreasonable force. The loss of teeth is not referred to.

52. The letter from the Police Complaints Authority states also that Mr McMahon was described as being drunk and aggressive in the custody office and he was placed in a cell to sleep off the alcohol and until such time as he could understand his rights when read to him.

53. In her August review, Ms Phillips assessment of risk of re-offending was "5 out of 8" and of serious harm to the public "3 out of 8". She used the same "unsophisticated" scale as Ms Shepherd (above).

54. By November 1996, his relationship with Ms B was referred to by Mr McMahon as a *"stabilising influence"*. This appeared to change very quickly as, by February 1997, he was recorded as deciding to move out of her flat because it represented a stressful situation for him. Ms B did have serious mental health problems of her own but the precise nature of the events supposed to be causing Mr McMahon stress do not appear to have been investigated, nor are noted in any review.

55. He had managed *"just"* to comply with reporting requirements and Ms Phillips noted that she used some discretion in the hope of containing him and getting him through the order rather than back in prison. She also noted that he had made considerable efforts to keep out of trouble, but she also noted that he continued to be the focus of police attention. Our records do not show any formal arrests by the police since the motor vehicle charge and this lends credence to the fact that he was in fact staying out of trouble.

1997

56. After Mr McMahon moved out of Ms B's flat, Ms Phillips found accommodation for him at Bridge Corner House, Poole, and the new stated objective was to find secure and permanent accommodation. There are no longer any records available of his stay there. The risk of re-offending was assessed at "2 out of 8" and of serious harm to others "1 out of 8", the lowest possible. Again, there is no explanation of the differences in the scores chosen.

57. On 14 February 1997, the police were called to Bridge Corner House and staff complained about Mr McMahon's aggressive and abusive behaviour. He was behaving in an unruly manner causing damage and threatening other tenants. On 17 February he was given 7 days notice to leave. He had threatened to "chin" the staff who were all women.

58. This case was taken to supervision with Margaret Harris, senior probation officer, in March, when a high risk of offending was noted, and again in April when his

accommodation difficulties were recorded with the comment that he could not be referred for accommodation due to his past behaviour (at Bridge Corner House) and needed to find his own accommodation. The May supervision review records, however, that he remained of "no fixed abode". He was feeling discriminated against by landlords due to his Irish accent and so a probation volunteer was enlisted to make contacts on his behalf. Mr McMahon was not impressed by these efforts which came to nothing and a promised deposit did not materialise.

59. Altogether, matters had deteriorated significantly in this period. His risk of re-offending had increased to 8 (although the risk of serious harm to others was still 3 out of 8). There is mention of new charges to which he was pleading "not guilty". We have no details of these. His fines remained unpaid, he was drinking more and associating with heavy drinkers. In addition, the bullet fragments in his right leg were causing him pain.

60. Ms Phillips noted that she was having difficulty trying to keep Mr McMahon moving in the right direction, *"it is something that he is still complying with the order".*

61. Although Ms Phillips recalls her relationship with Mr McMahon as moving forward at this time, and becoming closer than before, she still did not address anything from his past, and Northern Ireland in particular, with him. He knew that she had been told that he had spoken to Ms Shepherd and that he could speak to Ms Phillips whenever he wanted to. He considered moving from Bournemouth to Poole to be a step away from his usual haunts, albeit only four miles away but offering a fresh start.

62. She recalled to us that Mr McMahon had candidly expressed his fears of re-offending or causing harm as a result of drinking alcohol. She did not consider him to have an alcohol dependency requiring medical assistance and so this kind of change of environment, even if small, represented an attempt to deal with his drinking problems. As for anger, she said that she tried to deal with this as and when incidents arose. He certainly had a problem in controlling his anger. However, he saw himself very much:

> *"..as the victim, that things happened to him and he would react and he had every right to react in that way. I do not think that I had any success in getting him to see it in a different perspective or to see how in changing his behaviour he could then take control and take things in a different direction."*

63. From July 1997, things got progressively worse. On 1 July, the police were called out to Ms B's flat. The printout notes that a 999 call was received from a woman, but that before she could say anything the telephone was taken away. The operator rang back and spoke to:

> *"an Irish sounding male. Sound of male and female rowing in background. I asked to speak to the female. She came onto phone and said she did not wish police attendance but was crying and sounded terrified."*

A police unit attended, and it is noted that the occupants were drunk and the police left.

64. On 3 July, there was another call due to a small accidental fire at the flat. Mr McMahon went to see his GP on 7 July when fire and smoke inhalation were noted. On 24 July, there was another police call out to Ms B's address. This would appear to be the date on which she overdosed resulting in lengthy hospitalisation. The police print out noted the presence of an *"aggressive male called David McMahon"* at the scene. She was admitted to Bournemouth General Hospital.

65. It is clear that these incidents with Ms B in July were unknown to Ms Phillips at this time. Subsequently she became aware of the overdose, but probably not of the prior incidents.

66. By August 1997, Mr McMahon was still homeless. Ms B was still in hospital. Following his eviction from Bridge Corner House, Ms Phillips had referred him to Bournemouth Churches Housing Association for a rent deposit, and enlisted a volunteer as mentioned above. Additionally, she had made a referral to The Friary in West Dorset, an alcohol free environment away from the pressures of Bournemouth, and finally in June 1997 she had offered him a travel warrant to Manchester to reside with family. This he declined.

67. She was asked about a referral to local housing authorities and replied that he would have had to go on to the waiting list and would not have been considered for priority housing because he did not have a mental disorder.

68. The review at this time was not completed on the usual form and Ms Phillips told us that this must have been because he did not attend the appointment. There is a document which may support this and which explains that he had failed an appointment because Ms B had made a suicide attempt, was in a coma and on a life support machine.

69. The suggested programme was for obtaining secure accommodation, resolving relationship difficulties and avoiding drugs and alcohol to reduce the risk of re-offending. Ms Phillips said that she discussed the relationship problems with Ms B's probation officer, but we have no confirmation of this in the available records.

70. There was no explicit risk assessment in this document. Ms Phillips explained that she judged Mr McMahon's risk by his level of stability. Her view was that the risk to the public was of "indiscriminate" violence i.e. not focused on any one person. He may have "lashed" out at someone in the wrong place at the wrong time. She did not consider there to be a risk of a sustained attack on anyone. In terms of the "serious risk of harm", what was required was evidence of longer lasting harm than a common assault. She felt that this was also the understanding of her colleagues of this term. The format for assessment has now changed. Ms Phillips was quite critical of the forms being used even now, considering them to be over prescriptive in an unhelpful manner.

71. On 19 September 1997, Mr McMahon sought help from his GP. It was noted that he was very late and had overslept, also that he had been *"depressed for a few weeks, girlfriend has been on life support ..."*. He was prescribed the anti-depressant dothiepin to be taken at night.

72. On 19 October 1997, a police crime report was raised relating to an incident which prompted a referral to the CFT by Ms Shepherd later in November, when she became aware of it, and it was discussed at the High Risk conference in December.

73. The probation order was transferred back to Ms Shepherd in November 1997. Ms Phillips noted the difficulties she had experienced supervising Mr McMahon and that it had been a *"struggle at times to get along side him and ensure he completes the Order and avoids re-offending"*. She found herself responding at times of crisis rather than working to head off problems. She noted his *"wholly unsettled"* year, homeless and with a mentally unstable partner as well as trying to cope with past problems and experiences. She had suggested a CFT referral, which he had declined. He had failed to attend a GP appointment arranged in October with a view to a psychiatric referral. She had agreed with Ms Shepherd that she would manage the order to its close in March on "group reporting".

Comment

74. **It is clear that Ms Phillips felt that there was little more that she could do and that, as Ms Shepherd had previously experienced a closer working relationship with Mr McMahon, that she (Ms Shepherd) may be able to do more at this stage including getting him to accept a CFT referral, which of course she did. A suggestion that this transfer was simply because Ms Phillips was changing jobs is probably faulty because Ms Phillips recalled that she did not in fact move until about March the following year.**

75. **Ms Phillips did well in a difficult situation constrained by an apparent agreement that she would simply try to contain Mr McMahon. The notes indicate that she was struggling to achieve anything and indeed had done well to keep him reporting. Her response to his further deterioration and concerns regarding his mental health led her to transfer him back to Ms Shepherd. She says that she considered him a high risk to others at this time, but had not recorded it, leading to some confusion with Margaret Harris at the time of the High Risk conference. We have to be critical of the failure to record her views on risk at this time and to ensure that they were clearly available to the High Risk conference, which she would have been aware was taking place.**

76. **The risk assessment contained on the review forms was clearly uninformative and unexplained. Ms Phillips scored the risk of harm to others lower than the risk of re-offending and it is not clear on what basis she drew this distinction, particularly in the March review which came after Mr McMahon had been evicted from Bridge Corner House due to his aggressive behaviour. Terms such as "high" and "low" risk need clear definitions if they are to be used with consistency and meaning.**

77. **There is insufficient evidence of liaison between those supervising the probation orders of Mr McMahon and Ms B. The incidents in July were unknown to Ms Phillips. Here we have two vulnerable people involved in a volatile relationship and both subject to probation supervision. There was a source of accessible and important information about the behaviour of these two people in the community. A regular joint review would have been justified in these circumstances and the failure to do so in a formal manner at this time, and later, amounts to a 'blinkered' approach. This is a matter of basic practice and common sense in respect of which we do not feel an express recommendation would be of assistance. This is not to undermine the importance of this comment.**

78. Also of potential relevance here, is the comment in the Coombe report (chapter 4, Recommendation 1) relating to the rigid adherence to national standards. For Mr McMahon this resulted in simply containing him through the probation order, rather than working to address his offending behaviour. This may be partially explained by the reduction in resources being experienced by the Dorset Probation Service at around this time, allowing little time for more in depth individualised work in an apparently low risk individual, but such shortcomings make the imposition of a probation order of nominal significance only and cannot be excused (see chapter 19).

Chapter 14

PROBATION HIGH RISK CONFERENCE

CFT ASSESSMENT

NOVEMBER TO DECEMBER 1997

Summary:

This was a key period for Mr McMahon during which his mental state was deteriorating. He was taken to the RBGH (Royal Bournemouth General Hospital) on two occasions having overdosed, there were allegations by his "girlfriend" Ms B that he had tried to strangle her, his probation officer called a High Risk conference and he was assessed on a voluntary basis by the CFT.

Social services record keeping was poor and information relating to a supposed assessment under the MHA at the RBGH was not recorded nor passed on in an accurate form.

We are critical of the High Risk conference on 8 December 1997. We think that the available evidence was of insufficient quality to justify any final conclusion regarding high risk registration and that it should have been adjourned to allow further information to be obtained. The decision not to register was based on inaccurate, second hand information. In broad terms we criticise the:

a) Preparation for the conference
b) Limited scope of the conference
c) Lack of explicit criteria for high risk registration
d) Reliance on second hand information
e) Failure to take account of the record of violence and the allegations of domestic violence
f) Lack of a proper multi-disciplinary formulation and the failure to take the opportunity to plan for the management of the case in circumstances falling short of high risk registration
g) Failure to adjourn pending further information on relationship with Ms B and full assessment by CFT.

The CFT assessment conducted by an experienced and senior psychologist failed to appreciate the potential risk factors conjoined in Mr McMahon, including the possibility of a personality disorder.

RECOMMENDATION 13:

Poole and Bournemouth Social Services should conduct a full audit into the record keeping practices of its staff.

Summary continued

RECOMMENDATION 14:

The Probation Service should review its procedures for Potentially Dangerous Offender conferences to ensure that full account has been taken of the findings made by this Inquiry relating to High Risk conferences.

RECOMMENDATION 15:

The Trust should commission and promote a standard format of report writing designed to convey explicitly the available sources of information and any limitations on the opinions expressed.

RECOMMENDATION 16:

The Trust should ensure that forensic service clients are assertively followed up in the community and, in particular, where they fail to attend appointments.

Introduction

1. In October 1997, Ms B made a complaint that Mr McMahon had assaulted her but later withdrew it. The details she provided to the police are of a serious incident. However, her subsequent retraction of her complaint meant that there was no prosecution of Mr McMahon and the incident was discounted in assessing his risk to others at the probation High Risk conference on 8 December. The probation record noted that Ms Phillips as by this time only responding in times of crisis. Some effort is recorded of unsuccessful attempts to get him to deal with his increasing mental health problems. Dr Hockey, his GP referred him to the District Psychology Service in November 1997. The referral letter refers to an emotional crisis after finding his girlfriend close to death (July 1997).

2. In around late November 1997, the probation order was again transferred, this time back to Sheila Shepherd for reporting only, and Mr McMahon accepted a referral to the CFT. Ms Phillips transfer summary makes it clear that she was feeling frustrated at the lack of progress with Mr McMahon and felt that Ms Shepherd, who had previously developed a good rapport with Mr McMahon, may be able to do more. Ms Shepherd told us that she thought the case was transferred back to her because Ms Phillips was changing jobs and even though she was not holding a case load requiring 1:1 intervention. She could not give Mr McMahon the time and consideration required, but this was considered to be preferable to transferring him to someone new, and she agreed. The decision to reduce supervision to reporting only at this difficult time for Mr McMahon is a controversial one, which was not discussed at any supervision with the senior probation officer.

3. On 2 December 1997, Mr McMahon took two overdoses. We have evidence that he was seen twice at the Royal Bournemouth General Hospital. There is reference to an

assessment at St Ann's where he was taken by the police under section 136 MHA but refused admission. We have found no evidence of any assessment at St Ann's. Although an MHA assessment was intended, it has been difficult to establish what happened with any precision.

4. The documents and accounts of these events have been difficult to put together, and so the precise sequence of events has had to be reconstructed from memories and the sparse documentation available. What emerges is that these were important events in the assessment of risk posed by Mr McMahon to himself and to others. They confirmed to Ms Shepherd the need for a probation High Risk conference to be convened, but poor communication led to misleading and probably incorrect information being passed to that conference. This was compounded by the absence of key people at the conference including, relevant social workers, GP and the CPN referred to above and Ms B's probation officer and/or CPN. There are no social work records of any approved social worker assessment for MHA purposes and those records which do exist do not identify which social worker, if any, actually saw him at that time.

5. The High Risk conference was aware only of one overdose on this day and placed reliance on the supposed assessment under the MHA.

6. There was a further allegation of an assault on Ms B on his return home from hospital. This was known to both probation and CFT at the time of the High Risk conference but apparently not discussed at the conference. There had been contact between social services, probation and the CFT regarding these events.

7. There are some CFT notes for this period and a minute of the conference compiled by Margaret Harris. Other than that, the recollections of those involved are unsurprisingly poor. The High Risk conference on 8 December was called by Sheila Shepherd based on her concerns about his deteriorating mental health and reports of the assault on Ms B in October. This was attended by probation, police and CFT. The conference noted violence in the context of alcohol, and possible drug induced psychosis and presentation of PTSD related to his experiences in Ireland in 1986, but that he did not present a suicide risk and was "not sectionable". The CFT offered voluntary assessment and a Special Branch check was to be carried out into his activities in Northern Ireland. Mr McMahon was not registered as High Risk.

8. The minutes of the conference produced by the senior probation officer were disputed by Ms Brook-Tanker who wanted them amended in accordance with her recollection of her contribution to that meeting and in particular that she had not said that he was "not sectionable". This was refused on the basis that the minute represented Ms Harris's note of her contribution.

9. On 13 December, Mr McMahon went to his GP asking for admission to St Ann's. Prior to this, he had informed his GP that he was being seen by the probation service and the CFT. Dr Hockey rang the CFT and spoke to Joanna Brook-Tanker who agreed to send him a copy of her report when it was ready. Mr McMahon ended up in A&E having cut his wrist. He left with sutures and refusing further treatment.

10. A report was produced on 16 December 1997, by Joanna Brook-Tanker and Martin Koscikiewicz, psychologists with the CFT, based on two interviews with Mr McMahon. His long history of violence was noted and an initial diagnosis made of PTSD and severe

depression. Feelings of intense anger and anxiety were also noted. He was presenting as desperate for help. As he presented in "crisis" for assessment on both occasions, this was said not to be a full assessment and past medical records had not been received. He did not see Ms Brook-Tanker again after 15 December. He was referred for social work support, but again was never seen.

11. Mr McMahon was in a police cell on 31 December 1997 on a charge of burglary. He was seen by a CPN with the CFT, as part of the court diversion service, because he was being angry and difficult with the police. It was decided that diversion to psychiatric services was not necessary, as he was not displaying any signs of thought disorder.

12. The police message system has records of seven call outs to Ms B's address starting in July 1997. Mr McMahon moved into her flat to look after her after she was discharged from hospital following her massive overdose in July. She was advised not to let him back in after the assault in October, which advice she followed. He would, however, climb in through the window to gain access.

13. He was effectively of "no fixed abode" after this, a fact that was known to the services.

CFT referral: 25 November 1997

14. The October 1997 allegation was that Mr McMahon pushed Ms B through a window causing the glass to smash. The notes attached to the crime report state that she was pushed out of the window bodily and only prevented from falling by Mr McMahon pulling her back in. On interview, Mr McMahon claimed that she had pushed him out of the window. On 4 November, Ms B withdrew her complaints of assault and criminal damage. She had initially attended the police station, to withdraw her statement, in the company of Mr McMahon and the desk sergeant had persuaded her to go away and think it over.

15. Her statement to the police recounted this as a serious episode involving considerable jealousy on the part of Mr McMahon regarding Ms B's new partner. She filled in some background by saying that Mr McMahon stayed with her occasionally and had done so for no rent since July 1996. She stated that he was obsessed with her although *"we have never been partners"*. He had threatened to *"black my eyes"* when she had previously indicated her intention to visit her new partner.

16. Ms B and her partner had gone into her bedroom for some privacy, leaving Mr McMahon outside in the sitting room. Within seconds, she said Mr McMahon had barged into the room and tried to manhandle her partner out of the flat. She tried to telephone her parents whereupon he ripped the telephone out of the wall. She ran to the top of the stairs and he pushed her out of the window. She thought she would fall, but he dragged her back holding on to her neck.. He followed her out into the street where he was arrested by the police who had been called by a neighbour. There are no statements from either the neighbour or Ms B's partner. The custody record had attached a police national computer note relating to Mr McMahon reading: *"Firearms, Violent, Mental"*.

17. The next event available to us is that on 18 November 1997, Mr McMahon's GP, Dr Hockey, referred him to Tim Hollingbury, a consultant clinical psychologist and head of the district psychology service, for recent depression. He referred to Ms B's overdose and the Northern Ireland background and that:

> *"he feels that he has managed very well with a lot of painful memories for many years but, when he found his girlfriend close to death recently, it has brought about an emotional crisis".*

He indicated an improvement on dothiepin. Dr Hockey considered that he would benefit from discussing some of his past traumas in depth.

18. The clinical note relating to this also refers to the fact that Mr McMahon had said that his probation officer had also arranged for him to see a counsellor and that he did not have any suicidal thoughts. It refers to *"flashbacks to Ireland"*. Dr Hockey had no experience of referring directly to the CFT and there was no contact between him and the probation service or vice versa.

19. On 25 November, the CFT notes record that Ms Shepherd had made an informal referral to the CFT. This was prompted by learning of the event of October between Mr McMahon and Ms B. She was by then chairing CFT panel meetings herself, and Joanna Brook-Tanker, the recently appointed clinical and forensic psychologist with the CFT was present. The decision recorded was brief. The CFT would offer an appointment once Ms Shepherd had an address for him and that all available information was to be sent prior to the assessment. Another document noted that the report was due on 30 December.

20. Ms Shepherd recorded that the reason for referring Mr McMahon was due to his many violent previous offences. She noted that he had been shot, that his girlfriend was an ex-patient of St Ann's and he gets very drunk and *"appears emotionally disturbed getting flashbacks"*.

21. A further referral form to the CFT noted that he had found Ms B in a coma after a serious suicide attempt and thought she was dead. *"Has suffered flash backs of shooting in Northern Ireland. Very distressed state, weepy - can't sleep etc. "*

22. In the Probation Serious Incident Report post-dating the murder, Ms Shepherd is reported as having stated that the change in him since 1996 was *"stark, he presented in a shaking and tearful state with indicators of depression."* She also confirmed this to us in evidence.

23. It is clear that she attached to the CFT referral form, the earlier reports of Dr Rowton-Lee and Dr Leung, and probably probably her own probation report of March 1996. Her risk assessment was "high" and that he could *"be violent if drunk - has recently tried to curb drinking. Due to past history violence cannot be ruled out even when not drunk. I have known David for 18 months and I have never felt threatened."*

24. These referral forms and panel minutes are to be found in the correspondence section of the Trust records. The document immediately prior to the first form is Dr Hockey's letter of referral to Tim Hollingbury, which is referred to above.

25. The Probation November review and transfer summary must have been completed prior to this referral. It is also clear that there had been no High Risk conference arranged at the time of the CFT referral and panel assessment on 25 November.

Events leading up to the Probation High Risk Conference on 8 December 1997

26. On 1 December 1997, Joanna Brook-Tanker wrote to Mr McMahon at Ms B's flat with an appointment for 8 December, which he kept.

27. On 2 December, Mr McMahon took two overdoses that resulted in him being taken to hospital. At 00:22 in the morning Mr McMahon was admitted to the A&E department at the Royal Bournemouth General Hospital following an overdose at 22:00 the night before. He said he had taken 50 valium, temazepam and 2 pints of Stella beer. *"Wants to kill himself"*. His next of kin was recorded as Ms B's father. A psychiatric assessment form at that time indicated a low risk to self (scoring 2 out of a possible 10), but the management plan was for admission for a review of his history and assessment. A clinical note recorded that he had fallen asleep on the ward. After he awoke, the last entry is that he *"regrets actions"*. There is a later note (Out of Hours Social Services) to the effect that he discharged himself at 06:00 that same morning.

28. Later the same day he was taken back to the Royal Bournemouth A&E by the police under section 136 MHA. He remained at the A&E department between 18:00 and 18:20 and then left. We have no note of any psychiatric assessment at this time on the hospital records. Once again, he had taken valium and temazepam earlier that afternoon. He had called Ms Shepherd who called an ambulance and then telephoned Mr McMahon back. At that point, she heard the ambulance crew come in and Mr McMahon swearing at them. Knowing that he could be violent, she called the police.

29. The police printout noted that the ambulance crew was with a man who had taken a lot of tablets. *"Ambulance crew tried to calm man down but he is misbehaving again...can be violent.."* A doctor had been called and the police record that they were waiting until he arrived, but Mr McMahon left the premises and they arrested him under section 136 MHA. A note from the ambulance states that St Ann's would not accept him and he was taken to RBGH. We have not been able to discover why St Ann's refused to accept him or whether he was seen by anyone at that hospital.

30. The GP, Dr Hockey, and Out of Hours Social Services were involved. It was noted that the GP would sign a recommendation for admission. An ASW assessment was requested and the duty psychiatrist was notified and said to be on his way. This would appear to have happened prior to Mr McMahon being taken by the police to St Ann's and then the Royal Bournemouth General Hospital.

31. The ASW out of hours referral to Poole for an assessment was initiated at 17:20. Recollections of this period by those involved are poor, but it is clear now that there was no face to face social work assessment of Mr McMahon. An unsigned note on the out of hours social services referral form is timed at 6 p.m. (18:00) It has not ben possible to determine the provenance of this note. It referred to the earlier admission and to the medical assessment of "2/10" and that he declined admission. The GP was informed. It went on to note that his girlfriend Ms B had taken a massive overdose and had a history of depression. It mentioned Belfast and that he still had fragments of bullets in his leg

after being shot by the IRA. The single word "brother" appears and is obviously a reference to the shooting of his close friend. The note went on to record alcohol, history of violence, ABH, Sheila Shepherd's name and number, and the appointment with Joanna Brook-Tanker, and then post traumatic stress disorder and "binge drinker".

32. The following then appears *"He found [Ms B]. High risk suicide. High risk killing [Ms B]. Risk conference. Wrist cutter. Grace Leung."* The note concludes by referring to the CFT, probation and police bracketed against "mental health" and "high risk reoffending".

33. The note looks very much like a medical assessment, possibly at the Royal Bournemouth General Hospital on the second occasion, but there is no explanation as to why it should appear on the social services records and there is no corresponding note on the hospital records.

34. The next social services note was a Bournemouth Referral form of 3 December that contained information also appearing on a deliberate self-harm form completed by Terry Stewart on 4 December. The latter is the fuller note and records two overdoses within 24 hours and then refers to the second (but probably meaning to the first) when he was *"assessed as being a low risk of suicide but was offered to stay overnight. He self-discharged and was later picked up by the police under section 136 of the '83 MHA. However, he was seen by the duty psychiatrist and was not offered admission"*.

35. He had spoken to Ms B, who said Mr McMahon had tried to strangle her, and also to Ms Shepherd, whose opinion is recorded that Mr McMahon posed a high risk of suicide/homicide. She suggested that a High Risk conference with the CFT, police and probation would be convened to discuss her ongoing concerns. It is now also clear that it was the events of this day that reinforced for Ms Shepherd the need for that conference.

36. It is not clear that Ms Shepherd took away from her conversation with Terry Stewart an awareness that there were two A&E admissions that day (her own notes having been destroyed). She certainly could not recall knowing this and would never have actually seen the notes made by either the hospital or Terry Stewart. The information which Ms Shepherd received from Terry Stewart was passed on by her to Ms Brook-Tanker on 3 December.

37. In this process it was recorded by Ms Brook-Tanker *that "police arrived + CPN + Dr. Decided. Decided low risk - no admission"*. She was informed that Mr McMahon had attempted to strangle his girlfriend on his return home and that she had made her own recent suicide attempts. There is then a note that *"risk to self + others - req. sectioning"*. Ms Brook-Tanker interpreted this for us as *"requires sectioning"*. This is a note of Ms Shepherd's opinion. She was informed that the probation service was holding a High Risk conference on 8 December.

38. Ms Brook-Tanker noted the need to liaise with Victor Trimble and Terry Stewart, social workers. She then recorded information under Mr Trimble's name ("Victor") which she interpreted as being most likely to have been provided by Mr Trimble, it includes

reference to the two overdoses and that Mr McMahon was drunk. He was brought to St Ann's under a section 136 and *"released. Not sectionable"*. It will be apparent from what is written above that this is inaccurate information. John Bailey, a CPN was also mentioned, but there does not seem to have been any direct contact with him. It is also recorded that *"Appears that duty SW and Dr were aware of his attempts to strangle g/f"*.

39. The only social services notes available are those of Terry Stewart who was an ASW at Bournemouth Social Services. Part of his duties was to provide a risk assessment service for people involved in episodes of self-harm. He was based in the A&E centre at the RBGH. He assessed, on average between six and eight such patients a day and thus had no specific recollection of Mr McMahon. It is unlikely that he assessed Mr McMahon. The information he noted is likely to have been passed to him by the A&E department as a matter of routine. He confirms a telephone conversation with Ms B and his concern being such as to contact Ms Shepherd.

40. Mr Trimble neither recalls, nor has recorded, any contact with Mr McMahon on 2 or 3 December 1997, nor any follow up action in relation to him. Thus he has no record of a conversation with, nor any information he may have provided to, Ms Brook-Tanker and as recorded by her, or to Mr Stewart. He thinks that as duty ASW he is likely to have been off duty by the time of the call to assess Mr McMahon on his second admission.

41. John Bailey, CPN, told us that he had no involvement with Mr McMahon whatsoever, whether on 2/3 December or at any other time. He was the CPN to Ms B between June 1997 and April 1998, however, and was aware of Mr McMahon and the violence in the relationship although he never met him. His notes for 3 December do record the incident as another crisis for Ms B. She had said that Mr McMahon had attacked her the previous night and tried to strangle her. She put this into some context by saying that she often provoked him and they fought. He noted the overdose by Mr McMahon and that he had apparently been taken on section 136 to St Ann's but was not admitted. Mr McMahon was said to be currently staying with her parents.

42. It is possible that this information was passed on to either Ms Brook-Tanker either directly, or more likely, via Mr Trimble.

Comment

43. By a process not unlike Chinese whispers, the events of 2 December became distorted within a period of less than 24 hours. Our view is that there never was any assessment regarding a MHA section, but that Mr Trimble may have had some, albeit minimal, contact and/or imparted information regarding Mr McMahon that is not recorded by him.

44. The information recorded by Terry Stewart was passed on to Sheila Shepherd who passed it on to Joanna Brook-Tanker. The information passed on to him by the A&E department about a duty psychiatrist's assessment at St Ann's Hospital was probably inaccurate.

45. It seems to us that information was passed on to Ms Brook-Tanker by Mr Trimble as well, in respect of which we have seen no notes by him. Whatever Mr Trimble's recollection may now be, the contemporaneous notes of Ms Brook-Tanker quite

clearly mention his name in a way which leads to the conclusion that the information recorded was provided by him. The absence of an accessible written record of information received and imparted by him is, unacceptable. We also found a lack of record keeping by Mr Trimble during his involvement with Simon Coombe. In relation to that, we were told by him that his notes did exist but had gone missing. On this occasion, he says that he did not have any involvement at all. We are drawn to the conclusion that the arrangements for retaining and storing records by social services in these cases were consistently failing or Mr Trimble was very poor at keeping records or both. Overall, we have not been impressed by the quality of social services record keeping and interventions. Our view is reinforced by the unsigned note on the social services records. This criticism does not extend to what we have seen of Mr Stewart's practice.

46. **Ms Brook-Tanker was entitled to rely on the information she received in this way. This mis-information relating to a non-existent assessment that Mr McMahon was "not sectionable", played an important part in the High Risk conference and was probably persuasive in Mr McMahon's not being registered at that time. No steps were taken to verify the information, nor circumstances of the any assessment, directly with social services at that time.**

RECOMMENDATION 13:

Poole and Bournemouth Social Services should conduct a full audit into the quality and practice of record keeping by its staff.

High Risk Conference: 8 December 1997

47. On 8 December 1997, Mr McMahon kept his first appointment with Ms Brook-Tanker who saw him prior to the twelve noon High Risk conference. Ms Brook-Tanker is a clinical and forensic psychologist with ten years experience in the forensic field. She has worked in three regional forensic services as a chartered clinical psychologist. She has conducted research into post traumatic stress disorder (PTSD) and has a particular interest in the relationship between trauma and aggression in personality disordered offenders.

48. She had been in post with the CFT for a matter of weeks (since 3 November) at the time of the referral of Mr McMahon and so did not find herself under any undue pressure of work, although she did tell us that there was a very short expected turnaround time for court reports was of one month.

49. Although Ms Brook-Tanker is not now able to recall, and her eventual report (16 December) does not make it clear, we are quite confident that antecedent information and the March 1996 pre-sentence report were provided to her by Ms Shepherd on referral and would have been available at the conference. Additionally, she had the 1993 reports by Dr Rowton-Lee and Leung and Ms Higgins. The latter are noted with dates in Ms Brook-Tanker's notes of this conference.

50. Her notes of the meeting with Mr McMahon are detailed, covering nearly four pages. In summary, Mr McMahon provided considerable background to Ms B's overdose and

coma in July and his response to it. He told her about recent problems when sleeping involving flashbacks and a "bang", this had been worse in the last two months (later it was noted that the PTSD was reduced). He said he felt *"volatile"*, but that the last time he was violent to anyone was in 1993. As far as Ms B was concerned, they had *"verbals"*, but he denied the violence the previous week. He said that she was the violent one and had *"stabbed"* him. He had said that he was too old for violence now and his drinking was down, but that he had binges on a Thursday.

51. She told us that she would normally attempt to corroborate information obtained at an interview with any available documentation. She also told us that she would have been reluctant to have conveyed any sort of opinion on risk to the High Risk conference that day solely on the basis of only one meeting with Mr McMahon. She disliked the use of the categories "high, medium and low" and would have been motivated to give a formulation of clinical presentation and indicated the way forward, rather than ticking what she would consider to be a meaningless box.

52. We know from the Dorset probation procedures of the time that the High Risk conference was called under the category of "grave concern" and not because Mr McMahon fell into one of the pre-determined "prima facie high risk" categories due to his previous history of offending. It was called because of Ms Shepherd's concerns formed over a relatively short space of time but taken together with her more extensive prior knowledge of Mr McMahon.

53. The conference was chaired by Margaret Harris, senior probation officer and supervisor of both Ms Shepherd and Ms Phillips. It was attended by Ms Shepherd, Ms Brook-Tanker and Detective Inspector Edge. There was some disagreement between Ms Brook-Tanker and Ms Harris over the minute of her contribution to that meeting which she sought, unsuccessfully, to correct. It was Ms Harris's evidence that the minutes were a precise reflection of her contemporaneous notes of that meeting and any later change of opinion could be adequately reflected in Ms Brook-Tanker's own report of 16 December which would be available to all concerned.

54. Ms Harris told us that she had spoken to Ms Phillips about the impending conference. There is a direct conflict in evidence between Ms Phillips and Ms Harris over the contents of that conversation. Ms Phillips says that she made it clear that in her view, Mr McMahon was a high risk offender and Ms Harris says that she said the complete opposite i.e. that she had no concerns that he was a risk. We are unable to resolve this conflict definitively, although on the basis of Ms Phillips last review and transfer summary outlining her concerns and attempt to refer Mr McMahon to the CFT, her recollection is plausible. Ms Harris had not seen the transfer summary. The lack of surviving records put Ms Harris at a considerable disadvantage when giving evidence to the Inquiry and she was reduced to relying heavily on her memory.

55. Ms Harris was not aware of any concerns regarding Mr McMahon's mental health, in her view he had problems that were more psychologically based, by which she meant he had no mental illness. She said that this distinction would not have had any bearing on her assessment of his risk. She was also unaware prior to the conference of the referral to the CFT and that Ms B was a probation service client.

56. Mr McMahon's high risk category was not confirmed at this meeting. The minutes are contained on a form, the majority of which was not filled in as a result of non-registration. The background information recorded includes the details of the 19 October incident, together with the date on which Ms B withdrew her complaint and Mr McMahon's own account that she pushed him against the window. It is highly likely that this information was provided from the police documentation, which we have seen. It included information from Ms B's statement relating to the fact that Mr McMahon was only a "friend" and was obsessed with her.

57. An overdose on 2 December 1997 was noted. There then followed the incorrect information that CPN John Bailey assessed him as "low risk" of danger to himself or others and *"therefore not deemed under Section 25 for admission to hospital to be necessary"*. None of this is correct and the MHA reference is patently incorrect also. Additionally, there is no power within the MHA for a CPN to assess for compulsory admission. There was no reference to a second overdose, nor to the allegation by Ms B that he also attempted to strangle her at that time also.

58. The last paragraph is expressly said to contain information obtained from Ms Brook-Tanker. One version of this report in our possession has her manuscript corrections on it. This appears to be a very brief summary of her note of her meeting with Mr McMahon earlier that day.

59. The formulation presented by her in the unamended version is:

> *"He presents as post-traumatic stress disorder, which would relate to his experiences in Ireland and being shot there in 1986. He says that he has had flashes and heard loud banging noises from 1987. Johanna considered that he had a higher risk of suicide than harm to anyone else, but that he was not a serious suicide risk and was not sectionable".*

60. The material part of the amendment sought by Ms Brook-Tanker related to the final part of that last sentence i.e. ".. *but that he was not a serious suicide risk and was not sectionable"* from "but that" which she crossed out and replaced with *"She has produced a report dated 16-12-97 which describes the assessment in more detail"*. This begs the interpretation that perhaps she had changed her mind about the formulation she expressed on 8 December, or that she simply did not offer those opinions at all. Her evidence to the Inquiry was that she would have been reluctant to offer any opinion on risk on the basis of only one interview with Mr McMahon.

61. Ms Harris, who chaired the conference, told us that Ms Brook-Tanker was forthcoming with information and contributed well to it. The conference minutes clearly attribute the information provided by Ms Brook-Tanker and we have been advised that the formulation noted in the minutes of that meeting is purely psychological and not multidisciplinary. Further Ms Brook-Tanker confirmed that she had no notes of her own input to that conference because she was unable to speak and write simultaneously. We have, therefore concluded that Ms Brook-Tanker probably did make more of a contribution to this conference than she recalls.

62. More surprisingly, she told us that she did not know what input would be expected from her at the High Risk conference, this being her first. She was not provided with any procedures or protocols for them. Having subsequently attended three or four such conferences she was able to say that she understood her role to involve a *"discussion about issues pertaining to risk, predominantly of violence towards others, to record that information, but ultimately to categorise somebody's needing to be registered.."* She did accept that *"psychologists, perhaps more so than other disciplines, have a particular role to play with risk assessment."*. She did not recall clarifying her own approach to the issue of risk with the attendees at the conference.

63. Ms Harris based her decision on the balance of the evidence presented at the conference.

> *"I would not need many people at a conference to be saying they had grave concerns before the person would be registered, but if one person was saying it and everyone else was not saying it and had done some assessment and was putting in other information that may not go along with concerns, then that would be the balance."*

64. Ms Harris told us that she placed "quite a reasonable level" of weight on what Mr Bailey was reported to have said regarding a MHA section. Ms Shepherd considered Mr McMahon to present a high risk and presented that view to the conference. However, Ms Harris told us that *"there was no one else present and no other information given which was expressing other people's concern."*

65. She said that DI Edge's evidence was that Ms B was an unreliable witness which materially affected one of the main pieces of evidence of his behaviour at the time i.e. the alleged assault on 19 October, the conference was unaware of the attempted strangling reported on 3 December. The minutes record only that Ms B retracted her statement. Ms Brook-Tanker's contribution is noted as set out above.

66. Ms Harris told us that if Ms Brook-Tanker had said that she had not completed her assessment and was unable to provide an opinion on risk to the conference that day, it would have been possible to adjourn until she had completed her assessment. Equally, had she been made aware subsequently that Ms Brook-Tanker had serious concerns about Mr McMahon's risk to others (which she did not), then this would have been information on which a further conference could have been called.

67. There is no evidence that Ms Harris considered or offered to reconvene the conference on the basis of Ms Brook-Tanker's subsequent desire to amend the minutes or her report of 16 December.

68. Ms Harris's statement to us indicated that she was looking either for a previous conviction to justify high risk registration or an escalation in offending since the last offence of violence (1993) which there had not been. More specifically, she said that Mr McMahon's record of violence (1990 and 1993) was not considered in any detail because of its historical age. On reflection, she thought it possible that these offences had been considered at a High Risk conference in 1993 when he had again not been registered. That conclusion based on those offences at that time would have flowed into the subsequent conference and meant that there was no real consideration of those offences in 1997.

69. We have found no evidence that there was a High Risk conference in 1993, although we have noted that Rachel Newman, who wrote a pre-sentence report at that time, did have concerns which were serious enough to have warranted one (chapter 12).

70. The objectives recorded were firstly for Ms Shepherd to look with Ms Harris at whether the case should be transferred back to Ms Phillips. This was decided against and Mr McMahon continued on a reporting only basis to Ms Shepherd. Secondly, for Mr McMahon was to be assessed on a voluntary basis by the CFT and thirdly, for the police were to carry out a check with Special Branch, this was for verification of his experiences in Northern Ireland. There was no plan made regarding the management of this case following non-registration even in the light of Ms Shepherd's concerns, which remained undimmed.

71. Ms Brook-Tanker's are the only other notes of that meeting. They repeat the information in her earlier notes of her conversations with Ms Shepherd and Mr Trimble that following an assessment by a CPN and a doctor, Mr McMahon was a low risk and *"not sectionable"*. She recorded information under the heading "police" relating to the eviction from Bridge Corner House and his threatening behaviour at that time. *"Warnings of firearms. Mental condition"* was also noted and presumably reflects the PNC information seen on the police file. She noted the information regarding the incident on 19 October without comment. She ends with *"Ireland, ? role in Protestants"*.

Comment

72. This was a highly unsatisfactory High Risk conference. Probation officers have been required to follow County High Risk procedures since 1988/89 (amended 1992 & (1995)). The criteria and procedures current at this time would have been the same as those in 1993 (the 1995 changes appear to have been minor). They subsequently changed into Potentially Dangerous Offender (PDO) conferences.

73. The procedure stated that an offender was to be identified as "prima facie high risk" where there is a "risk of serious crime against the person, or where there is a real danger to life because violent behaviour is identified". It was "designed to alert the Service to a possible High Risk Offender case and to set in motion the necessary conference to examine all available evidence and to decide whether or not to designate an offender as a High Risk Offender".

74. The offence categories listed, by which an offender was to be identified as falling into the "prima facie" category, did not include GBH or ABH, but included a "catch all" category of "grave concern" due to attitude or behaviour both to the public and/or risk to staff because of the "infinite variety of cases [which defied] simple classification".

75. Conferences were to be chaired by a senior probation officer and every conference was to be attended by an assistant chief probation officer whose role was to endorse the conference decision. It is immediately apparent that this latter requirement was not followed at the conference on 8 December. We have been told that the requirement for assistant chief probation officers to attend High Risk conferences

had ceased prior to 8 December 1997, a measure to ease the pressure of work on them. This was reflected in subsequent PDO procedures required an assistant chief probation officer to be invited only where the senior probation officer identified the case as a particularly complex one. We were told of the large number of High Risk conferences being called in this period.

76. It was also for the senior probation officer to ensure that all information is collated and available to those attending the conference. There is no evidence that Ms Harris saw it as part of her role to prepare for this conference in the sense of reading the past records and familiarising herself with Mr McMahon's file. She acknowledged that what she knew of Mr McMahon prior to the conference was very limited and this is reflected in the fact that she was unaware of any mental health concerns over Mr McMahon, or that Ms B was a probation client. As chair person of the conference whose function was to bring together a consensus of opinion on the need for a high risk registration, background knowledge would have been essential in evaluating the contributions being made by those attending.

77. The procedures (at this time and later) did not set criteria for the actual registration of an offender as "high risk". We were told that the practice was for registration where there was evidence of an imminent risk of serious harm against the person.

78. Ms Shepherd expressed her frustration with this system. She felt that the title "Actually Dangerous Offender" would be more appropriate because her experience was that a conviction or charge was needed prior to registration. We cannot accept Ms Harris's evidence that consideration of the 1990 and 1993 offences at a previous High Risk conference would have justified precluding in-depth consideration of them in 1997. These offences had occurred within ten years of the conference and we know of no valid basis on which they could be excluded from a consideration of risk in 1997. We have found no evidence that there was a previous High Risk conference.

79. We were told that an imminent risk of serious harm required evidence of a recent conviction or of an escalation in violent behaviour. The registration of an offender as "high risk" is a serious matter which would result in closer supervision, and monitoring and sharing of the categorisation with other agencies and so it is right that the threshold for registration should be high and based on reliable evidence. If registration is to be based on information other than a recent and serious conviction or charge, then that information must be carefully gathered and evaluated.

80. On the occasion of 8 December 1997, the evidence presented to the conference was incomplete and inaccurate. It was unacceptable that there was no social worker present at the meeting to provide a first hand account of the events of 2 December, thereby avoiding the misunderstanding that in fact took place. Additionally, this was an occasion for information sharing with Ms B's probation officer and/or Mr Bailey, the CPN to consider the risk posed to her by Mr McMahon. Mr McMahon's GP would also have been in a position to offer relevant and contemporaneous information as he had referred him to the district psychology service in November.

81. **In our view, the absence of social workers and Ms B's probation officer or CPN at this conference was glaring and resulted in an over-reliance on second hand information. Ms Harris accepted with hindsight that the list of invitees to this conference was incomplete. We were told that it was the responsibility of the officer calling the conference, i.e. Ms Shepherd to ensure that all those who should be present were invited to the conference and she failed to do so. However, Ms Harris, was also in a position to appreciate that further evidence was required, whether before or during the conference, and she could have adjourned to ensure that it was available.**

82. **If Ms Brook-Tanker had made it clear that her assessment was incomplete and she could offer no view on risk, then this too would have indicated a clear need for an adjournment pending the completion of her assessment. In our view, her evidence in this regard is unsupported.**

83. **We have been told that Ms B's withdrawal of her allegations of assault was taken into account in not registering Mr McMahon because she was considered unreliable. The circumstances of her retraction are set out above and we are surprised at how easily this incident became devalued, because it fits into a known pattern within domestic violence i.e. that the victim is often powerless to press charges. It, raises a question over the status of "domestic violence" when assessing risk to others and again points to the need for some first hand information relating to her, from her probation officer. We do acknowledge that the use of unsubstantiated allegations is a difficult area within practice. Our view is that they cannot be safely ignored in the assessment of risk and sufficient information needs to be gathered to allow a careful consideration of the similarity and relevance of past events to the issues in hand (See Recommendation 2).**

84. **Ms Shepherd felt that Mr McMahon's risk had increased dramatically and conveyed this to the conference. However, context in which that Ms B had withdrawn her complaint and there was to be no prosecution was material and should have been taken into account in the final decision by Ms Harris. Mr Stewart's note (not available to the conference) provides independent evidence of Ms Shepherd's concerns for Ms B's safety and we accept that she must have put forward this view to the conference.**

85. **Based on the information actually available to the conference it is possible to see why Mr McMahon was not considered to present an " imminent risk of serious harm" to others. However, the information at that conference was seriously flawed and at the very least, the conference should have been adjourned for further information regarding the relationship with Ms B. This is because Ms Shepherd's opinion was formed over a lengthy period of knowing Mr McMahon and we think that to discount the alleged assault on the basis of Ms B's retraction of the allegation, in the context of domestic violence, was highly unsatisfactory.**

86. **There was the additional issue of the risk he posed to himself, based on his attempts at self-harm, and in relation to which his supposed assessment as not being "sectionable" was material.**

87. **We think that if accurate information had been presented to the conference, i.e. he had not been assessed for MHA purposes, there had been a series of allegations of assault made by Ms B against Mr McMahon and his record of violence, then there would have been grounds for high risk registration on the basis of an imminent risk of serious harm to Ms B.**

88. **We understand that the prevailing view of the time, was that Mr McMahon was no different to a host of other probation clients amongst whom domestic violence was not unusual and that this, too, is likely to have influenced the conclusions reached on Ms B's allegations. We think that this is unacceptable in the absence of a proper consideration of the facts of the alleged assaults.**

89. **The failure to adjourn, demonstrates the stark choice which faced the conference:**

    a) **register as high risk, whereupon closer monitoring and supervision would follow to the end of the probation order, not on a reporting only basis, and more steps would be taken to ensure that the order did not terminate without some support in place for Mr McMahon or,**

    b) **not to register, whereupon, all that would be required of him would be that he should report to his probation officer and there would be no further consequence of the fact that the High Risk conference was thought necessary and that Ms Shepherd had continuing concerns.**

    There were no "shades of grey" and no requirement to address or record the level of risk posed by Mr McMahon in some category below that of "high". From being considered for registration, Mr McMahon went to reporting only at a time when he was particularly vulnerable and the subsequent progress of his probation order was not considered in supervision between Ms Shepherd and Ms Harris.

90. **When a decision is made not to register a person as presenting a high risk of harm to others, this does not diminish the concerns which led to the calling of the conference in the first place, and should lead to a full multi-agency review of the case with a plan for future management. A failure to do so is a lost opportunity and a waste of effort and resources. Our impression is that the High Risk conference process at this time was very narrow in remit, confining itself to a consideration of issues of imminent risk. It is a matter of common sense that this is also an excellent opportunity for a full multi-agency review.**

91. **The final document produced, and referred to as the "minutes" of the conference, is inadequate in that it does not explain the basis on which the decision not to register Mr McMahon was taken. It is as important to note carefully the reasons for not registering a person as the reasons for registering them. This is especially so if the person is close to the end of his order and reduced to reporting only to his probation officer.**

92. **It should have set out the pros and cons of registration, the views of those attending and the reason for the final decision should have been clearly expressed. DI Edge's own diary note showed that the conference lasted one hour and ten minutes, which is a considerable length of time in which much information could be discussed. How Ms Shepherd's views in favour of registration were balanced against other evidence presented to resulted in a decision not to register is totally unclear. The minutes of the meeting do not show where the points of disagreement arose between those involved.**

93. **The fact that it was possible to record in the minutes of the conference that:**

> ***"there was an assessment by a CPN, John Bailey, who felt that Mr McMahon was at low risk of danger to himself or others and therefore not deemed under Section 25 for admission to hospital to be necessary",***

and that this part of the record was unchallenged by anyone reading it subsequently, is extremely alarming to us. Apart from the factual error that Mr Bailey never assessed Mr McMahon at all, there are two glaring errors in that statement. Firstly, it is not for a CPN to assess a person for admission under the MHA, secondly, there is no such thing as a "section 25" admission to hospital (except in the Mental Health Act 1959 and defunct since 1983).

94. **This was a high level, multi-agency conference attended by health, probation and the police, all of whom should be intimately acquainted with at least the basic requirements and criteria for an admission to hospital under the MHA. This would include assessments by a social worker and two doctors. Further, it is a matter of basic understanding that admission to hospital for assessment is achieved under section 2 and for treatment, under section 3. Such sloppy errors of notation should not be allowed to persist in any documentation.**

95. **Although we do think that Ms Brook-Tanker was a practitioner of sufficient seniority and experience not to require an explicit briefing on the expectations of a High Risk conference, we do also think that the role of all individuals invited to attend a High Risk conference should be made explicit. The criteria for registration must also be understood by all those present.**

96. **We are critical of Ms Phillips' failure to record her assessment of Mr McMahon's risk on either her transfer summary or the November review, this was clearly an important fact to record. We are, however, inclined to accept her evidence that she did tell Ms Harris her view that Mr McMahon was a high risk of harm to others.**

97. **Although the high risk procedures have now changed, it is our view that the current procedures should be reviewed in the light of the recommendations below.**

RECOMMENDATION 14:

The Probation Service should review its procedures for Potentially Dangerous Offender conferences to ensure that full account has been taken of the findings made by this Inquiry relating to previous High Risk conferences and in particular:

- **a) Preparation for the conference**
- **b) Limited scope of the conference**
- **c) Lack of explicit criteria for high risk registration**
- **d) Reliance on second hand information**
- **e) Failure to take account of the record of violence and the allegations of domestic violence**
- **f) Lack of a proper multi-disciplinary formulation and the failure to take the opportunity to plan for the management of the case in circumstances falling short of high risk registration**

Events after the High Risk Conference: assessment by CFT

98. On 8 and 11 December 1997, the police were called out to Ms B's address. On the first occasion, they had an anonymous call that a woman was being assaulted at that address. On arrival, no violence was noted and no complaints were made. There is a reference to seeing a solicitor about an injunction. On the second occasion, Mr McMahon was "trying to beat the door down and was drunk". He was taken to the night shelter. These incidents remained unknown to Mr McMahon's probation officer and it would appear to Ms B's probation officer or CPN.

99. On 13 December Ms Brook-Tanker returned a telephone call from Dr Hockey, Mr McMahon's GP. He said that he had seen Mr McMahon the day before and he had been:

> *"talking of wanting admission to St Ann's in context of difficulties getting here (no funding) for CFT contact. Smelt of alcohol. No meds prescribed - appeared mood was stable. Agreed to send a copy of CFT report when ready - with patient's permission".*

He also presented on this day to the A&E department at the RBGH having cut his wrist. He received a tetanus vaccination and a primary suture of the skin, but left the department having refused treatment.

100. On 15 December, Mr McMahon attended a second appointment with Ms Brook-Tanker in preparation for her assessment report. Her notes show that he expressed dissatisfaction with the probation service at this time and had accommodation problems. She noted his temporary address. It is also noted that he went to a public house and drank 9 or 10 pints before 7.30 p.m. before becoming increasingly hopeless and cutting his wrist in from of everyone.

101. Ms Brook-Tanker's report is dated 16 December 1997. She recorded the reason for referral as Ms Shepherd's concern that his psychological difficulties affected his capacity to respond to supervision. He was assessed for his suitability for psychological treatment. At the outset, it was noted that he responded "positively" to the interview

process, although at the end it was noted that he had presented in "crisis" on both occasions. This meant that it was not possible to conduct a full assessment. This was discussed at some length with Ms Brook-Tanker when the Inquiry panel interviewed her.

102. In her written statement, *"crisis"* was referred to as *"anxiety and hopelessness"* which accords with the Inquiry's understanding of the term. Additionally, one might expect this to refer to presentation in distress, exhibiting symptoms of psychosis and so on. In evidence, the Inquiry was told that during these two meetings Mr McMahon was controlling the interview and not allowing Ms Brook-Tanker to follow a chronological history with him, she said *"he is actually keen to convey certain information to me"*. She told us that this was a *"crisis of social circumstances as distinct from a clinical crisis"*. He had wanted, for example, to discuss the difficulties he was experiencing in obtaining employment for example.

103. Also a reference to awaiting "past medical records" was probably to the Leicester in-patients notes, rather than the 1993 CFT assessment reports, which it is noted above she has been provided with.

104. In her report, Ms Brook-Tanker recounted Mr McMahon's history relating to Ms B's overdose and his response to it leading to a possible precipitation of PTSD symptoms for his experiences in Northern Ireland. She recounted that his symptoms had worsened over the last two months and provided examples of the symptoms including: flashbacks, consisting of a flash of a gun and the sound of a bang, usually while he was trying to fall asleep. Fireworks and loud noises triggered *"intrusive experiences"*. He avoided casualty scenes on the television as well as programmes depicting scenes of drug abuse. In general, he avoided the Irish community. He appeared to exhibit symptoms of emotional numbing and scored maximum on the majority of items on the Impact of Events Scale, an index for PTSD. Her provisional opinion, she told us, was expressed as *"overall, he appears to meet the criteria for Post Traumatic Stress Disorder, based upon his self-report of symptoms"*. There is no mention, even on a provisional basis, of the possibility of any kind of personality disorder that may require further testing.

105. Ms Brook- Tanker told the Inquiry that she held the possibility of a personality disorder in her mind. Most of her clients did usually have some form of personality disorder. She was not in a position, she said, especially when trying to develop a therapeutic relationship with Mr McMahon on a voluntary basis, to administer what she would have considered to be overly intrusive psychometric tests for personality disorder (MMPI and Millan). She was not trained to administer the Hare psychopathy checklist (PCL-R). Additionally, she did not consider that this would be information of value to the probation service which would not be in a position to do anything about it, and so she did not think that there was anything to be gained from speculating on the existence of a personality disorder in her preliminary report.

106. She then dealt with an overdose on 2 December, the facts of which mirror those that are incorrectly stated in the notes and the High Risk conference. She noted the subsequent allegation of assault on Ms B and that she was reluctant to press charges, but not the prior assault in October. Mr McMahon had blamed his difficulties on tension in his relationship with Ms B and the thoughts associated with his experiences in Ireland that had begun to get more intense.

107. In the next section, she dealt with her interview with him on 15 December. Having then discussed with him what his needs were, and the pros and cons of an admission to St Ann's, he *"appeared to agree with my suggestion that we attempt to support him in the community with, perhaps, increased support by the Community Forensic Team"*.

108. Psychometric test results showed that:

a) he was experiencing symptoms of a severe depression;
b) he was experiencing a great deal of frustration and

> *"frequently intense angry feelings. He tends to invest very little energy in preventing the experience of anger and, as a result, he can be quick tempered and may express his angry feelings aggressively with little provocation directed towards other persons or objects in his environment."* (State-Trait Anger Expression Inventory);

c) he is a *"highly anxious"* individual who was, at that time, experiencing *"high levels of anxiety"* (State-Trait Anxiety Inventory).

109. She concluded by mentioning his long history of violent behaviour with associated interpersonal difficulties and summarising her findings regarding PTSD. She recorded that:

> *"Precipitants to his recent disturbed mental state would appear to be his relationship problems with his girlfriend, and his Probation Officer having begun to talk about his experiences in Ireland. He has become increasingly hopeless and vulnerable with little real support in the community. He occasionally abuses alcohol in an effort to cope with his problems and this has led to disinhibited aggressive and self-abusive behaviour."*

There is nothing more about his anger and quick temper. He presented politely but desperate for help. It was agreed that following an assessment of his background over two sessions, eight further sessions would be spent looking at ways of exploring his suicidal ideation and behaviour. Once he was more stable, they would begin to address his PTSD. A referral was made to Linda Anderson, a social worker attached to the CFT, for support in the community.

Comment

110. Ms Brook-Tanker is a very experienced clinical and forensic psychologist whose areas of particular expertise and interest were ideally suited to assessing the problems of Mr McMahon. Her evaluation of the PTSD and psychological assessment was adequate although only limited details about the specific content of the trauma were obtained. However, as on earlier occasions, only the most salient features of the case were evaluated and appreciation of personality issues is limited to mentioning his long history of violent behaviour with associated interpersonal difficulties, and there was no formulation of future risk of dangerousness.

111. We would have been able to accept more easily that the existence of a personality disorder was missed, and the report necessarily provisional, because Mr McMahon had presented in a clinical crisis for each meeting. Initially, from Ms Brook-Tanker's written statement to the Inquiry, this appeared to be the explanation for a preliminary report. This may, of course, have begged the question of what should have been done about such a crisis. Her subsequent evidence, however, was that the "crisis" related more to his social circumstances, i.e. he had no employment, and had also been about his controlling behaviour during her interviews with him. We have been advised that this kind of behaviour points more clearly to the possible existence of a personality disorder which, together with a possible diagnosis of PTSD, a fairly recent history of binge drinking and reported difficulties in controlling anger, raises immediate concerns about the risk of violence to others. Advice to the Inquiry has been that this should have been apparent to an experienced forensic psychologist and consequently should have been considered in even a provisional report.

112. Ms Brook-Tanker's notes of her meetings with Mr McMahon do not give any indication of any clinical crisis, nor of the controlling behaviour she now remembers. Additionally, her report states expressly that he co-operated with the assessments which appears to contradict the statement that he was controlling the session with her.

113. As for records available to her, we conclude on the basis of her contemporaneous manuscript notes that Ms Brook-Tanker did have available the 1993 CFT reports which should have alerted her to the need for some neuropsychological investigation and would also have given her quite a lot of background information (Dr Rowton-Lee). We think it advisable for all report writers to include an opening paragraph stating what documents and information were available at the time of writing their report together with a specific statement as to the limitations on the opinions expressed. Ms Brook-Tanker stated correctly that she did indicate that this was a provisional report, but our view is that there should be an explicit explanation of such a statement. What does it mean? How does it affect the views expressed? What further assessments or work needs to be done before a full assessment may be completed? Our comments on court reports and their content in chapter 12 (see para. 57) also apply here.

114. We commend a format in which there is an introductory section outlining all the sources of information relied upon and what information is missing or is yet to be obtained. Any limitations operating on the report, for example, a distressed client or one in crisis, should also be explained at this early point.

115. The record of Ms Brook-Tanker's findings on psychometric testing gives a more serious picture of Mr McMahon's response to provocation directed to others in his environment or to objects, than is expressed in her conclusions. This, together with the acknowledged problems in his relationship with Ms B and the known allegations of assault on her, required more explicit consideration.

116. Had there been a full appreciation of risk this would have been an opportunity to advise the need for a further High Risk conference and more proactive follow up when he failed to attend appointments. Alternatively, had it later come to her knowledge that Mr McMahon was again seeking help, and again expressing concerns regarding his volatility and potential for violence (May 1998), this is may have led to a more urgent referral back to the CFT for assessment and support.

RECOMMENDATION 15:

The Trust should commission and promote a standard format of report writing designed to convey explicitly the available sources of information and any limitations on the opinions expressed.

CFT follow up

117. Linda Anderson was the CFT social worker responsible for those clients resident in the Poole area. Victor Trimble was her counterpart responsible for those in Bournemouth. She had been appointed to this role in January 1997 and had very limited experience of working with offenders. She had previously spent two years in the Eastleigh Community Mental Health Team in Hampshire. Ms Anderson had been appointed by Poole Borough Social Services and there had been no involvement by the Trust in her appointment. Similarly, the Trust had no involvement in the appointment of Mr Trimble by Bournemouth Social Services.

118. Her role fell into three roughly equal parts, i.e. assisting CFT psychologists in conducting assessments at St Ann's Hospital, supervising CFT clients in the community (Poole) and additional duties for the Borough of Poole. The latter was an "add on" because there was insufficient CFT work to fill a full time post. Mr Trimble on the other hand had a larger CFT work load, being responsible for the larger conurbation of Bournemouth.

119. Ms Anderson says that she had been asked to see Mr McMahon to offer advice regarding housing when he attended for subsequent appointments with Ms Brook-Tanker but, as he never did attend, she did not see him. This conflicts with what is recorded in Ms Brook-Tanker's report i.e. that she (Ms Anderson) was to assess with a view to offering support in the community. She would not have visited him because he lived in Bournemouth. She believes that she was asked to see him because Mr Trimble was on annual leave. Had he lived in Poole she may have followed him up more proactively, but there was no requirement for her to do so.

Comment

120. It seems that the case should have been passed on to Mr Trimble for follow up when Mr McMahon failed to attend his appointments with Ms Brook-Tanker. We think that clients of the forensic service in particular, require proactive follow up. That

means that positive steps need to be taken to identify why they have failed to attend rather than simply closing the file.

RECOMMENDATION 16:

The Trust should ensure that forensic service clients are assertively followed up in the community and, in particular, where they fail to attend appointments.

Chapter 15

1998

GP AND PSYCHIATRIC ASSESSMENT (DOMICILIARY)

MURDER OF WILLIAM BODLE

Summary:

Mr McMahon had deteriorated again by May 1998 and was feeling volatile. There was information available to the police of an increase in the violence to Ms B which did not come to the attention of the probation or health services.

Mr McMahon sought help from his GP who arranged a speedy assessment by a consultant psychiatrist attached to the North Bournemouth CMHT. This was a poor assessment based on a lack of information and no consideration of risk. Once again, there were limitations on the scope of this assessment, which were not made explicit.

RECOMMENDATION 17:

The Trust should review its system of keeping records to ensure that any request for information is capable of being complied with rapidly, and of providing all relevant information and not simply the most recent assessments.

RECOMMENDATION 18:

All agencies involved in the care, assessment and treatment of people with mental health problems should ensure that their staff record explicitly what limitations (if any) there are on the assessments they make. (See also Recommendation 15, chapter 14).

Introduction

1. Following his interview with Ms Brook-Tanker on 15 December 1997, Mr McMahon failed to attend any of five further appointments with her. There was also subsequently no contact with Linda Anderson, CFT social worker. Letters were written to him, but as his contact was voluntary, no further action was taken except to notify Sheila Shepherd. Dr Hockey, his GP, also attempted, unsuccessfully, to chase Mr McMahon by letter. This may have been because letters sent to Alma Road did not reach him, but we do know that at least one notification of an appointment that he did not attend, did reach him there. The last appointment, for 19 February 1998, was sent to him via Ms Shepherd.

2. On 31 December 1997, Ian Oxborrow, CPN with the CFT saw Mr McMahon as part of the Diversion Scheme at Bournemouth police station and wrote to Ms Brook-Tanker. He noted that Mr McMahon had been arrested for burglary and had been focusing intense anger at the police. There was no evidence of thought or mood disorder. He was apparently aware of a meeting with her on 5 January.

3. On 6 January 1998, a CFT panel meeting chaired by Sheila Shepherd noted that Mr McMahon had started 1:1 treatment for PTSD on a voluntary basis, and that he appeared motivated. He had, by this time, already missed one session.

4. Ms Shepherd was subsequently notified of his failure to attend for treatment and tried to persuade him to attend. The police records show that there were two call outs to Ms B's address in January because Mr McMahon was causing problems, but no violence was recorded. On 21 January the CFT were informed by Ms Shepherd that he had been in a fight and sustained injuries.

5. On 7 March 1998, his probation order came to an end and he was then left with no follow up save for ad hoc visits to Ms Shepherd.

6. In March 1998, also there were also three serious incidents with Ms B. In the first, she stabbed him after he assaulted her, resulting in damage to his spleen. He was admitted to the RBGH and operated on. He remained in hospital between 5 and 13 March. On discharge from hospital he committed a serious assault on Ms B when he head-butted her, kicked her, split her nose open and gave her two black eyes in retaliation for the stabbing. We have seen photographs, kept by her parents, showing these injuries. When asked about this Mr McMahon told us that he had once given her "a bit of a dig". There was a further assault on 27 March when the police noted that he preyed on her fragile mental state. He was said to have tried to burn her breast with a cigarette, twisted her breasts and urinated on her.

7. She did not press charges for the assault on discharge from hospital, because of the threat of his pressing charges for the stabbing. On the third occasion (27 March), she alleged rape and then assault. There had been no rape and she declined to proceed with the assault complaint.

8. On 19 May 1998, Mr McMahon sought help again from his GP, Dr Hockey, who arranged a speedy assessment by the duty psychiatrist, Dr G. Searle, on 20 May. This was his last contact with mental health services before the murder of William Bodle on 2 June.

Probation closing summary: 7 March 1998

9. The closing summary records that Ms Shepherd continued to see him at times of crisis and, that he had a very depressed period over Christmas. The charge of burglary was still outstanding and, in her view, was not his type of offence. She noted that Ms B had stabbed him. She recounted his version of it i.e. *"apparently for no reason"*. Ms B was still being seen by a CPN at this time. Ms Shepherd also noted that the "money payment supervision order", MPSO set up by Ms Phillips, was still active and so queried whether the file should remain live. However, the Part C records were destroyed as if his file was now closed and in accordance with the policy of the time.

10. In her opinion, his risk of re-offending remained high, including to the public if he was drunk.

11. The Probation "Serious Incident Report", prepared shortly after the murder, indicates that Ms Shepherd saw Mr McMahon in hospital on 11 March, and again on 17 and 25 March. From 10 to 17 April, when he attended the office to see her, she was on leave.

Dr Hockey and Dr Searle: May 1998

12. We have not been able to identify precisely what Mr McMahon's movements and whereabouts were in this time. He was apparently sharing a flat with a male, taking on casual work and mixing with itinerants and drunks. By the time he went to see Dr Hockey, his GP on 19 May he said he was starting to get violent again and wanted to see a psychiatrist. Dr Hockey arranged a rapid referral to Dr Geoffrey Searle, adult general psychiatrist attached to the North Bournemouth CMHT.

13. Dr Hockey's referral letter of 20 May 1998 described some features of concern. These included that he had become increasingly depressed and had started drinking heavily. Mistakenly it said that there was no history of alcohol or drug abuse. He was feeling *"very angry and very violent"* and was very tearful but Dr Hockey noted that he had never been violent towards him, but was always polite and well mannered. Dr Hockey asked for a home visit because Mr McMahon was not in a state to travel and he had advised him to stop drinking and await Dr Searle's call. It was recorded that Mr McMahon's principle objective seemed to be attendance at an anger management course. His concluding remark was;

> *"He is clearly very frightened about what he may do to himself and, I suspect, what he may do to others."*

14. Dr Hockey told us that his concerns related far more to Mr McMahon's background, which he considered to be a major source of danger to Mr McMahon and to others, than to his mental state or any alcohol or drug dependency. He perceived this culture as one in which physical injury and murder was an everyday occurrence. There is little doubt that Dr Hockey wished the risk that Mr McMahon posed to himself and others, to be assessed. He also told us that he did not believe there to be any question of imposing a section of the MHA at this time. He sought a psychiatric opinion on the existence of mental illness.

15. Dr Searle had access to the GP notes and correspondence. These, and in particular, the entries of Dr Hockey from November the previous year, were clear and legible, indicating the ongoing nature of concerns around Ms B's overdose, his paramilitary activities, depression and attempts at suicide. Although it was difficult for Dr Searle to have a precise recollection of the documents he had available at the time of his assessment in 1998, we are confident that he had the report of Ms Brook-Tanker of 16 December 1997, and it is likely that a fax from Dr Leung at the CFT contained the same report. There are no copies of any of the other reports from 1993 on the GP records. He would not have known that there had been a probation High Risk conference in December.

16. Ms Brook-Tanker's report contained no detail of Mr McMahon's antecedent history but did note assaultative behaviour toward the police when Ms B overdosed in July 1997 and also an assault against her in December. It also contains detail of his attempts at self harm.

17. Dr Searle left Dr Hockey a very brief hand written note of his conclusions and followed it up with a longer letter dated 27 May, which he told us he would have dictated in his car. He took no other notes of his interview with Mr McMahon. His hand-written note to Dr Hockey mentioned mild to moderate depression, anger and PTSD and that he needed CFT involvement. In the subsequent letter, he noted a long history of violence and the symptoms of PTSD. This was contained in Ms Brook-Tanker's report. Mr McMahon was referred back to the CFT, (subsequently an appointment for 16 June was arranged and notified to Mr McMahon), and he was offered an outpatient appointment with Dr Searle on 27 July. He was also to be seen by his GP every couple of weeks until the CFT appointment.

18. Although Dr Searle's letter mentioned the history of violence, it also stated that the forensic history was not discussed in detail and that, as far as he knew, Mr McMahon had never been charged or convicted of any grave offences, although he said he believed there to *"have been a number of episodes related to violence"*. In fact, the letter also stated that Mr McMahon was not asked about his past medical or psychiatric history. Mr McMahon's mood had certainly improved since the previous day. He had said that he was not a regular drinker but admitted being intoxicated when being seen by Dr Hockey. The letter does not address the issue of risk.

19. Dr Searle told us that he had no training in risk assessment at this time and that the Trust's risk policy deliberately did not apply to domiciliary visits for fear of otherwise increasing an already over large work load. Dr Searle also told us that Mr McMahon had an obvious history of violence and drinking, but that he did not consider he could do anything about it. His remit in the CMHT was severe mental illness. He would have addressed issues of violence and alcohol in discussion with Dr Hockey, but that it would be unwise to note such things down because it would simply lead to unfounded complaints from patients.

20. He also told us that Mr McMahon *"inevitably has got a personality disorder"* which was either "anti-social" or "psychopathic" but this was also outside his remit, and such diagnoses can have the effect of excluding patients from services.

21. Dr Searle's assessment was based very much on the actual presentation of Mr McMahon on the day. He was clearly better than he had been the day before and was not tearful or drunk. Dr Searle had assumed some personality difficulties but had again not focused upon them because they were outside his remit, hence the referral back to the CFT. Mr McMahon presented well to him that day and so he told us that he did not consider there to be an immediate risk of violence. Even if he knew that Mr McMahon had been assessed a high risk offender, this is unlikely to have changed his immediate assessment of him. He may, at most have made a telephone call to the CFT, but would not have expected that they would accept him as an urgent referral.

Comment

22. **Dr Hockey's work with Mr McMahon was of a high quality throughout. His actions were thoughtful and prompt. He did well to arrange a psychiatric assessment so quickly, and this is also to Dr Searle's credit.**

23. The package of support put together by Dr Searle was adequate and the appointment with the CFT, arranged for two weeks later, was rapid. We accept that even if Dr Searle had been aware of his full history, based on his presentation on the day, a more urgent referral to the CFT is unlikely to have been achieved and detention, for example, under the MHA, was not an option.

24. We also accept that hastily arranged assessments of this kind are quite often conducted without all the relevant material available. However, once documentation has been requested, then it is essential that, at the least, all reports and discharge summaries (where appropriate) are provided as quickly as possible. When the request is made by another doctor within the same Trust, or local GP, then we would expect that a full Trust file should be made available within a short period of time. In this instance this should have included the CFT file and should not have been limited to only the most recent report.

RECOMMENDATION 17:

The Trust should review its system of keeping records to ensure that any request for information is capable of being complied with rapidly, and of providing all relevant information and not simply the most recent assessments.

25. We accept additionally that first assessments, particularly if conducted under domiciliary conditions, will not necessarily be comprehensive and doctors (and others offering services) will be called upon to make fine and often difficult decisions regarding what may be offered.

26. Against this background, we found that Dr Searle's approach to this assessment was firstly, circumscribed by the limits of what he could offer, and he directed his focus primarily on mental illness. Secondly, he was informed by a protective attitude. This was protection from complaining patients who disagreed with an assessment, e.g. to do with violence or alcohol, but also to do with not outlining risk features which he considered may be a hostage to fortune if they were ever manifested. This was especially so, given that there was nothing he could do to manage the risk.

27. We think it would be unacceptable to say that the possibility of a personality disorder was not mentioned either because there was nothing he could do about it, or it may lead to exclusion from the services. We understood Dr Searle to be saying that he held the possibility of a personality disorder in his head and it was not a diagnosis which eluded him, but it is not clear how much to the fore this possibility was and whether indeed, it is more with hindsight that the possibility exists at all. We could not criticise him if he did not consider this diagnosis during this assessment. Once recognised as a possible diagnosis, however, the potency of the cocktail of personality disorder, depression, PTSD and alcohol misuse should have been appreciated and been highly significant in the planning of treatment and prognosis.

28. The Inquiry's expert advice was that:

> ***"even though Dr Searle may not have been able to do anything about the patient's personality disorder, he should have mentioned the diagnosis. It has implications for the safety of the professionals and others who work with the patient, it had implications for judgments as to the likelihood of the patient responding to interventions with regards to any alcohol problem, it has implications for the treatment of his post-traumatic stress disorder, it affects considerations as to the likely causes and course of his depressive disorder and it has a bearing on the assessment of the risks of accident and deliberate self-harm and the assessment of risk to others".***

29. On balance, we find that at the time in question Dr Searle did not consider the possibility of a personality disorder and, given the circumstances of the assessment, this was acceptable.

30. However, we do find that in view of his history, it was important to come to a conclusion about Mr McMahon's alcohol use and particularly to note if it was being underplayed by him. The fear of subsequent complaint or legal action is wholly unacceptable as a reason not to record a proper assessment of this information.

31. Similarly, there is no record of any assessment of risk to self or others. Again, any limitations on the ability to manage risk do not provide justification for a failure to record risk. Also, by identifying risk, a practitioner is not held responsible if a risk materialises subsequently. Nor if he identifies a risk of violence and says that he cannot do anything to minimise or prevent the violence from occurring.

32. If as appears to be the case, Dr Searle did not ask about past history, or consider his forensic records, he was in no position to answer the concerns of Dr Hockey or offer anything more than a snapshot assessment based on the presentation of the patient at that moment in time. If he was genuinely unable to assess risk or was unsure of risk, then he should have said so expressly and considered more immediate arrangements for further assessment or short term management pending the referral back to the CFT. This may have involved community support from members of his team as well as the GP. PTSD fell within the definition of "severe mental illness" being used by the Trust to define eligibility for CMHT services and Mr McMahon would, therefore, have been eligible for such services.

33. The comments we have already made about the need for limitations operating on assessments and reports to be made explicit are also underlined by our findings here also. (See Recommendation 15, chapter 14.)

RECOMMENDATION 18:

All agencies involved in the care, assessment and treatment of people with mental health problems should ensure that their staff record explicitly what limitations (if any) there are on the assessments they make.

34. Our conclusion, which is supported by our expert evidence, is that this was a poorly managed assessment by Dr Searle. The lack of formal risk training from the Trust should not have prevented him from performing an evaluation of risk or dangerousness. The process of offering a prognosis is part of a general psychiatric examination and one that inevitably involves a view on risk. Dr Searle told us that he passed on this issue to the CFT, but this is not in the documentation. The reasons he gave for omitting this from his letter are unacceptable.

35. Additionally, Dr Searle made no notes of his interview and only a brief hand-written note to Dr Hockey, which was inadequate especially as it made no reference to the particular problems raised by Dr Hockey.

36. There is evidence of an escalation in the level of violence displayed by Mr McMahon towards his ex- partner, Ms B, in the months preceding this assessment. This was known to the police but not to probation or mental health services.

37. This was important information relating to two people who had been under probation supervision, one of whom had been the subject of a probation High Risk conference. This was known to the police who were present at that conference. It is our view that this information should have been shared by the police with the probation service and the CFT. Such action would have represented proper multi-agency work in which the police service now has an important role to play. (See recommendation 2 and chapter 13).

38. Our conclusion, however, is that even if this information had been known to Dr Hockey or Dr Searle, the only real option at this stage would have been an immediate referral back to the CFT. Even if such a referral had been arranged it is likely to have been on an outpatient basis and the possibility of an incident still occurring, such as the one leading to the death of Mr Bodle, cannot be excluded.

Murder of William Bodle: 2 June 1998

39. William Bodle, 45, was living the life of a vagrant and had mental health problems which had brought him into contact with mental health services and the criminal justice system. In terms of public sentiment, he was not a character to arouse a great deal of sympathy, which in no sense diminishes the gravity of Mr McMahon's actions. On 2 June, he was subjected to a brutal attack. He received repeated blows to his pharynx of "unusual severity" causing shock and heart failure. The blows were probably caused with a foot while Mr Bodle was prone, and he had also been hit with a bottle. Both men had been drinking. Mr McMahon was convicted of his murder on 11 February 1999 and sentenced to life imprisonment.

40. In the early hours of 2 June a statement to the police by Ms B, states that Mr McMahon broke into her flat. He was very drunk. She was frightened but kept talking to him and eventually he lay down on the sofa and went to sleep. Later she woke him, gave him coffee and he left. She next had a message from him on 3 June to say that he was looking for her, and then a call from a male friend saying he had heard that the police were looking for Mr McMahon for a murder.

41. The murder occurred in a derelict building due for demolition and being used as a squat. Mr Bodle had lived in the squat for most of the year with three other men. On 2 June, Mr McMahon began his day drinking at the Winton Working Men's Club. He then did some casual work with another man and returned to the Club. He mentioned then going to see Ms B and by the end of the evening ended up in the squat. One of his friends had been begging and had a £10 note. He bought three bottles of sherry which were taken back to the squat.

42. In interview, Mr McMahon admitted having a drink with Mr Bodle but denied any serious attack. He admitted punching him once, following an argument over the TV. The murder of William Bodle was the result of repeated blows to the pharynx. Mr McMahon pleaded not guilty to his murder and, following a trial, at which no medical or psychiatric evidence was put forward on his behalf, he was convicted of murder and sentenced to life imprisonment on 11 February 1999.

Chapter 16

DIAGNOSIS AND FORMULATION

Introduction

1. The following formulation of Mr McMahon's behaviour and mental state is summarised from the evidence to the enquiry of Professor Malcolm J MacCullough, Professor of Forensic Psychiatry and Dr Nicola S Gray, Consultant Clinical and Forensic Psychologist and Senior Lecturer.

Background

2. Mr McMahon was born with a congenital abnormality that required operative intervention, which was never fully successful. Problems of this kind can create emotional difficulties for boys, especially those growing up in the male culture of Belfast.

3. We are inclined to accept that there was some history of violence from his alcoholic father, although we have no independent evidence of this. This is known to have the effect of predisposing children to emotional difficulties including fear, combative behaviours, conduct disorders, criminal behaviour and PTSD.

4. The parental and family dynamics were such that his parents separated when he was seven years old and he was brought up in the home of an uncle. Additionally, he was reared in socially abnormal conditions relating to paramilitary attitudes. The combination of this, together with his disrupted upbringing, means that a behavioural disorder or mental illness in later life was not unexpected.

5. The early onset of offending behaviour is associated with personality problems and is highly predictive of continued criminal development and behaviour. His significant criminal history (GBH and ABH: 1990 and 1993) was driven by loss of control and marked violence.

6. Mr McMahon's recorded offending history started when he was aged 14 (1979) and by 1996, it included 9 offences against the person, 3 public order offences, 3 offences relating to the police/courts and 1 offence relating to firearms (Belfast). Such a rich prior offending history is predictive of future offending.

7. The Inquiry has received independent evidence of, and accepts, that he was shot in Belfast in 1986 in a punishment shooting. Although he was careful not to give any details of his paramilitary activities when seen by the Inquiry Panel, we also find he is likely to have witnessed and participated in far more violence, for example, reprisal shootings, than this incident alone. Experiences of this kind have a high conversion rate to Post Traumatic Stress Disorder which, in vulnerable victims, is likely to incubate and worsen with time. It is associated with violence, drinking, depression and failure in relationships. PTSD is known to sensitise victims so that they react with violent decompensation when reminded of the index experience.

8. In relation to substance and alcohol abuse, our conclusion is that Mr McMahon drank heavily and was a binge drinker. There is no evidence of any real dependency on alcohol.

9. The 1990 admission to Leicester General Hospital with symptoms of paranoid psychosis was likely to have been an episode of psychological decompensation and was a one-off episode.

10. There is good evidence that Mr McMahon probably developed PTSD as a result of his experiences in Ireland. Additionally, there is good evidence to support a diagnosis of personality disorder marked by a violent lack of control, exaggeration, lying and being predatory (1993 assault on neighbour), which in MHA terms would be labelled "psychopathic".

Personality Disorder

11. This is a complex case, and characterised by many co-morbid difficulties. One of the features of Mr McMahon's care was that professionals working with him only ever recognised a sub-set of these difficulties, and never achieved a coherent overview and formulation of the complexity of his psychological and psychiatric problems. This then impacted upon the accuracy of the resulting risk assessment. The areas of clinical difficulty which arose have been separated out for ease of comprehension, but it should be noted that they would have overlapped and interacted:.

12. Mr McMahon fulfils the diagnostic criteria for personality disorder. This is characterised by repeated and various criminal behaviours, as set out above, stretching back to his youth and including a spell in a Young Offenders Centre. His history includes alcohol and substance abuse and deliberate self-harm. His lifestyle was chaotic and he was often of no fixed abode. His early life in England and Scotland was itinerant and he drifted from city to city forming no lasting ties.

13. An assessment of upbringing and cultural background (family and paramilitary) is also important in any evaluation of future risk.

14. His behaviour was characterised by impulsivity and poor behavioural controls, often leading to violent and dangerous behaviour some of which led to convictions and others which did not, (e.g. through the repeated retractions of allegations by Ms B, or lack of corroborative evidence).

15. Mr McMahon's violent behaviour often appeared to be entirely unprovoked or related to minimal "perceived" provocation (e.g. the neighbour in 1993). He has shown a marked failure to accept responsibility for his actions, continually placing the blame upon his victims and other external sources (e.g. his drink being "spiked"). He regularly provided inconsistent information, for example, to do with his drinking habits. These features may amount to pathological lying which is a characteristic feature of some forms of personality disorder. He presents as charming, gentle and pleasant to some professionals and angry, difficult, aggressive and intimidating to others. This may be an indication of poor behavioural control and erratic mental state or may indicate glibness and superficial charm towards people in perceived positions of power. There is also

some evidence of manipulative behaviour. These are all features of "Hare Psychopathy", a known sub-set of anti-social personality disorder that is associated with a high risk of future dangerousness.

16. Mr McMahon had a history of interpersonal difficulties, substance misuse and deliberate self-harm. There is evidence that he used the fact of "saving" her life in July 1997 to exert emotional control over Ms B, and also of physically abusive and sadistic behaviour towards her which is said to have included burning her with cigarettes, twisting her breasts and urinating on her.

17. The focus of the assessments of Mr McMahon was upon his mental state within the context of a mental illness (PTSD and depression). Yet even prior to the murder of William Bodle there is evidence of a personality disorder.

Post Traumatic Stress Disorder

18. Mr McMahon shows clear symptoms of PTSD relating to his experiences in Northern Ireland. This is evidence of both intrusive and avoidance symptoms of PTSD, including increasing social isolation and emotional numbing. He reports flashbacks to the shooting in 1986, with triggers to these including fireworks and loud noises. He reports behavioural avoidance of television programmes about hospitals and casualty situations. He avoids the Irish Community. He reported that finding Ms B apparently "dead" led to a precipitation of his PTSD symptoms. He achieved near maximum on a psychometric measure of PTSD symptom frequency (administered by Joanne Brook-Tanker in December 1997). He also reported severe symptoms of anxiety at that time.

19. Mr McMahon reports a number of clinical problems often associated with PTSD. These included depressed mood, anger and drug and alcohol abuse.

20. The DSM -IV (1994) in a section on PTSD labelled Specific Culture and Age Features states:

> *"Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of PTSD. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals."*

Additionally, standard textbooks of psychiatry such as the Oxford Textbook of Psychiatry (1994) specifically refer to the associated violent behaviour to be expected in cases of PTSD:

> *"there may be maladaptive coping responses of persistent aggressive behaviour, the excess use of drugs and deliberate self-harm."* (p.141).

One of the original papers describing PTSD (Cardiner, 1941) also emphasises the link with violence.

Neuro-psychological problems

21. There is a reference to an early head injury (pre 1990) in relation to which the details are few. He was hit by a baseball bat, needed 18 stitches and did not report any loss of consciousness, convulsions or amnesia. His prolonged history of alcohol abuse and binge drinking may also have led to cognitive impairment. Both a head injury and severe alcohol abuse could have led to brain damage and neuropsychological impairment which is often associated with behavioural impulsivity, lack of planning, volatile and labile affect, disinhibited behaviour and a lack of awareness of the consequences of one's actions.

22. No neuropsychological assessment was ever carried out, although his cognitive functioning was briefly assessed in 1993 by Dr Grace Leung (see chapter 12), but the test results were not adequately interpreted in terms of whether this indicated a short term impairment of functioning relating to acute alcohol intoxication and abuse, or whether these impairments constituted permanent cognitive dysfunction.

Risk: an actuarial assessment

23. VRAG, an actuarial assessment tool for the prediction of violent recidivism and which gives a dimensional score (between -26 and +38, the higher the score the higher the future risk of violence) was used to estimate the level of risk posed by Mr McMahon prior to the murder. For this purpose, the offence of GBH was used as the index offence as this was the most serious offence prior to the murder the murder was itself was excluded from all calculations.

24. The test was scored conservatively i.e. if there was uncertainty over any item it was rated on the lower end of the scale. On this basis, Mr McMahon obtained a score of 25. This placed him within risk category 8 (second highest). An individual within this category has a 76% chance of re-offending violently within 7 years of the index offence and an 82 % chance of re-offending violently within 10 years of the index offence.

25. The actuarial assessment of risk is considered further in chapter 18.

Chapter 17

DAVID McMAHON

CONCLUSION

and

EXECUTIVE SUMMARY

Introduction

1. Mr McMahon's main contact with Dorset services was with the community forensic team (1993 and 1997) and probation service (1994-1998). Additionally, he was assessed once by Dr Rowton-Lee (1993) and by his general practitioner and a consultant psychiatrist from the North Bournemouth Community Mental Health Team (1998). These periods of contact overlap closely with those of Mr Coombe.

2. The main features of his presentation to these services included:
   - **a)** a history of violence, including
     - i. offences of GBH and ABH in 1990 and ABH in 1993,
     - ii. being brought up in North Belfast at the height of the sectarian conflict,
     - iii. involvement in paramilitary activities including a punishment shooting which resulted in him fleeing Belfast to England for fear of his life in 1986 and
     - iv. incidents of domestic violence in 1997 and 1998;
   - **b)** an early history of offending and family difficulties including the divorce of his parents;
   - **c)** a psychiatric admission in Leicester in 1990;
   - **d)** symptoms of post-traumatic stress disorder linked to his experiences in Northern Ireland and depression;
   - **f)** a personality disorder;
   - **g)** binge drinking which could result in outbursts of anger and violence.

3. Mr McMahon's was a complex presentation, the causes of which were never fully unravelled and assessed. In particular, the possibility of an underlying anti-social personality disorder was not recorded although all the practitioners who assessed him between 1993 and 1998 told us that they held this diagnosis "in their heads". This was an important factor in assessing risk. The assessments were all short term and only that of Joanna Brook-Tanker (CFT psychologist) had the potential to be more, although her sessions were aimed at post-traumatic stress disorder and he failed to attend them. Given the brevity of individual contacts with health services, the fact that a diagnosis of personality disorder was not made is understandable. However, the recurrent violence and binge drinking by Mr McMahon was an important part of his presentation to explore or flag up, because it might have signified that he had a personality disorder with the extra risk level that implied. Even putting aside the presence of personality disorder, the potential link between PTSD and violence could and should have been recognised.

4. Too much reliance was placed on the fact that his last recorded offence of violence was in 1993. The reality was that there were several allegations of assault against him

subsequently, of which most were made by his former girlfriend, Ms B, who was also a probation client. These would have been relevant to his risk assessment but were not properly communicated between the probation officers involved.

5. There is evidence of an escalation in the seriousness of these assaults on Ms B in early 1998, prior to the murder of Mr Bodle, which was known to the police but did not come to the attention of probation or mental health services.

6. The features of this case highlighted the need for a proper risk assessment to be carried out. This applies particularly to the period around November 1997.

7. In common with past inquiries we have found shortcomings in:

a) the standards of **information gathering** and **verification** (1993 checking of details of events in 1990 and the information available to Dr Searle in 1998). This includes an over-reliance on the self-report of Mr McMahon, particularly by probation officers (1993 and 1996),

b) health and **risk assessments**,

c) social services record keeping and **communication** (1997).

8. Mr McMahon's most prolonged contact was with the probation service at a time when he was not assessed as having any mental health needs (1994-1997). This inquiry has not, therefore, focused on issues such as multi-disciplinary working and the use of the Care Programme Approach. Mr McMahon's health service contact was either through court diversion (1993) or as an out -patient (1997 and 1998) via the probation service.

9. We have had difficulty assessing the quality of probation assessments in this case due to the destruction of the part C record of daily contact. We have had available pre-sentence reports, quarterly reviews and transfer summaries in addition to the recollections of individuals. It is not easy to assess the quality of the reviews and summaries without the detail of the daily contact. We have attempted to fill in, where possible, evidence of Mr McMahon's daily existence, but have encountered a paucity of reliable, independent witnesses to assist in this process.

10. Issues specific to the **probation service** which we have identified include

a) **intra-agency communication** whereby there was insufficient liaison concerning the potential for violence in the volatile relationship with Ms B, also a probation service client,

b) unclear arrangements for the **supervision** of probation officers,

c) lack of clarity in the organisation of the **high risk conference** and criteria for registration to be applied.

11. Of key importance in this case were the:

a) Health assessments (1993, 1997 and 1998) and,
b) the probation High Risk conference (1997).

Health assessments

12. ***Dr Rowton-Lee (1993).*** This was an assessment for the court, following a probation referral to the CFT and a direct referral by defence solicitors. The issues expressly raised for Dr Rowton-Lee's consideration, included the possible existence of any mental illness, the effect of the 1986 shooting on his mental state, whether his problems were due to personality or psychological problems and the question of the impact of his upbringing on his mental state.

13. We have found that these issues, except for mental illness, were not properly addressed.

14. The expert evidence received by the Inquiry is that it is very probable that Mr McMahon does suffer from PTSD and that his uncontrolled anger (as evidenced by the 1990 and 1993 offences) and binge drinking are related to it. As the provider of court reports, even if he was not a qualified forensic psychiatrist, Dr Rowton-Lee should have been aware of this likely connection and his admitted lack of this knowledge is surprising and worrying. He should have expected, and sought, a full investigation of the PTSD from the CFT. In the view of our expert, early offending (from age 14) and PTSD puts an offender into the high risk category. In general, one would expect offending to diminish over the years, except where there is a personality disorder coupled with drinking. This is a volatile mix. This knowledge would have been available in standard texts of the time. The Inquiry has been advised that Mr McMahon also probably suffers from a severe personality disorder falling into the category of psychopathic disorder within the MHA.

15. Recognition of a high risk of harm to others at this stage is likely to have led to closer supervision of the probation orders made in 1994 and 1996. It may even have led to registration as a high risk offender at the conference in December 1997.

16. The whole issue of PTSD was rather undermined at this time. It is, however, not reasonable to suggest that detention under the MHA should have been considered based on "lingering symptoms" of PTSD or personality disorder. Compulsory admission with a primary diagnosis of PTSD would, in any event, have been an unusual practice in 1993 as it would be today.

17. ***CFT (Dr Leung) (1993).*** There are two issues arising here: the quality of assessments and the remit of the CFT. The free court assessment service provided was, not surprisingly, much in demand and meant that Dr Leung was overwhelmed with work, and coping with the demand by employing psychology assistants who were usually graduates in psychology with no clinical qualification. Dorset was one of the first local areas to set up a community forensic team and this was an innovative service, but its structure, leadership and remit were not properly thought through. (see chapter 19 for management accountability for this service and problems with its leadership).

18. An appreciation of the clinical limitations of the membership of the team in this field,

should have led to a clear definition of the restrictions within which the service operated. Thus, if the team was unable to assess PTSD or personality disorder, or if time permitted only a limited assessment, this should have been made explicit and those using the service should have been provided with a clear briefing of what assessments and treatments were available. This was not done.

19. It seems clear that a standard battery of tests was generally used in assessments and not necessarily tailored to the needs of the individual. This led to poor assessments and, in this case, the undermining of the diagnosis of post-traumatic stress disorder (and failure to identify the possibility of a personality disorder) resulting in a failure to understand the whole presentation and the potential for risk to others.

20. The advice we have received, is that it may not have been unreasonable to have missed the extent and severity of a personality disorder at this time, but not to have performed any testing for PTSD given the contents of Dr Rowton-Lee's report is less easy to justify. Thereafter, to dismiss as "exaggerated" Mr McMahon's reports of the symptoms of PTSD, as Dr Leung did, without further explanation was clinically unacceptable by the standards of a chartered clinical psychologist.

21. Equally, the lack of some risk assessment was unjustifiable. We have found a reluctance then, and later in 1997, to deal with an assessment of risk explicitly. There seem to be many possible reasons for this ranging from a lack of expertise to a disapproval of a system of simple classification. Such an assessment must be recognised to fall squarely within the remit of the CFT and is vital to the courts and probation service in coming to a conclusion about the protection of the public and the appropriate sentencing options. the assessment would also be necessary in determining the likelihood of compliance with any community supervision, including the safety of those who would act as supervisors or otherwise come into contact with the patient.

22. The probation service was grateful for this speedy source of assessment. There were, however, reservations about the quality of the service. There was also a perceived hierarchy between the services within which probation officers found it difficult to address issues of the quality of psychiatric and psychological reports. There is no proper system in place for them to obtain advice and assistance in relation to such difficulties. In the modern climate, court diversion and probation services have a high profile in the protection of the public. Systems need to be able to address the quality and reliability of assessments. Proper, and effective, multi-agency working can only be achieved on the basis of an equal partnership for all agencies and by taking positive steps to eradicate any hierarchies between agencies, whether actual or perceived. We have made recommendations with regard to this issue in the Coombe report.

23. As has been stated many times by now, the CFT had no specialist forensic expertise to offer prior to November 1997 when Joanna Brook-Tanker joined the Trust. Yet, it operated with seemingly little or no reference to the specialist service available at Ravenswood Medium Secure Unit. As a standard local psychological assessment service offering a limited service, it may be difficult to criticise, but even such a service as that, must know when specialist input is required and not stand proud of it. The apparent reluctance or failure to make such referrals, or to limit and define the acceptance of referrals, is a real failure and cannot be excused. (See chapter 19 on management accountability).

24. ***CFT (Joanna Brook-Tanker) (1997).*** Ms Brook-Tanker is a very experienced clinical and forensic psychologist whose areas of particular expertise and interest were ideally suited to assessing the problems of Mr McMahon. Her evaluation of the PTSD and psychological assessment was adequate. However, as on earlier occasions, only the most salient features of the case were evaluated, while her appreciation of personality issues and risk was limited.

25. The possible diagnosis of PTSD, a fairly recent history of binge drinking, reported difficulties in controlling anger together with allegations of assault against Ms B and incidents of self-harm, raise immediate concerns about the risk of violence to others and to self. Ms Brook-Tanker failed to demonstrate that she had properly considered the issues of risk. Regardless of any resistance which psychologists may feel to this, risk is always an issue which falls squarely within the remit of forensic services assessments.

26. Had there been a full appreciation of risk at this stage, this would have been an opportunity to advise the need for a further probation High Risk conference. Alternatively, had it later come to her knowledge (May 1998) that Mr McMahon was again in difficulty and again expressing concerns regarding his volatility and potential for violence, such an appreciation is likely to have led to efforts for a more urgent referral back to the CFT for assessment and support.

27. It is also our view that there should be more assertive efforts to follow up CFT clients who default on appointments. Mr McMahon failed to attend all of his appointments with Ms Brook-Tanker and was never seen by the CFT social worker.

28. ***1998: Dr Hockey and Searle.*** Dr Hockey's work with Mr McMahon was of a high quality throughout. He speedily arranged a psychiatric assessment and it is also to Dr Searle's credit that he responded promptly.

29. The package of support put together by Dr Searle i.e. to be seen by Dr Hockey fortnightly until a CFT appointment could be arranged and by himself again on 27 July 1998 to monitor the arrangements for follow up, was adequate on the basis of what was known to him at that time. Even if he had assessed a more imminent risk of violence and managed a more urgent referral to the CFT, detention, for example, under the MHA, was not an option.

30. The eventual CFT appointment arranged for 16 June was, however, for sixteen days later and this cannot be said to have incurred an unreasonable delay in the context of what was actually known.

31. We found, however, that Dr Searle's approach was firstly, circumscribed by the limits of what he considered he could offer; and he directed his focus primarily on mental illness. Secondly, it was informed by a protective attitude. This was a desire to protect himself from complaining patients who disagreed with an assessment, for example, relating to with violence or alcohol. Additionally, he wished to avoid outlining risk features in respect of which he felt he could offer no management options. He showed a marked reluctance to become involved with potentially dangerous patients.

32. Against that background it is unacceptable to say, as he appeared to do, that the possibility of a personality disorder was not mentioned because there was nothing he could do about it, or it might lead to a patient being excluded from services. If he had recognised personality disorder as a possible diagnosis he should have appreciated the potency of the cocktail of personality disorder, depression, PTSD and alcohol misuse as highly significant in the planning of treatment and prognosis of Mr McMahon.

33. The possibility of personality disorder had implications for the safety of the professionals and others who worked with the patient, it had implications for judgments as to the likelihood of the patient responding to interventions which addressed regards to any alcohol problem, it had implications for the treatment of his post-traumatic stress disorder, it affected considerations as to the likely causes and course of his depressive disorder, and had a bearing on the assessment of the risks of deliberate self-harm and the risk to others.

34. We have found that at the time in question, Dr Searle did not consider the possibility of a personality disorder and that, in the context of a rapidly arranged domiciliary assessment, this was acceptable.

35. Dr Searle made no record of any assessment of risk to self or others. Again, any limitations on the ability to manage risk do not provide justification for a failure to record risk. Also, by identifying potential risk, a practitioner is not held responsible if a risk materialises subsequently. Nor if he identifies a risk of violence and says that he cannot do anything to minimise or prevent the violence from occurring.

36. We have a great deal of sympathy surrounding the limitations within which services operate. We accept that hastily arranged assessments of this kind are quite often conducted without all the relevant material available. However, once documentation has been requested, as it was by Dr Hockey, then it is essential that at the least all reports and discharge summaries (where appropriate) are provided as quickly as possible. When the request is made by another doctor within the same Trust, or local GP, then we would expect that a full Trust file should be made available. In this instance, this should have included the CFT file.

37. He did have available to him the report of Joanna Brook-Tanker of December 1997. Dr Rowton-Lee's report contained details of Mr McMahon's history (as given predominantly by Mr McMahon himself), which is likely to have assisted Dr Searle at this time.

38. We accept additionally that first assessments, particularly if conducted under domiciliary conditions, will not necessarily be comprehensive and doctors (and others offering services) will be called upon to make fine and often difficult decisions regarding what may be offered.

39. If Dr Searle was unable to manage, or was unsure of, risk then he should have recorded this expressly and more immediate arrangements for assessment or short term management should have been considered. This may have involved community support from members of his CMHT as well as the GP.

High Risk conference and risk assessments (December 1997)

40. This was a highly unsatisfactory High Risk conference. We have identified the following problems with it:

a) ***Lack of preparation for the conference.*** The senior probation officer chairing the conference did not see it as part of her role to prepare for the conference in the sense of reading the past records and familiarising herself with Mr McMahon's file. She acknowledged that what she knew of Mr McMahon prior to the conference was very limited and this is reflected in the fact that she was unaware of any mental health concerns over Mr McMahon and that he had been referred to the CFT, or that Ms B was a probation client. As chair person of the conference whose function was to bring together a consensus of opinion on the need for a high risk registration, background knowledge would have been essential in evaluating the contributions being made by those attending.

b) Additionally, Ms Brook-Tanker, as a newcomer to the locality, was unaware of the criteria to be applied by, and the scope of, the conference. She had had her first meeting with Mr McMahon that morning and said she felt unable to offer much assistance to the conference. Although the minutes do contain a psychological formulation, she disputed that this was an accurate record of her contribution to the conference.

c) ***Limited scope of the conference.*** This refers to the fact that evidence of risk which supports registration, had normally to be in the form of a conviction or a charge, leaving little room for the evaluation of other potentially dangerous behaviour. In this case, the allegations of assault against Ms B were discounted because she had withdrawn them and was regarded as an unreliable witness, yet the allegations were numerous and fitted a known pattern in domestic violence cases. The offences in 1990 and 1993 were considered to be too historical to be taken into account. The use of unsubstantiated allegations is one that also arises also in the Coombe report.

d) Further, in the absence of registration, there was no requirement to proceed to evaluate what level of risk was involved and how it was to be managed in the future. The opportunity was not taken to produce a proper multi-disciplinary formulation of Mr McMahon's needs and presentation nor to plan for the management of the case in circumstances falling short of high risk registration.

e) ***Reliance on second hand information.*** Key participants were not invited to the conference. They were:

i) social workers who had information regarding two overdoses taken by Mr McMahon resulting in his being brought to the Royal Bournemouth General Hospital on one occasion under a section 136 MHA by the police. The information regarding these episodes was materially inaccurately recorded and passed on to the probation service and CFT, then relied upon at this conference.

ii) Ms B's probation officer or CPN who should have been able to offer advice on her reliability and the threat posed to her by Mr McMahon as perceived by her.

41. Based on the information actually available to the conference, it is possible to see why Mr McMahon was not considered to present an "imminent risk of serious harm" to others. However, the information available to the conference was seriously flawed and at the very least, it should have been adjourned for the further information regarding the relationship with Ms B and a full assessment by Ms Brook-Tanker. This is because Ms Shepherd's (Mr McMahon's probation officer) opinion was formed over a lengthy period of knowing Mr McMahon and, we think that to discount the alleged assault on the basis of Ms B's retraction of the allegation, in the context of domestic violence, was highly unsatisfactory. We think that if full and accurate information had been presented to the conference and had been taken into account, then there would have been grounds for high risk registration on the basis of a serious risk of harm to Ms B.

42. The failure to adjourn demonstrates the stark choice which faced the conference:

a) register as high risk, whereupon closer monitoring and supervision would follow to the end of the order, not on a reporting only basis, and more steps taken to ensure that it did not terminate without some support in place for Mr McMahon, or

b) not to register, whereupon, all that would be required of him would be that he should report to his probation officer and there would be no further consequence of the fact of the High Risk Conference being thought necessary and that Ms Shepherd had continuing concerns.

There were no "shades of grey" and no requirement to address or record the level of risk posed by Mr McMahon in some category below that of "high". From being considered for high risk registration, Mr McMahon went to a reporting only situation at an extremely vulnerable time for him, and the subsequent progress of his probation order was not considered in supervision between Ms Shepherd and Ms Harris, senior probation officer.

Murder of William Bodle

43. Applying the VRAG actuarial risk assessment tool for the prediction of violent recidivism, and using the 1990 offence of GBH as the most serious offence, Mr McMahon's score prior to the murder placed him within the second highest risk category and gave him a 76% chance of re-offending violently within seven years of the GBH, and an 82 % chance of re-offending violently within ten years of it. Mr Bodle's murder took place in 1998.

44. It was not the norm to use actuarial tools such as this at the time of Mr McMahon's assessments. This is a confirmation, however, that had one been done it would have alerted those assessing and caring for him to the real possibility of a risk of serious harm to others. In our view, the evidence was available on which to reach the conclusion that he presented a serious risk of harm to Ms B. Mr McMahon was also clearly reporting his own concerns over his volatility and seeking help for himself. What he was not able to do, was to follow through on the assistance that was made available to him.

45. The murder of Mr Bodle was committed while Mr McMahon was under the influence of alcohol and in response to an argument over a television programme. It does not fall outside the pattern of his known offending behaviour and, to that extent, was not unpredictable.

46. There is evidence of an escalation in the level of violence displayed by Mr McMahon towards his ex partner, Ms B, in the months preceding this assessment. This was known to the police, but not to probation or mental health services, and we have made a recommendation relating to the sharing of such information and the role of the police service in the multi-agency process.

47. Our conclusion, however, is that even if a more urgent referral back to the CFT had been arranged by Dr Searle, it is most likely to have been on an out -patient basis and the possibility of an incident, such as the one leading to the death of Mr Bodle, cannot have been totally excluded.

48. Equally had the level of risk posed by Mr McMahon been recognised at the probation High Risk conference, or following the assessment by the CFT in November 1997, we find it impossible to say that more assertive monitoring and supervision is likely to have prevented a serious act of violence even against the tragic Ms B. All that can be said is that it may have done so.

49. It is a fact of life that even with proper and thoughtful practices, probation and mental health services cannot be expected to guarantee the protection of the public.

50. We have identified serious shortcomings in the services available to Mr McMahon and hope by our findings to promote more accountable services.

Chronology

DAVID GARY McMAHON

1965 - 1983

23 February 1965	Born in Belfast
01 August 1979	Belfast Juvenile Court re Threatening words and behaviour - Fined.
18 June 1981	Belfast Juvenile Court re Threatening words and behaviour - Fined
13 May 1982	Belfast Magistrates Court .re Common assault on an adult. Fine £40.
16 November 1982	Belfast Magistrates Court re Criminal Damage & . Common Assault on adult. Fine £50. Youth Custody for 3 months wholly suspended for 2 years
06 January 1983	Belfast City Hospital - Assaulted - Head injury
15 June 1983	Belfast City Hospital - Admitted with Appendicitis
22 July 1983	Belfast Magistrates Court. re 7 offences: burglary, going equipped, threatening words, common assault x 2. & Obstructing police. Youth Custody 3 months.

1984 - 1986

14 February 1985	West London Magistrates Court re ABH - CSO 120 hours
06 October 1986	Belfast City Hospital: Punishment shooting gunshot wounds to both legs.

1987 - 1988

29 September 1987	Mr McMahon in Southampton area
02 March 1988	Mr McMahon in Hastings area
04 March 1988	Mr McMahon in Leicester - sees GP re sick note renewal.
18 May 1988	Mr McMahon in Southampton area - X ray at Hospital re knee.

1989

01 February 1989	Leicester City Magistrates Court re Possession of offensive weapon in public place - absolute discharge
01 March 1989	Leicester Magistrates Court re ABH x 2 - 14 days imprisonment

06 April 1989	Mr McMahon in Aberdeen area - sees GP
24 May 1989	Chester Magistrates Court re. Theft/shoplifting - Conditional Discharge for 2 years.

1990

08 February 1990	Leicester Crown Court re GBH and ABH. - 15 months and 6 months imprisonment consecutive. Released August 1990.
30 August 1990	Leicester General Hospital - probation officer sends Mr McMahon to A&E re mental health concerns - Admitted to hospital.
05 September 1990	Section 5(2) MHA. Very abusive. Restraint by 6 staff. Transfer to Wycliff (Psychiatric) Ward.
07 September 1990	Social Worker refuses to sanction Section 2, MHA. Mr McMahon discharged. Outpatient appointment given with Dr Walker.

1991 - 1992

30 January 1991	Liverpool Magistrates Court - ABH - plea and adjudication not known
23 May 1991	Mr McMahon in High Wycombe area - sees GP
November 1991	Mr McMahon In Ipswich area
16 December 1991	Mr McMahon in Lowestoft, Suffolk - sees GP
30 April 1992	Mr McMahon in Croydon area - sees GP re claim to Social Security for permanent disability as a result of bullet in knee.
12 November 1992	Bournemouth - charged with ABH against girl-friend Ms G - case not pursued

1993

22 April 1993	Bournemouth –charged with ABH (on neighbour). Sentenced in April 1994
19 May 1993	Case considered by Dorset Probation - Trish Best, Senior PO
20 May 1993	Referral from Rachel Kidner (P.O.) to Grace Higgins (P.O.) at Community Alcohol Team for assessment.
01 June 1993	Bournemouth Magistrates Court C- remanded on bail to 29/6/93 Pre Sentence Report by Rachel Kidner.

04 June 1993	Report of Dr Rowton-Lee-L for defence solicitors following assessment of 28/5/93.
17 June 1993	Referral to Dr Rowton-Lee-L from GP (Dr Blick) for help with Post Traumatic Stress Disorder relating to Northern Ireland.
23 June 1993	Letter to solicitors from Dr Rowton-Lee re perused medical notes from Leicester General Hospital admission in August 1990.
28 June 1993	Grace Leung sees Mr McMahon for assessment. Requested by Rachel Kidner (P.O.) Grace Higgins (Community Alcohol Team) report for Bournemouth Magistrates Court, Mr McMahon failed to keep two appointments, CAT unable to assist.
29 June 1993	Court request community forensic assessment
05 July 1993	Report of Grace Leung.
09 July 1993	Pre-sentence report Rachel Kidner. Mr McMahon seen by Community Forensic Team, Dr Rowton-Lee and Grace Leung.
16 July 1993	Mr McMahon's case adjourned to 13/8/93. Court requested re-assessment with a view to consideration of residential rehabilitation treatment
30 July 1993	Mr McMahon sees Community Alcohol Team
04 August 1993	Pre Sentence Report by Rachel Kidner
05 August 1993	Referral from GP to Dr Choudry re drinking and possible attendance at Sedman unit.
12 August 1993	Addendum court report of Grace Higgins. Mr McMahon referred to Sedman unit.
16 August 1993	Sentenced at Bournemouth Magistrates Court re - assault on police x 2, failure to provide a specimen, no insurance x 2, no licence and criminal damage. 4 months imprisonment and 2 years driving disqualification
02 November 1993	Pre-sentence report by Rachel Kidner for hearing on 5/11/93 re ABH on 22/4/93. Case deferred to 18/4/94

1994

18 April 1994	Bournemouth Crown Court re ABH - 2 year Probation Order with condition to attend Anger Management Group. Re-arrested on sentencing, on warrant from Leicester for theft of £1200 in 1991.

April 1994	Probation casework initial assessment. Allocated to Trevor Hopkins (caseworker) & Sheila Shepherd to supervise.
20 April 1994	Liverpool Magistrates Court - Offence not identified - Conditional Discharge + £180 fines
27 April 1994	Dorset Police - charged Mr McMahon with drunk & disorderly in Bournemouth. Bailed to 20/5/94, but failed to attend - arrest warrant issued with no bail.
May 1994	Dorset Police - arrest & charged with handling stolen goods - a driving licence and insurance certificate.
July 1994	Probation transfer summary: Failed to attend Anger Management Course - Breach proceedings instigated. Bournemouth Magistrates Court on 10/8/94 - failed to attend - arrest warrant issued with no bail.
August 1994	Probation - case transferred to Sheila Shepherd.
December 1994	Probation update by S Shepherd.

1995

March 1995	Probation update by S Shepherd. Warrants still outstanding and no contact with Mr McMahon.
July 1995	Mr McMahon to London, then Ireland and back to England.
16 August 1995	Arrested on warrant. Psychiatrist called to the cells re failure to attend Bournemouth Magistrates Court August 1994
17 August 1995	Bournemouth Magistrates Court charged with criminal damage and breach of Probation Order. Psychiatrist unable to conduct interview due to drug induced state. Bailed to a Southamptonton address. Overseen by Southampton Probation.
13 December 1995	A&E Bournemouth Hospital - attended re feeling unwell. Rib sprain
16 December 1995	A&E Bournemouth Hospital - transfer to Salisbury District Hospital: Knife incident results in deep laceration to left hand. Surgery to re-attach part severed thumb.

1996

10 January 1996	Bournemouth Crown Court requests request .
26 January 1996	Arrested by Dorset Police re ABH

07 March 1996	Pre-sentence report by probation for Court hearing on 8/3/96 – prepared by Sheila Shepherd.
08 March 1996	Probation Order without conditions for 2 years.
24 May 1996	Probation transfer summary: S Shepherd
June 1996	Probation - case transferred to Elaine Phillips.
June 1996	Dorset Police - Mr McMahon arrested re tampering with vehicle.
01 August 1996	Bournemouth Magistrates Court for vehicle interference. £60 fine.
28 August 1996	Review of Probation supervision plan
27 November 1996	Review of Probation supervision plan

1997

08 January 1997	Mr McMahon living at Bridge Corner House, Poole
03 February 1997	Review of Probation supervision plan
07 February 1997	Bournemouth Magistrates Court for non-payment of fines. MPSO £400.
16 May 1997	Review of Probation supervision plan
August 1997	Review of Probation supervision plan
19 September 1997	Sees GP re depressed for a few weeks.
19 October 1997	Dorset Police - arrest Mr McMahon re complaint from girl- friend Ms B that Mr McMahon physically assaulted her - Statement retracted on 4/11/97.
November 1997	Review of Probation supervision plan
18 November 1997	GP (Dr Hockey) refers Mr McMahon for depression to to Tim Hollingbury, clinical psychologist. Letter sent 1/12/97 by Kalpita Kunde - on waiting list.
25 November 1997	CFT panel meeting. Chaired by Sheila Shepherd. Present: John Reid, Martin Koscikiewicz, Joanna Brooke-Tanker. Referral to CFT by probation and report due on 30/12/97. Mr McMahon recently found Ms B in a coma.

02 December 1997	2 visits to A&E Bournemouth Hospital re separate overdoses. S.136 MHA used. Poole Social Services: Request by David Hosie for ASW assessment. Duty Social Workers at St Ann's - Vic Trimble and Terry Stewart
03 December 1997	Mr McMahon returns home and attempts to strangle Ms B.
04 December 1997	Bournemouth Social Services - Terry Stewart spoke to Ms B who alleged that Mr McMahon tried to strangle her. Probation informed - Sheila Shepherd.
08 December 1997	Dorset Probation High Risk conference. High risk category not confirmed.
13 December 1997	Attends A&E Royal Bournemouth General Hospital, re open wound to wrist.
16 December 1997	Report of Joanna Brook-Tanker and Martin Koscikiewicz (CFT psychologists). Referred by Sheila Shepherd PO SW on team (Linda Anderson) to assess for support in community.
24 December 1997	Kalpita Kunde, clinical psychologist, Dorset Healthcare NHS Trust offers appointment on 31/12/97 following request from Dr Hockey 11/97.
31 December 1997	Dorset Police - Mr McMahon arrested for burglary, angry and difficult with police. Mr McMahon seen as part of Diversion scheme at Bournemouth Police Station Letter to Joanna Brook-Tanker from Ian Oxborrow. Charge sheet to P.O. "Elaine Phillips" - Bail form with conditions to appear on 4/2/98.

1998

06 January 1998	CFT panel meeting.
21 January 1998	Telephone call from Sheila Shepherd to CFT. Mr McMahon has been involved in been in a fight and sustained injuries. Attending Hospital
05 March 1998	Admitted to Bournemouth Hospital - stabbed in abdomen by Ms B. Minor injuries. Discharged on 13/3/98. Allegations against Ms B subsequently withdrawn by Mr McMahon.
March 1998	Dorset Probation closing summary:
18 March 1998	Mr McMahon sees GP (Dr Hockey) re depression

27 March 1998	Mr McMahon arrested re complaint from Ms B that Mr McMahon physically assaulted her. Matter withdrawn after Ms B declined fully to complete her statement.
02 April 1998	Formerly discharged by CFT and Probation Officer informed. Letter to Sheila Shepherd from Joanna Brook-Tanker.
05 May 1998	Mr McMahon arrested re complaint from Ms B that Mr McMahon physically assaulted her. Matter dropped when Ms B withdraws complaint.
19 May 1998	Mr McMahon sees GP Dr Hockey, requesting urgent help re mental state.
20 May 1998	Seen by Dr Searle following urgent request from GP Dr Hockey. Offered CFT appointment for 16/6/98 and Outpatient with Dr Searle on 27/7/98.
27 May 1998	Report from Dr Searle to Dr Hockey. Dr Searle referring Mr McMahon for assessment with CFT
02 June 1998	Murder of William Bodle.

1999

11 February 1999	Mr McMahon convicted and sentenced to life imprisonment for murder.

Chapter 18

RISK ASSESSMENTS

RECOMMENDATION 19:

The Trust, probation and social services should review the provision of training and procedures to all levels of staff in relation to the use of actuarial risk factors in risk assessment.

RECOMMENDATION 20:

The Trust and other agencies should review arrangements for communication and sharing of information.

RECOMMENDATION 21:

The Trust, probation and social services should develop guidance for staff on the methods of accessing key information held by agencies, regarding offending and history, for the purposes of risk assessment and management.

Risk assessment in Dorset

1. The term "risk assessment" refers to suicide, vulnerability and neglect, in addition to the risk of harm to others. In these two reports, which deal with forensic clients, we have dealt with it largely in the latter sense.

2. We noted some concerns about risk assessment in the Shane Bath report. During the time he was under the care of local services, the assessment of risk issues, and any multi-agency consideration of their management, was limited. There were few opportunities to share information and consider how risk might be managed more effectively. We were advised that work in this area had started and it is clear that, since well before the publication of that report in July 2000, much work had been done locally to address risk assessment processes.

3. In these two reports, we have found an inconsistent approach to risk assessment. Mostly there was no risk assessment at all and on the rare occasion when some attempt at completing a risk form was made (see St Ann's inpatient period for Mr Coombe), it was incomplete and not properly considered. The probation service were using a risk scale (of 1 to 8) which was undefined and idiosyncratically applied by individual officers (see McMahon, chapter 13). The CFT applied no risk screening process and individual practitioners were resistant to simple classifications of risk (high, medium, and low). The quality of the evidence available to, and the decision-making of, the high risk conference held in relation to Mr McMahon was poor.

4. Nationally, the response of service managers to the need for better quality and greater consistency in risk assessment, has usually been to provide training for staff and to require those involved in care and treatment to complete a risk screening pro forma as

part of the CPA. A system of differentiating degree of risk is then applied. This should then indicate the kind and level of services an individual needs. Roughly speaking, this has been the approach in Dorset since 1997.

5. Issues such as information gathering and sharing, communication and acknowledging the limitations of assessments are of crucial relevance to risk assessments across all agencies, especially those dealing with forensic clients.

6. In this chapter, we focus on the wider issues pertaining to risk assessment and management, which arise from these two reports, before turning to a brief consideration of individual services.

The wider picture

7. Over the last ten years, service planning in the public mental health services has increasingly been influenced by the issue of risk assessment - how to improve it and how to apply it.

8. The pathway to better risk assessment has been strewn with many obstacles, not least of which has been the concern of mental health professionals and users' groups that the focus on risk among mentally disordered people has added to prejudice and stigma. The reporting of high profile murder cases, where the perpetrator has had some contact with mental health services, has usually been ill informed and sometimes even hysterical. It is often stated, or implied, that those who are charged with the care and treatment of mentally ill people failed to predict what should have been obvious.

9. All this assumes, of course, that there is:

a) A well established, tried and tested way by which a risk to others from an specific individual can be assessed.

b) This method is based on a common knowledge base.

c) That this is understood in the same way across all disciplines and agencies

d) That there is a robust, quasi-scientific process that can deliver high rates of predictive accuracy.

10. In reality, while there are reliable methods of predicting recidivism among groups of those who have offended, an individual has to have committed a violent offence, or a series of offences, to get into that higher risk group. Some of those with mental disorder who have killed have committed none (such as Simon Coombe), or none of any significance, prior to the index offence. Also, these methods are based on class or category risks (much like life or car insurance) rather than individual risks.

11. Not all those who have to make judgements about risk in mental health services come to the task with the same set of tools. Psychologists, criminologists, psychiatrists and probation officers will each apply their own professional expertise and knowledge when making a risk assessment. Doctors might emphasise the importance of symptoms and

downplay offending history, probation officers might focus too much on an individual's capacity for insight while neglecting important psychiatric information such as a diagnosis of personality disorder, and so on.

13. No one can predict with complete accuracy what one human being will do to another. Risk assessment at its best, and most well informed, cannot deliver 100% prediction. The uncomfortable reality is that, whatever professionals do, people will continue to commit violent offences and, in extreme cases, some people will die. This is a truism that neither politicians nor the media find palatable.

14. Presently, there is a move away from purely clinical approaches to risk assessment towards actuarial methods in relation to groups of individuals with like characteristics. Actuarial methods usually take a wider view than individual clinical assessments, as well as looking at mental health state phenomena, account is also taken of offending, substance misuse, family history, school conduct, demographic data and so on. Actuarial methods have been validated and the probability of future offending can be calculated within a given timescale.

15. There are limitations to both approaches:-

Clinical

16. The research suggests that even if this is well informed, this is likely to be no more than one third accurate at the very best.[3] That is, for every three predictions of future harm there are two that do not happen. Clinical methods by themselves do not forecast the future accurately. Such methods do not always take sufficiently into account any non-mental health factors, particularly factors in relation to offending and early life history.

Actuarial

17. There is now available in the mental health field some relatively sophisticated methods of assessing the probability of risk to others. These usually take into account such variables as:

- Family history including parental separation
- school maladjustment or other forms of conduct disorder in childhood
- substance misuse
- age of first arrest, frequency and type of offending
- marital status
- age
- employment
- imprisonment
- diagnostic information
- attitudes towards crime

18. Some of these are viewed as "protective" factors, reducing risk.

19. These can deliver high accuracy levels but within a limited time span - one to seven years. However, they depend on the information being used in the assessment as fitting

[3] See Monahan, J. (2000) Clinical and actuarial predictions of violence. In D. Faigman, D. Kaye, M. Saks, and J. Sanders (Eds), Modern Scientific Evidence: The Law and Expert Testimony (Vol. 1). St Paul, MN, USA, West Publishing Company.

the criteria for input, and being accurate. There may also be an issue about having the information available in the first place.

20. They can only predict future probabilities for a cohort of people. We do not sufficiently understand how human beings work, well enough to say that a particular person under a specific set of circumstances will definitely harm someone. All we can say is that someone sharing certain common characteristics with other people is more likely to cause harm than another in a group without those characteristics. In other words, it is not person specific and someone from a high risk cohort may well not commit another offence while another in a low risk group could commit an offence even though the group he was in is low risk. Also, actuarial information until recently was entirely historical and did not factor in future plans for an individual.

21. While such methods of risk assessment are limited insofar as they will only indicate a probability of future harm for a group of individuals with like characteristics, rather than the probability for a particular individual from that group, they do represent, arguably, the most *'scientific'* way available of determining a risk baseline for patients at the moment. Our advice is that research shows that in terms of risk, such tests are more reliable than clinical assessment, unless the clinical assessment is carried out on the first day of contact i.e. interpersonal factors intervene later to make a clinical assessment less reliable.

22. In reality, both approaches need to be used to maximise the effectiveness of risk assessment and management. One without the other will not be sufficient. Actuarial methods are improving and some can now take into account information on future care options for individuals. However, generally speaking, only the "here and now" clinical assessment can take into account what future care arrangements are most likely to minimise the level of risk.

23. The actuarial risk assessment is the essential baseline for effective clinical risk assessment. It is the starting point, however, not a substitute.

24. Actuarial approaches have increasingly been taken on board by those providing mental health services but not always in the full knowledge of what is meant by the term or what key factors are involved. It has become a buzzword in the lexicon of service planners, senior clinicians and managers.

25. Yet, staff involved most directly with patients or clients have often not been introduced to basic actuarial risk factors or adequately trained in how to take them into account when making a risk assessment.

RECOMMENDATION 19:

The Trust, probation and social services should review the provision of training and procedures to all levels of staff in relation to the use of actuarial risk factors in risk assessment.

26. The importance of high quality risk assessment has been emphasised by these and many other inquiries. It is very much part of the national services framework for mental health.

Yet, some clinicians in general psychiatric services still have reservations about it. They may be sceptical about the degree of attention managers expect them to place on risk or be anxious about it because:

a) They may feel their patients are further stigmatised by too great a focus on risk.
b) They are painfully aware of their limitations in this area, their ability to influence or change aspects of human behaviour beyond the diagnosis and treatment of mental illness. They may believe that it is only where risk emerges as an issue arising from mental health state, that it is something on which they should be expected to pass judgement on.
c) In an age of patient access to records they may be anxious that they do not create too many litigious hostages to fortune by basing opinions about risk on non-verifiable information or speculation.
d) They may feel that risk assessment in psychiatry is principally a subject for their forensic colleagues

27. Yet, as far as the courts and the public are concerned all psychiatrists are regarded as the experts in this field in relation to mental disorder. Any registered medical practitioner may make written or oral recommendations to the court under Part III of the MHA. Psychiatrists, even when they work in general settings, cannot avoid making judgements about risk. It therefore behoves anyone working in the mental health services and offending fields to ensure that his or her understanding of risk assessment is adequate to the task.

28. Many of the recent advances in risk assessment, and actuarial risk assessment in particular, have come about via forensic psychiatry, criminology and psychology. Forensic psychology, in particular, has made great strides in developing reliable assessment methods that are very useful for constructing risk baselines for individuals.

29. A rational debate on risk in mental health can be difficult to hold in a climate of name, blame and shame. Nonetheless, those working in the mental health services must continue to define and refine what can be done in this area and what cannot be done. The best that can be done at present in cases where a high risk level is suspected is to:

a) Identify what information is necessary to construct an actuarial baseline and from where.
b) Do what is necessary to add to this, for example, PCL-R screening or other personality profiling.
c) Obtain the necessary information cross -discipline and cross- agency.
d) Apply a validated actuarial guide or schedule, either manually (e.g. VRAG) or use a computer programme (e.g. OASYS or OGRES) to obtain a risk probability rating.
e) Use this with other clinical information to inform an inter-professional risk assessment taking into account individual factors such as, predicted treatment compliance, potential victims of violence, mental health state factors, substance use etc.
f) Agree an inter-agency level of risk and a strategy for risk management.

30. If this, or something like this, was done for potentially high risk cases and the worst happened, then at least it can be demonstrated that what could be done was done. Nothing more can reasonably be expected.

31. In all other cases, for example where a low risk has been identified, actuarial assessment will provide a useful and potentially reassuring measure of risk upon which to base decisions on the provision of services and the appropriate intensity of resources to be made available.

32. We have commented in relation to the probation services that a low risk appears to attract the application of national standards, which must be regarded as a minimum requirement and a starting point only. However, individual officers (probation and others) must be in a position to apply their professional judgment on issues of risk arising in any particular case with confidence.

33. To assist in this process we think that our findings in relation to the need to evaluate and identify the available sources of information, and any limitations applying to assessments and reports, are of real importance. Thus, if there is a list of the available information made together with a consideration of any limitations, including the availability of facilities or any restrictions in service provision, then this should help to identify missing information and promote the development of defensible professional opinions.

Health Service: Trust and Health Authority

34. The Trust, with social services, developed a clinical risk screening policy in 1997. Subsequently a joint training package for staff, in partnership with Bournemouth University, was provided and a risk screening tool (a pro forma) introduced. However, an audit in November 1998, commissioned by the Health indicated that risk screening was only being completed in 47.6% of the cases sampled, that it was most likely to happen on hospital admission and discharge and least likely when a contact was defined as a new domiciliary visit or in outpatient clinics. The report queried the number of patients on the Supervision Register. It went on:

> *'There is ..... a disparity between staff perceptions of their risk management and management practices, and the audit data. The latter suggest that compliance with policy requirements is variable and generally low with significant differences between professions .....*
>
> *Where high levels of risk were identified the links between evidence, rationale and action were often unclear or non-existent in the records'*

35. It would seem that, at the time, greater awareness of risk has led to more individuals being defined as 'high risk' and while it has not been possible to establish any definitive causal relationship between this and more cautious care and treatment practices:

> *'Associations with increased bed usage, increased admission/re-admission rates, increased numbers of service users at CPA level 2, increases in violent incidents*

and variations in the use of special observations were, however, identified'

36. Staff identified developmental needs with both the risk assessment screen and the policy in the areas of multi-disciplinary involvement, resources/time, the historical focus of the risk screening form, the wording of the screen content and the inflexibility of the policy.

37. It was further suggested by staff that the screening tool should:

> *'concentrate on contemporary indicators of risk more than historical factors. There was need to agree and gain support for the principles of risk assessment and management'.*

This suggests to us that staff wanted to focus on the 'here and now' of risk rather than past events.

38. The 1997 risk assessment policies and procedures applied at the time Mr Coombe and Mr McMahon were in service contact. The extent of non-compliance with risk assessment procedures reported in the audit of 1998 reflects what happened, or rather did not happen, in these two cases.

39. The current risk screening tool has been in use since April 1999. It covers areas of risk in relation to violence to others, suicide, vulnerability and neglect. Staff are asked to note diagnosis, MHA status and previous admissions (formal and informal) in all cases. In respect of violence, they are asked to note whether the patient is currently violent or threatening, if there is a history of violent acts, substance misuse, availability of weapons, vulnerability of a victim, antisocial personality factors, poor adherence to care plans, poor impulse control and morbid jealousy. They are then asked to circle three levels of risk from high to low.

40. We are concerned by any move away from historical data. While not downplaying the importance of information about contemporary events we firmly believe that, without a good understanding of a patient's history and background, particularly in relation to offending, any past substance mis-use, and family, and educational history, then there is no actuarial baseline on which to build a sound clinical judgement.

41. The CFT had no formal risk assessment policy during service contact with Mr Coombe and Mr McMahon although it did sometimes proffer opinions on risk. Risk assessment is clearly within the remit of any forensic service. The new Dorset Forensic Team's policy states that it follows Trust policies and procedures on risk.

42. Risk assessment is now seen as very much part of an integrated CPA process.

Social Services

43. Mr Harry Capron, from Bournemouth Social Services, advised us that his department jointly developed the above policy (pre 1999) with the Health Trust and that it was linked to the CPA.

Probation Service

44. We understand from Mr Barrie Crook of the Dorset Area National Probation Service that, at the time of service contact by Mr Coombe and Mr McMahon, the only formal risk arrangements applicable were in relation to High Risk conferences, the supervision plan and the review of the supervision plan. These last two asked probation officers to score both risk of re-offending and risk of serious harm to the public on scales of 1 (low risk) to 8 (high risk).

45. Subsequently, a great deal of attention has been paid to developing better risk assessment mechanisms. The High Risk conferences have been re-named "Potentially Dangerous Offender Conferences" and the procedures revised to strengthen,tighten up and give more of a focus to, both the risk assessment and the management of risk.

46. The service is helping to develop three methods of actuarial assessment and will be employing a psychologist to assist it in this area of work.

Inter-agency co-operation on risk assessment. The role of the police.

47. While there appear to have been substantial advances within each agency in respect of the development of risk assessment and management processes, we are concerned to note that inter-agency co-operation may not be as close as it needs to be.

48. We accept that each agency has its own set of responsibilities to adhere to and that the type and depth of risk assessment needs to reflect this, for example, the trust with social services has to deliver on the CPA, the probation service has a specific responsibility for sex offenders, Social Services has to include risk as a factor in its community care assessments. Each agency has its different focus, mental health care and treatment, offending or social care, and assumptions about common goals across agencies may be too simplistic.

49. However, the degree of overlap between these agencies when working with forensic service clients is considerable. Many offenders have mental disorders and many of these are also socially vulnerable. Actuarial and clinical risk assessments by any single agency will probably have to draw on information held by one or another of the other agencies. Without such information, risk assessment will be incomplete and potentially misleading. A partly informed risk assessment may give a false sense of security to those involved in someone's supervision, care or treatment.

50. In this context, we would like to highlight our findings in relation to the role of the police service in sharing information relating to known service users with relevant agencies. Allegations of violence or indecency, whether proved in court or not, and details of the same, are of vital importance in the assessment of risk. The police are now partners in multi-agency working in the arena of public protection. The development of a protocol for the sharing of such information and training for staff on its use is an essential component of practice (see also Recommendation 2 and chapters 5 and 13).

RECOMMENDATION 20:

The Trust and other agencies should review arrangements for communication and sharing of information.

RECOMMENDATION 21:

The Trust, probation and social services should develop guidance for staff on the methods of accessing key information held by agencies, regarding offending and history, for the purposes of risk assessment and management.

Chapter 19

CONCLUDING COMMENTS

ACCOUNTABILITY

AND ISSUES COMMON TO BOTH REPORTS

RECOMMENDATION 22:

The Trust and social services should review its forensic service provision by reference to the level of skill and training within its staff and, by this means, identify any gaps or shortcomings in the service.

Accountability: CFT and Trust services

1. Neither Mr Coombe, nor Mr McMahon, fitted into neat diagnostic categories of mental health needs. They both required a more thoughtful and flexible approach to assessment and service provision than we have found was available.

2. Both Mr Coombe and Mr McMahon were assessed by the CFT for pre-sentence court reports in mid-1993. Mr Coombe was subsequently assessed and treated by the CFT and Dr Rowton-Lee as an in-patient, on transfer on remand from prison, from January to June 1997. This was at the request of the court under section 35 MHA, as advised by probation and Dr Rowton-Lee. Mr McMahon was assessed by the CFT in November 1997 following a probation referral.

3. Our main findings in relation to the CFT are:

   a) Its membership up to November 1997 did not have sufficient forensic training.

   b) There was confusion over the leadership of the team. Many people were under the impression that it was led by Dr Rowton-Lee. He was not formally a member of the team, which was in fact under the leadership of Dr Leung and whose leadership and management skills were poor.

   c) The lack of forensic skill seriously impacted on the quality of CFT assessments, whether on an in-patient or out-patient basis, and the overall effectiveness of the service. Out- patient assessments of Mr Coombe and Mr McMahon, particularly in 1993, were limited and of questionable assistance to the court.

   d) The workload of the CFT expanded in an uncontrolled fashion and the demand on it as a free court service was such that Dr Leung, working alone as the only qualified clinical psychologist (until November 1997) attached to the team, was under ever increasing pressure.

e) In the light of c) and d) above there was no attempt to redefine the limits of what the service was able to offer, to control the through put of cases or to streamline it in accordance with the level of skill of its practitioners.There was, additionally, poor communication between the CFT and the ward during Mr Coombe's in-patient period, and no participation in the discharge process. This led to a waste of effort and resources.

g) The role and functioning of social services within the team has been difficult to determine. We have questioned the commitment of that service to the team.

h) Dr Leung provided chaotic and unfocused leadership. Record keeping was very poor and notes of treatment sessions with Mr Coombe during his in -patient period did not reach the main CFT file until after the murder. Evidence of the team's dissatisfaction with Dr Leung's leadership and interpersonal skills, was not recognised by the Trust until 1998, after which time the team was effectively disbanded until the new Dorset Forensic Team was set up under new leadership in 2001.

4. We have previously commented that:

> *"community forensic services must be fully resourced and run by trained and competent staff in order to be truly effective. It is clearly essential that in this sensitive area of practice proper leadership by skilled clinical staff is provided. Anything less is likely to lead to a service which is unclear as to its own capabilities and limitations. There may equally be an over-reliance on it by other services with no forensic expertise and with unrealistic expectations as to its effectiveness with difficult clients."* (Shane Bath para. 27.19)

5. To this, we can now add that this was a service which although innovative in 1993, required closer management scrutiny, and an appreciation of its potential risks and pitfalls, in order to provide an effective and safe service. In particular it required a careful and close management style to ensure that it did not over-stretch itself in terms of both the numbers of referrals it accepted and the abilities of the team.

6. This was one of the first local forensic services in the country and which, we were told, received praise nationally. It was an initiative which brought the health and probation services together at a local level. The worthy intention was to implement the principles of the report of the Reed Committee (Dept of Health and Home Office, 1992), that services be provided in the least restrictive setting.

7. Up to May 2001, as general manager of adult mental health services for the Trust, Linda Boland was the manager responsible for the CFT. In May, this changed and that role was effectively divided so that she is now the operational director for specialist mental health services only. Responsibility for adult mental health services now falls within a separate full time position. This was done partly in recognition of Ms Boland's need for a part-time role post maternity leave, but also she told us because it was recognised that her previous role was over burdened. Ms Boland's areas of responsibility now cover forensic, addictions and rehabilitation services, assertive outreach and out of area treatments.

8. The operation of the CFT was overseen by a multi-disciplinary steering group that met quarterly. The steering group consisted of Ms Boland, Dr Grace Leung, senior representatives from probation, police, Bournemouth Churches Housing Association responsible for Creek House/Dorset Lodge, and social services. Dr Rowton-Lee would attend occasionally at Ms Boland's request and from 1995/6, Dr Huw Stone, consultant forensic psychiatrist from the regional secure unit at Ravenswood House, Knowle Hospital also attended. We have seen the steering group minutes between October 1996 and October 1998.

9. Additionally, and until 1998, Dr Leung reported directly to Ms Boland who in her turn was accountable directly to the Chief Executive, Roger Browning. In May 1998 line management of Dr Leung switched to Anne Lennon, St Ann's Hospital manager.

10. By the end of 1998, members of the CFT made a series of complaints against Dr Leung that led to her suspension and ultimate resignation in June 1999 (see below). The Inquiry Panel is concerned that it was not made aware of this during the Shane Bath Inquiry, which heard evidence in early 1999, or at any time prior to the publication of that report.

11. We heard that the CFT held weekly minuted team meetings on a Monday or Tuesday. No copies of these have been found.

Definition of MDO services and expansion

12. The multi-agency Strategy for MDOs 1997/1998, known as the County MDO Strategy provides the following definition of "mentally disordered offender":

> *"Individuals who come to the notice of the police or courts as a result of offending or criminal behaviour who may be acutely or chronically mentally ill or have a learning disability. Included in the group will be those persons with or suspected of having:*
>
> - *neurosis, behavioural and/or personality disorders;*
> - *mental health problems linked to alcohol and/or substance misuse;*
> - *a degree of mental disturbance which may not be severe enough to meet criteria laid down by the Mental Health Act 1983."*

13. It is clear that both Mr Coombe and Mr McMahon fell within this wide definition.

14. Although the County MDO Strategy appears to have been in development over a number of years, and we were provided with the 1997/98 document for the Shane Bath inquiry, it does not appear to have been implemented until about May 1998 when it was styled the 1997/99 strategy document. A Review of Mentally Disordered Offenders and Sex Offenders was produced in April 1994 by the Dorset Health Commission (predecessor to the Dorset Health Authority).

15. Evidence to the Shane Bath Inquiry was that the priority of the Trust's mental health services were patients with a "severe mental illness" which was intended to included personality disorder, but it was accepted that this was not sufficiently clear with regard

to the co-morbidity of other disorders or those with only a personality disorder. The documentation clearly includes post-traumatic stress disorder within this definition. Mr McMahon would also have fallen within this definition.

16. There is evidence that the North Bournemouth CMHT was working to exclude the potentially more dangerous and personality disordered patients from its services even where they came within the Severe Mental Illness category. We have been told that this approach has now been formalised with the formation of the new county- wide Dorset Forensic Team which is to target the most dangerous people in the community, but which will also exclude personality disordered people. We do not know the precise basis on which this split in responsibility is to be achieved.

17. Ms Boland told us that she had no role in setting up the CFT, but rather inherited it once it was operational. Although she took steps to inform and educate herself about the type of service this was, she and the Trust were effectively learning on the job. We have formed the view that Ms Boland and the Trust were slow to appreciate the sensitivity of the work of the CFT and the difficult nature of its client base.

18. We think the Trust was "swept along" with in the praise it was receiving nationally for this innovative service, as well as the enthusiasm both of its two lead clinicians: (Dr Rowton-Lee and Dr Grace Leung), and of the probation service. They were seen as being hard working and committed which we cannot dispute. The CFT was providing a much needed service for difficult clients for free.

19. We have been told that the Trust was not misled as to the lack of forensic expertise within the team, but the Trust documentation, e.g. the County MDO strategy (above) referred to the CFTs "consultant clinical/forensic psychologist". There is no evidence that the lack of forensic expertise was viewed as a shortcoming by either the Trust or subsequently the DHA. The 1994 Review document, however, indicates that at that time the need for a forensic psychologist was appreciated and that *"as far as possible, all workers should have forensic experience or receive some degree of forensic training" (7.11).*

20. Our view is that the Trust, through passivity, encouraged the expansion of an ambitious service that was offered to a wide client group without proper account being taken of the available skills and resources.

21. We think it is difficult for the Trust to plead ignorance of the aspirations of the relevant clinicians for this service. In one document[4], which we were assured was never committed to policy, the plan included:

> *"to receive referrals from prison for treatment/assessment if funded. To liaise with prison psychologist. To widen the service to include specialist support to the ICU St Ann's and dangerous persons who have not offended."*

The service was in fact widened to support the expanded Studland ward, the St Ann's ICU in 1997.

22. Ms Boland acknowledged that difficulties emerged as the service evolved, partly through the high level of demand. She said that by this means people who would

[4] Objectives and Policy document 1992 by Dr Leung and Peter Schaapveld

otherwise have nothing to do with the health service, because they had no identified mental illness falling within the remit of a CMHT, came to be admitted via the CFT to St Ann's and Studland ward. These were predominantly personality disordered clients and those with behavioural problems, whose needs the CFT was not in fact qualified to deal with.

23. It is apparent to us, that a proper understanding of the service would have indicated that this was precisely the group of people that was likely to come within its remit. If the service was unable to deal with them, it should have been refined so as to identify those aspects of service provision in which it could be most effective.

24. The service was free and much in demand by the probation service. During the period 1993 to 1997, Dr Leung was the only qualified clinical psychologist with the CFT. She told us of the pressure she was working under and that she often brought the issue of her work load to the attention of Ms Boland during their supervision meetings. Ms Boland disputes that this was brought to her attention in this explicit fashion, although she acknowledged that Dr Leung was pressing for a second qualified psychologist.

25. The steering group meeting minutes contain regular "activity" information for the CFT, namely the number of referrals in a given period. For the quarter July to September 1996, there were 53 referrals. In the next quarter there were 85 referrals, including 30 for violence against a person. In the two months leading to May 1997 there were 113 referrals with again a majority being for violence against people. In the following quarter, there were 78 referrals. On that occasion it was minuted that *"GL [Dr Leung] noted that the number of discharges was less than the number of referrals and that therefore the CFT was accumulating increased numbers of cases."* In the quarter to February 1998, there were 59 referrals and an increase in referrals from consultant psychiatrists was noted. Violence against the person remained the largest category of referrals.

26. Certainly in the 1996-98 period, the Trust were by this means aware of the large number of referrals being dealt with by one qualified clinical psychologist with no forensic training. Ms Boland pointed to the appointment of three new CPNs in 1996 as a response to the expansion of the service and to Ms Brook-Tanker's appointment in late 1997. The latter was expressly related to the expansion of Studland ward in April 1998 to a twelve bed, low secure unit and the CPNs had no forensic training.

27. Social services provided social work input from January 1997 with Linda Anderson and Victor Trimble being appointed to cover Poole and Bournemouth respectively. Neither had any forensic background and nor were the Trust or probation service involved in their recruitment.

28. The case of Mr Coombe also underlines the issues of the clinical competency of the CFT, the quality of its assessments and the chaos of its recording keeping. Prior to 1995, we were told, professionals were left to find their own clinical supervision and it was an area in which the Trust did not get involved. This has now changed through the process of clinical governance and there are monitoring arrangements whereby every area within the Trust has to produce evidence of their clinical supervision arrangements. Problems still arise in specialist areas, such as the forensic services, where the expertise does not exist within the Trust for clinical supervision and it must be sought from outside.

29. Record keeping could and should, however, be monitored by the Trust and is likely to give an indication of the standards of a team. In the case of Mr Coombe, we have found a lack of records both of the dates of therapy sessions of therapy and, also, of the records of the sessions themselves. Those few notes of therapy that do exist, were not kept with the main CFT file and did not find their way into it until after the murder. This formed part of the complaint made by the team in November 1998 about Dr Leung. The lack of feedback from therapy sessions to both ward rounds and multi-disciplinary meetings could also have been discovered by proper management scrutiny.

30. There is no requirement within the NHS for clinical supervision of consultant medical staff. The Department of Health has introduced a system of appraisal for NHS consultants (April 2001) which is intended to complement the proposals of the General Medical Council regarding a five-yearly demonstration of all doctors' fitness to practise. This is clearly to be welcomed.

Conclusion

31. In our view, there is evidence that the service was over ambitious and too broadly defined, without a proper consideration of the level of skill and resources within the team. The evidence we have received demonstrates a lack of proper monitoring of the effectiveness of this team by those responsible for managing it.

32. We know that a system of integrated records has been set up, but we have not inspected how it works. Our findings go beyond this to a need to monitor the quality of record keeping.

33. We were told, and are aware of, the difficulties of recruiting fully trained forensic staff. It is clear to us that a local forensic service, if it is to function safely and provide assessments and treatments at a standard that engenders confidence, must be staffed by suitably trained people. Such services are resource intensive if they are to provide a reasonable and useful service, which includes assertive follow up in the community.

34. The provision of such services, which are set up to deal with the most challenging and dangerous members of our community, needs to be closely defined and understood by all those concerned, including all those who rely on it. A by-product of this, particularly where there is a shortage of specialist skill, is that services will be defined to exclude those considered most dangerous and from whom the public expects protection.

35. Thus by excluding personality disordered clients from the DFT and CMHTs there is an inevitable gap in services which the criminal justice agencies are left to close. The reasons for this need to be understood. Health services are not equipped to deal with untreatable patients and are naturally resistant to acting as gaolers of patients simply on the grounds of dangerousness or potential dangerousness (as to which see chapter 18 on risk).

36. Defining services carefully, and by reference to the level of skill available, should readily identify where the gaps in services lie. There must be a demonstrable and rational basis for any gaps that remain unfilled.

37. Among the basic requirements for those community services that are to be responsible for dangerous service users are the need for proper forensic training, risk assessment tools and protocols for risk management, multi-disciplinary and multi-agency work including sharing confidential information, and rigorous background and fact checking, proper management and quality control are amongst the basic requirements.

38. It must be emphasised that the significant shortcomings which the evidence received by these inquiries has uncovered, did not have any impact on the eventual outcomes i.e. the murders, in the case of Mr Coombe and are unlikely to have done so in the case of Mr McMahon. It has always been our view that it must be accepted that even properly managed and defined services cannot guarantee public safety.

39. What is required to raise public confidence is for services to have properly accountable systems and to be able to demonstrate defensible practices.

RECOMMENDATION 22:

The Trust and social services should review its forensic service provision by reference to the level of skill and training within its staff and, by this means, identify any gaps or shortcomings in the service.

Complaints against Dr Leung: November 1998

40. As mentioned above, in November 1998 a series of allegations was made against Dr Leung by CFT staff. These were initiated by Ms Brook-Tanker and Mr Koscikiewicz. The Inquiry only learned of these during preparations for these two inquiries when our Inquiry manager became aware of them. We encountered some initial reluctance to providing us with the full details of the allegations, but these were subsequently made available to us.

41. In general, the allegations did not relate to Dr Leung's clinical performance. Of the specific allegations made, those of relevance to these inquiries were:

    a) That Dr Leung had asked staff to insert/delete items from patient records. This includes the copies of records of contact with Mr Coombe in 1997 and the poor clinical note keeping practices;

    b) That she allowed known offenders to access patient records;

    c) The denigration of members of the Trust in front of others;

    d) General concerns regarding the lack of supervision of clinical cases with the CFT;

    e) Use of chartered forensic psychologist status when not entitled to do so;

    f) The complaint was of a general picture of intimidation and poor communication with associated problems of low staff morale and poor professional practice.

42. On 4 January 1999 Dr Leung was suspended from St Ann's and asked to work from home. Dr Leung offered explanations for or denied these allegations. There was a review by the hospital manager, Anne Lennon, who by then was also Dr Leung's line manager and externally by Ron Tulloch, Consultant clinical psychologist and Chartered Forensic Psychologist. Dr Leung resigned in June 1999 without returning to work at the CFT. No disciplinary proceedings were, therefore, taken.

43. In the course of her interviews with CFT staff, Anne Lennon found general dissatisfaction among members of the team. There were concerns about her lack of professional boundaries, lack of involvement in management issues and they way the, and colleagues, were treated by Dr Leung and that some of them felt ostracised. Mr Tulloch concluded that communication within the team was "dysfunctional" and that the service was engaging in practices that would not be considered "good practice" by peers and colleagues in the forensic arena.

44. These complaints were referred to the British Psychological Society, the professional body responsible for psychologists. A hearing was held on 26 January 2001 by the disciplinary committee based on documentary evidence only.

45. Dr Leung was found guilty of (1a) failing to take all reasonable steps to preserve the confidentiality of information she received through her professional practice and specifically the security of records held on computer and (2b) laying claim on official documents to a psychological qualification that she did not possess, namely, the title "Consultant Clinical Forensic Psychologist (Chartered)". The committee required Dr Leung to give an undertaking that she would not repeat the offending conduct in future.

Conclusion

46. It is our view, that with proper management, the dissatisfaction among members of the CFT should have been discovered, and dealt with, sooner. Additionally, there should be clear procedures by which staff should feel confident, safe and comfortable in raising serious concerns with team functioning and the practices of individuals. We are pleased to see that the Trust now has implemented a "whistleblowing" policy which aims to take account of this need. In our view such a policy is complementary and not an alternative to the recommendation we have made with respect to a complaints procedure (Recommendation 8).

The probation service

47. Where there are gaps in the health services for mentally disordered offenders in the community, it will usually be for the probation service to provide supervision, either on its own where no health needs have been identified, or in collaboration with health services where appropriate. We have found that there need to be proper protocols in place for such collaboration, making clear how decisions are to be taken and who is to take responsibility. The procedures established under the CPA should be used where possible, and extended if necessary to cover a situation where there is a condition of treatment attached to a probation order.

48. We have commented on the process of High Risk conferences in Dorset. We have heard that this is a highly resource intensive procedure. The truth of this does not require much

reflection to be appreciated. High level, multi-agency conferences lasting an hour or so for each service user, and involving key professionals, is time consuming and expensive. Our view is that a proper use of these resources would include the consideration and recording of the future management of cases cases that do not achieve high risk categorisation.

49. We were told, that in Dorset it is proposed to hold two-tier risk conferences. At one level risk conferences, or "public protection panels", will consider those considered to present an imminent risk of serious harm and, at another level, those who present a less imminent and serious, but still significant risk. The difference in approach in any particular case will be based on the use of actuarial assessments of risk which are being introduced nationally.

50. Thus, the actual process of risk assessment and management will now be reliant on the dependability of actuarial tools and their application. It follows, in our view, that while this may allow services to proceed with more confidence, there may still be cases, for example, where there have been no past convictions, in which actuarial tools will have a more limited role to play.

51. Furthermore, it is natural that service provision should be based on prioritising those assessed as presenting a high risk. Where, on an actuarial assessment, a person is considered to present a lower risk and, therefore, a lower priority requiring fewer resources, increases in service provision will be dependent on evidence of an imminent risk such as an offence of violence occurring. Finite resources mean that it may be difficult to justify more intensive service involvement if the actuarial data does not identify the person concerned as high risk. The paradox, of course, is that some individuals could be prevented from becoming high risk if more resources could be focused on them before that happens. We have emphasised the need for individual professional judgments to be exercised as an aid to more sensitive decisions about risk and the intensity of service to be provided. (See chapter 18 on Risk Assessments for more detail).

52. Probation services are demand led. If a court makes a probation order, it is incumbent on the probation service to supervise it. More probation orders are being made, there is an increase in the number of violent offenders requiring supervision and yet we have heard that the Dorset area, in what is now the National Probation Service, experienced severe cutbacks in its allocation of resources in 1997. All this means that probation officers are often working with higher than desirable caseloads. This must have had an impact on the capacity to assess and manage risk, and the apparently mechanistic adherence to national standards (1995) which we have noted throughout these inquiries is perhaps a response to this reduction in resources.

Conclusion

53. Overall, we have been impressed by the quality of probation officers and the efforts within this service to deal with difficult clients against a background of the changing expectations of what a probation service must offer. It is now increasingly likely to be the probation service that will be at the cutting edge of supervising dangerous people in the community. We have been told about new proposals within the service aimed at dealing with this changing role and which we consider to be appropriate.

Internal Inquires

54. The scope and effectiveness of internal inquiries was addressed in the Viner report (Dorset, 1996). We endorsed the recommendations made in that report with regard to this issue in the Shane Bath report (para. 32.6), and do the same here.