REPORT OF THE INDEPENDENT INQUIRY PANEL INTO THE CARE AND TREATMENT OF TK

A report commissioned by
Camden & Islington Health Authority

January 2000

Preface

The Panel were requested in March 1999 by Camden & Islington Health Authority to undertake an Independent Inquiry into the care and treatment of TK.

The Panel now present their report to the Health Authority.

Terence Etherton QC
Chairman

Professor Hugh Freeman

Michael Hennessey

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Chapter 1 – Background to the Independent Inquiry

1.1 Introduction

1.1.1 At 7.30am on 22nd April 1997, police were called to a disturbance in Dame Street, Islington, and upon their arrival discovered the near lifeless body of NB, a minicab driver aged 43. NB was taken by ambulance to hospital and was pronounced dead at approximately 8.15am.

1.1.2 On 22nd December 1997, TK was charged at the Old Bailey with the murder of NB.

1.1.3 TK, who was twenty years of age at the time of his trial, had previously been detained in hospital on two occasions under the Mental Health Act 1983.

1.1.4 The Court noted previous offences of possession of an offensive weapon in a public place in 1990 and threatening behaviour in May 1995, as well as common assault in June 1990 and again in October 1990. It also noted a number of offences of dishonesty in the intervening years.

1.1.5 TK pleaded not guilty to murder but guilty to manslaughter on the grounds of diminished responsibility. The Court was presented with two psychiatric reports, both of which concluded that TK was suffering from schizophrenia.

1.1.6 TK was ordered to be admitted to, and detained in, Rampton Hospital under Section 37 of the Mental Health Act. A restriction order was also made under Section 41 of the Act, thereby limiting the circumstances in which he could be released from detention in the hospital.

1.2 Internal Investigations

1.2.1 Following the death of NB, two internal investigations were undertaken. The first was by Islington Council and the resulting report, completed in June 1997, examined the care and treatment of TK by Islington Neighbourhood Services. The second investigation was undertaken by Camden & Islington Community Health Services NHS Trust (C&ICHST), and was completed in August 1997.

1.3 Independent Inquiry

1.3.1 Under the requirements of NHS Executive HSG(94)27 issued in May 1994, in cases of homicide by a mentally disordered person, Health Authorities are required to hold an independent inquiry after the completion of any legal proceedings.

1.3.2 In March 1999, such an inquiry was constituted by Camden & Islington Health Authority concerning the care and treatment of TK. The Members of the Panel were as follows:-

Chair - **Mr Terence Etherton QC** - *Barrister and former non-executive Director of Riverside Mental Health NHS Trust. Chairman of Broadmoor Hospital Authority from 1st July 1999.*

Professor Hugh Freeman - *Honorary Consultant Psychiatrist, Salford Mental Health Trust, Honorary Visiting Fellow, Green College, Oxford, Chairman, Public Policy Section, World Psychiatric Association, and former editor of the British Journal of Psychiatry.*

Mr Michael Hennessey - *former Director of Social Services at Shropshire County Council and Bolton Metropolitan Council, a member of the Steering Committee of the National Confidential Inquiry into Homicide by People with Mental Illness and a lay member of the Parole Board.*

1.3.3 The Terms of Reference of the Panel were to:-

1. Investigate

- the care TK was receiving at the time of the incident on 22nd April 1997
- the suitability of that care in view of his history and assessed health and social care needs
- the extent to which that care corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies
- the exercise of professional judgement
- the adequacy of the care plan and its monitoring by the key worker

- the adequacy of the collaboration and joint working between health and local authority services and other relevant bodies and individuals

2. make recommendations, so that as far as possible in similar circumstances for the future, harm to patients and the public is avoided.

1.3.4 The Panel met on nine occasions, and examined clinical notes, statements, Social Services and Housing files, the two internal reports, previous independent inquiry reports and other relevant material.

1.3.5 During the course of the investigation, panel members interviewed the following persons (listed with reference to their posts/roles at the time of their involvement with TK and not with reference to their current roles):-

Ms JA - Clinical Services Manager, Waterlow Unit, Whittington Hospital

Ms SB – Commissioning Manager, Mental Health, London Borough of Islington

Dr JB - SHO to Dr NH, Whittington Hospital

Ms KC – Approved Social Worker, Islington Social Services

Ms JF - Sister of NB

Ms MF - Social Work Manager for Angel Mental Health Team, London Borough of Islington

Dr NH - Consultant Psychiatrist, Waterlow Unit, Whittington Hospital

Mrs SK, mother of TK

Mr TK

The Metropolitan Police Service

Dr PG – RMO to TK, Rampton Hospital

Mr DS – Director of Mental Health and Learning Difficulty Services, C&ICHST

Dr T, General Practitioner, was invited by the Panel to give evidence but did not do so.

Nurse BL, Staff Nurse on Jaffar Kareem Ward, was invited to give evidence but due to prolonged absence on leave was unable to do so.

Chapter 2 – Events up to 22nd April 1997

2.1 The Life of TK Up to 5th April 1996

2.1.1 TK was born on 16th August 1977. He is the eldest of three children, two years older than his twin brothers. His father was Turkish, and Mrs K is Turkish/Cypriot, born in the UK. TK's father died in a car accident in 1982 when TK was 5 years old.

2.1.2 The family became known to Islington Social Services shortly after the father's death, when Mrs K requested help, wanting her children to be received into care for a period of respite. Places were arranged at a local day nursery. From 1982 onwards, a number of allegations of racial harassment were made by Mrs K, and as a result of this the family moved to a squat for a short period, before moving back home.

2.1.3 In January 1984, the children were received into care for a weekend to offer respite for Mrs K. Later that year the family was placed in temporary accommodation for a short period due to Mrs K's fear of reprisals from the family of a partner of hers who had attacked her with a knife.

2.1.4 In 1985, there was increasing concern about the three children following police reports of them being found wandering alone, and being left by themselves at home for long periods without adult supervision. The children were received into care on a number of further occasions, with Mrs K's agreement.

2.1.5 In 1986, TK and one of his younger brothers were placed into care with a local foster carer. TK remained with her after his younger brother returned home. He moved from there to his paternal grandparents, whilst Mrs K was in Turkey arranging her second marriage. TK did not return to his mother's house until after his new step-father was established in the family. This marriage ended in 1989.

2.1.6 Following requests for a management transfer, the family was moved in December 1987 to a tenancy at 287 Packington Square, Islington, where they remained until April 1997. This was an inner-City area in which there were elements of criminal activity, gangs, violence, racism and deprivation.

2.1.7 Throughout this period, there were ongoing complaints about racial harassment from Mrs K. On one occasion TK was reported to have been involved in a fight with other youths which Mrs K perceived as racially

motivated and used in support of her requests for a transfer out of Packington Square.

2.1.8 During the period around 1990, there are several social work reports of serious disputes between Mrs K and TK, with the Police being called to disturbances and the Emergency Duty Team, Social Services, involved late at night. TK was received into care at the request of both himself and his mother when it was not possible to resolve these difficulties, but would usually return home a few days later. Two of these reports involved alleged incidents of TK fighting with his younger brother with a knife. The Housing and Social Services files indicate that the police perceived these as being part of ongoing family difficulties and did not pursue them further.

2.1.9 TK's attendance and behavioural problems at school had been the subject of concern since primary level. Attempts were made to get Mrs K to attend Child Guidance with him, but without success. From 1989, TK's schooling was characterised by spasmodic attendance and periodic exclusions. He was finally excluded in Easter 1993, but in reality had been out of the educational system for two or three years before that. The numerous attempts made to get him back into the educational system had not been supported by either TK or Mrs K. TK frequently claimed that he was being bullied, whilst school reports observed that TK himself was the bully. These problems were exacerbated by Mrs K's ambivalent attitude to his education. Though assessments showed TK to be of above-average intelligence, his learning had been delayed by irregular attendance and he left school with no formal qualifications.

2.1.10 Throughout this period, there is extensive correspondence on the files of Islington Council, both Social Services and Housing, detailing the affairs of the K. family. The Social Services files describe a slow but steady breakdown in the relationship between TK and his mother, with him becoming increasingly out of control. However, neither Mrs K nor TK appear to have been receptive to efforts to explore conflicts in their relationship; throughout, Mrs K gave conflicting messages about whether or not she wanted him to live with her. Mrs K was in frequent contact with Social Services for a range of support, including a considerable number of requests for financial assistance.

2.1.11 Both Housing and Social Services files make frequent references to TK's capacity for violence. A Social Services entry of 6th June 1991, recording a joint interview with Mrs K and TK following increasing concerns about TK's education, states 'I've never seen a worse relationship between mother and thirteen year old. He constantly verbally abused her ... She told him he was evil, devil, mad, should leave home' and 'my worst fear is that he could harm her'.

2.1.12 In June 1990, TK was convicted of possessing an offensive weapon in a public place and common assault. This marked the beginning of a range of convictions over the coming years, which can be summarised as follows:

Conviction	Number	Period
Offences against the person	2	1990-1997
Offences against property	2	1993-1994
Theft and kindred offences	15	1990-1995
Public disorder offences	1	1995
Offences relating to Police/Courts/Prisons	2	1994-1995
Offensive weapons	2	1990-1995
Miscellaneous offences	2	1993

2.1.13 It has proved difficult for the Panel to establish accurate details of TK's convictions, but the following table has been constructed from the various documents the Panel has examined:-

Date	Conviction
June 1990	Common assault Possession of offensive weapon
October 1990	Theft Common assault Possession of offensive weapon
January 1991	Burglary Theft
October 1991	Going equipped for theft Theft from motor vehicle
November 1992	Taking conveyance without authority
May 1993	Criminal damage Interfering with motor vehicle
July 1993	Interfering with motor vehicle
October 1993	Taking conveyance without authority Driving without insurance Driving whilst disqualified
May 1994	Theft from vehicle Failing to surrender to bail Theft
June 1994	Criminal damage
May 1995	Burglary and theft Theft from motor vehicle Using threatening, abusive, insulting words or behaviour with intention to cause fear or provocation of violence

	Possessing offensive weapon in public place Failing to surrender to custody at appointed time

2.1.13 TK was technically in the care of the local authority some seven times, having been remanded there by the courts on five occasions. He was actually accommodated on three occasions, each time being placed in a children's home. He was also made the subject of a supervision order on three occasions. He did not comply with the terms of the supervision orders and failed to keep in contact with the supervising officers. Because he was in breach of the order, TK was returned to Court in June 1993. As a result of this and other matters, TK was sentenced to three months in a Young Offenders Institution.

2.1.14 During this period, Mrs K tried to get moved from the Packington Estate, claiming racial harassment, and attempted a homeless application on these grounds but this was eventually rejected.

2.1.15 In turn, a number of complaints were also made against TK and other members of the family for anti-social behaviour, including smashing windows, breaking and entry, playing loud music and problems with rubbish disposal. The Council obtained video evidence of TK undertaking some of these activities, but perceived the police to be reluctant to pursue the case with much vigour. In April 1996, Islington Council decided to proceed with an injunction against TK, but by this time he was in hospital.

2.1.16 On 27th May 1993, TK was treated at the Whittington Hospital for punches to the face and said that a screwdriver had been pushed into his ear. He claimed to have been walking along the street when he was kicked and punched by an unknown assailant.

2.1.17 TK's relationship with his mother continued to be volatile and destructive; throughout the files, there are references to Mrs K complaining of feeling threatened and frightened of him, and believing that he was out of control. In September 1993, Mrs K barred TK from the family home, claiming it was forever. TK was placed in Bed and Breakfast accommodation, but in fact returned home intermittently.

2.1.18 Because of concerns about TK's mental state following an appearance in the Juvenile Court for theft, the Bench asked for a psychiatric report and a referral was made to a child psychiatrist. On 21st April 1994, TK was seen and assessed by a consultant psychiatrist. He diagnosed TK as having a moderate psychiatric disorder characterised by depressive, hypochondriacal and obsessional features which would need to be addressed in any attempt at rehabilitation. The psychiatrist felt it was unlikely that his mental state was directly caused by drug taking, but was

more likely linked to the known long-standing disturbance in his personality development. Factors in TK's background such as his family dysfunction and its resultant effects on his upbringing had, the psychiatrist felt, played a significant part in both the development of TK's psychiatric state and the anti-social behaviour for which he was appearing in Court. The psychiatrist concluded that whatever the Court's response to TK's admitted offences, he would require a great deal of supervision in any programme of rehabilitation.

2.1.19 On 21st April 1995 TK visited his GP, complaining of a 'severe head disability' and stating he was unable to work because of the 'pressures of each day'. TK told the doctor he had taken LSD three years previously, and had 'loads of problems', and asked to see a psychiatrist. It is unclear whether a referral was ever made.

2.1.20 In October 1995, TK's case was passed to The Angel Community Care Team from The Angel Children & Families Team. TK was no longer regarded as the responsibility of the latter, as he was aged seventeen years. By then, he was considered a vulnerable adult by Housing Needs, a section of the Housing Department of Islington Council responsible for clients with special needs.

2.1.21 TK's needs were perceived as being primarily related to mental health, and he was therefore referred to The Angel Mental Health Team. TK was interviewed by Ms MF, Social Work Manager for The Angel Mental Health Team, in October 1995. Ms MF did not have a summary from The Angel Children & Families Team on handover. She noted that he 'appeared to have auditory hallucinations to which he responded', and arranged a joint interview with a Duty Social Worker from the Adult Team to assess his mental health and general vulnerability. This took place on 11th December 1995, and concluded that TK needed counselling to work around his feelings and perhaps 'anger management' help from a psychologist. Ms MF concluded that TK needed considerable emotional support to help him establish his life, and noted the need to contact his GP to find out if he had referred him to a psychiatrist.

2.1.22 Also in October 1995, TK made an application for rehousing, claiming to be homeless after being told to leave the family home by Mrs K, and was intermittently in and out of Bed & Breakfast accommodation. The Housing files at this time noted that TK was showing signs of abnormal behaviour, talking to himself loudly and in an aggressive manner, saying he felt like he wanted to beat somebody up.

2.1.23 On 22nd December 1995, TK was transferred to new accommodation, following an incident in which he threatened the manager of his Bed & Breakfast accommodation. A file entry on this date also notes 'He is harassing Asian people - is leading a 'gang' terrorising people'.

2.1.24 On 12th January 1996, a letter was sent to TK saying that although he was defined as homeless, he was not considered to have a priority need for a Council flat.

2.1.25 Also on 12th January, TK again moved to a new address due to 'threats to women' in his Bed & Breakfast accommodation. Apparently, TK had attacked a female resident with a noticeboard, and when her husband intervened, he had been assaulted.

2.1.26 Following this incident, TK was interviewed by Ms MF and Mr VL (Housing Needs Manager). In the interview, TK asked for self-contained accommodation away from people. He spoke about 'stabbing him in the stomach' in relation to a person he thought had said something outside his door. The file note of this interview records 'Discussion with Ms MF - TK appears not quite sectionable at the moment ... decide to try and identify male-only hostel ... and also to arrange urgent appointment with psychiatrist'. A male-only hostel was identified, but TK in fact returned home to his mother. The Mental Health Team offered him another appointment, which he did not keep, and a decision was made on 21st February 1996 to take no further action until there was contact from TK or another agency.

2.1.27 In March 1996, TK again presented as homeless, but on this occasion he was assessed as not being homeless.

2.1.28 On 5th April 1996, TK went to the Accident & Emergency Department of the Whittington Hospital and reported that he was feeling depressed and hearing voices. He was seen by the Duty Psychiatrist and admitted to the Waterlow Unit as an informal patient.

2.2 First Admission to the Waterlow Unit – 5th April 1996 to 8th July 1996

2.2.1 The Waterlow Unit, based on the site of the Whittington Hospital in Archway, North London, comprises three wards for psychiatric patients. All inpatient wards are mixed-sex. Mental Health Act Commission visit reports of 1996 noted concerns about pressure on beds, the general environment and mixed-sex wards.

2.2.2 At the time of TK's admission to Jafar Kareem Ward, the Unit was under extreme pressure, and bed occupancy on this ward in March 1997 was 118%. The ward also suffered from nurse recruitment problems, with ten nursing vacancies out of a total establishment of thirty, and vacancies

covered by agency staff. This is typical of many inner-city acute psychiatric wards.

2.2.3 Dr NH told the Panel that approximately two-thirds of the patients suffered from schizophrenia and that three-quarters were detained under Section 3 of the Mental Health Act 1993. Dr JB noted that there were many very ill psychotics, the majority being young males, nearly all of whom had problems with drugs and a percentage with criminal behaviour.

2.2.4 Ms MF and Ms KC gave their impression of Jafar Kareem Ward at the time as being under pressure. They referred to detained patients frequently absconding, high use of agency nurses, no consistent ward manager, drugs taken on the ward, and female patients intimidated by male patients.

2.2.5 Two Consultants had beds on Jafar Kareem Ward, Dr NH being responsible for the North Islington sector with a catchment population of around 32,000. He had one SHO working with him, but no Specialist Registrar or other doctor.

2.2.6 On admission, TK reported feeling 'demented' and said that people were watching him, wanting to kill him. He said that he could not sleep, was very tense and could not find peace. He was prescribed chlorpromazine and procyclidine.

2.2.7 On 6th April 1996, TK tested positive for cannabis.

2.2.9 TK left Jafar Kareem Ward on 7th April, against the advice of nursing staff. He apparently returned home to his mother. A report by Mr PL, Social Worker, Emergency Duty Team, dated 7th April 1996, relates a discussion with Dr P (SHO to Dr NH at that time), who said that TK was 'completely psychotic, experiencing persecutory and grandiose ideas. He has talked about having a need to beat women and poses a real risk to them ... he had been uncooperative on the ward and had refused medication.'. Dr P had examined TK and had asked that he be put on Section 5(2) of the Mental Health Act if he attempted to leave the ward.

2.2.10 Mr PL also spoke to the local police, who stated that TK was well known to them and had often been extremely violent and that they 'would not contemplate making a visit for a mental health assessment without six or eight officers with riot shields'. The policeman commented that 75% of the time, TK was perfectly reasonable, but that at other times he was quite likely to attack people violently who annoyed him, and advised against visiting without a police presence.

2.2.11 Dr P's medical recommendation for detention under the Mental Health Act noted that TK had 'aggressive thoughts, feelings and tendencies towards women' and that 'he is impulsive and could lose control. He is at risk for himself and others.'. TK returned voluntarily to the Ward on 9th April 1996 when he was detained under Section 5(2) of the Mental Health Act. This was followed by detention under Section 2 of the Act.

2.2.12 On 11th April 1996, TK set off the fire alarms and in the resulting evacuation he absconded, but returned after a few hours.

2.2.13 On 12th April, Ms KC and Mr SL, Approved Social Workers from The Angel Mental Health Team, visited TK on the Ward. They spoke to Dr P, and gave him more background information on TK from Social Services files. They saw TK with his mother present, and TK talked about events leading to his admission. He stated he had been feeling very depressed and had been experiencing aggressive/frustrated feelings about women. He noted that he had been taking medication since arriving and felt that this was making him 'less deluded'.

2.2.14 Dr NH returned from annual leave on 18th April and this was the start of his involvement with TK.

2.2.15 During TK's admission, the nursing and clinical notes indicate that his behaviour fluctuated markedly, but that he gradually settled down. He absconded again on 20th April, but returned later to the ward. He attended ward community meetings and went to occupational therapy. By 26th April, the Occupational Therapist reported that he was able to engage in longer and more complex activities. The Occupational Therapist referred him to the Day Hospital for post-discharge support. However, TK did not turn up for this appointment and did not respond to the follow-up letter.

2.2.16 TK was discussed at a ward round on 2nd May 1996. It was noted that previous delusions were no longer being mentioned. TK was taking his medication, but it was noted that he could still be quite hostile and critical towards hospital staff.

2.2.17 By 3rd May, TK had improved sufficiently to be allowed one hour a day unescorted leave under Section 17 of the Mental Health Act.

2.2.18 Nursing notes from this time point to him keeping a low profile, having limited interaction with nursing staff and presenting no particular management problems.

2.2.19 Dr NH on 9th May 1996 that TK was 'Relaxed ... no longer has violent fantasies ... no skills, determined to improve himself. Allow Section 2 to lapse and refer to Day Hospital'. TK's Section expired on 12th May 1996 and he agreed to stay as an informal patient.

2.2.20 At a ward round on 23rd May, Mr SL, Approved Social Worker, acknowledged the need to start making plans for TK's discharge. It was agreed to invite Mrs K to the ward round the following week to discuss the situation, but she failed to attend.

2.2.21 On 26th May, TK said he was feeling better and that his preoccupation with illness had stopped. He denied paranoid ideas and expressed interest in getting a job. He asked to be discharged, saying he was missing his home and family.

2.2.22 At the ward round on 6th June, TK said he felt he was ready for discharge. It was noted that nursing staff had made a referral to Southwood Rehabilitation Hospital for TK. Mrs K and TK were both at this ward round, and housing options were discussed. Mrs K was at this time in Bed & Breakfast accommodation, as a result of claiming racial harassment on the Packington Estate. TK expressed an interest in Sunnyside Road, a twenty-four hour supported medium-term hostel provided by Islington Council. Mrs K did not want TK to stay at Southwood Hospital or at St Mungo's Hostel, which is supported accommodation. Instead, she wanted him to return home with her. TK, with the support of his mother, later discharged himself against medical advice. He did, however, return to the ward in the evening.

2.2.23 On 20th June, 1996 Ms KC, an experienced Approved Social Worker, was allocated as the social worker for TK's case.

2.2.24 On 25th June, Ms KC visited TK on the Ward. TK stated that he wanted to be discharged, agreed to take medication when out of hospital and asked to move into Bed & Breakfast accommodation until his mother was rehoused. TK also talked about his fears of living on the estate, and how he felt himself to be in danger. He asked for continuing support from social workers after discharge from hospital.

2.2.25 On 27th June 1996, a pre-discharge Care Programme Approach (CPA) meeting was held.

2.2.26 Ms KC was named as key worker. At the meeting, the possibility of discharge and transfer to a hostel was discussed. Sunnyside Road was suggested. Ms KC agreed to arrange Bed and Breakfast accommodation as an interim measure while negotiating a move to Sunnyside.

2.2.27 The care plan, which was undated, placed TK on Level 2 of the CPA. The diagnosis was drug-induced psychosis and personality disorder; against the category of risk there was listed 'agitation and ideas of persecution'; and TK's risk behaviour was detailed as 'aggressive lifestyle on the criminal fringes of society'. The care plan had three elements:-

1. Attend Dr NH's out-patient clinic two weeks after discharge

2. Social Services to arrange Bed & Breakfast accommodation as an interim measure, with a view to referring him to Sunnyside Road

3. Referral to the Day Hospital.

The medication details were completed (chlorpromazine 100 mg & 150 mg nocte, procyclidine 5 mg BD), and the form was signed by TK and Dr NH (but not by Ms KC).

2.28 A discharge summary was completed by Dr P on 9th August 1996, noting the date of discharge as 8th July 1996. Diagnosis was drug-induced psychosis/personality disorder.

2.29 TK was discharged on 8th July 1996.

2.3 Care in the Community – 8th July 1996 to 29th October 1996

2.3.1 Upon discharge, TK went to The Angel Neighbourhood Office of the Local Authority and was booked into Bed & Breakfast accommodation by the Housing Needs Section.

2.3.2 Ms KC made a referral to Sunnyside Road and booked a visit for 15th July. A transport requisition for this journey, completed by Ms KC and authorised by Ms MF, states that 'Client could be potentially violent. Help facilitate long term placement at Sunnyside Road'.

2.3.3 On 22nd July 1996, Ms KC met TK, who informed her that he was no longer interested in Sunnyside Road. After this meeting, she noted 'It seems to me that his mental health is already deteriorating. He appears to be very stressed up. Possibly responding to voices as he consistently had this grin on his face. He admits to not taking his medication. Did not feel that they were helping him.'.

2.3.4 Later that day, TK had his first out-patient appointment with Dr NH, who noted that TK was living in Bed & Breakfast accommodation and that the visit to Sunnyside Road had taken place. TK stated that whilst he had liked Sunnyside, he did not want residential accommodation. Dr NH noted that TK stated he was not taking any illicit drugs but was taking his

medication (although Ms KC had noted earlier that day that TK had ceased his medication). Dr NH wrote to TK's GP, notifying him that TK was no longer interested in Sunnyside Road, but that he had advised him that he would receive more support there. A further out-patient appointment was made for 23rd September 1996, but this was cancelled due to Dr NH's absence on annual leave. The rescheduled appointment was arranged for 7th October 1996, but this was cancelled due to Dr NH's need to delay the start of his holiday because of the difficulties of arranging cross-cover. A further appointment was made for 2nd December, by which time TK had been readmitted to the Waterlow Unit.

2.3.5 On 8th August, TK visited his GP and the notes record that he had returned home to live with his mother. TK made this visit because of his belief that the medication prescribed on discharge was preventing him from sleeping. The GP notes record that TK had stopped taking the chlorpromazine and that he was saying he had voices in his head which made him 'restless'.

2.3.6 TK did not attend further GP appointments on 14th August and 16th August. On 22nd August, TK visited his GP after being assaulted and suffering bruising to the head. He visited again on 30th August and was seen by a locum GP. TK complained of insomnia and agitation. The locum noted that TK was 'agitated' and still not taking the chlorpromazine; he was given a repeat prescription.

2.3.7 On 29th August, Ms KC wrote to TK offering an appointment for 2nd September, but TK failed to attend.

2.3.8 On 3rd September 1996, Ms KC noted a telephone call from the locum GP who had seen TK on 30th August. The locum was concerned because TK had not attended his appointment that day and was possibly continuing not to take his medication.

2.3.9 On 17th September 1996, Ms KC again wrote to TK offering an appointment for 20th September, which TK failed to attend.

2.3.10 TK saw his GP again on 27th September, and then on 10th October. His principal concerns then appear to have been related to his ability to function sexually and continuing insomnia.

2.3.11 On 1st October 1996, a report from Mr PL, of the Emergency Duty Team, to the Mental Health Team detailed a telephone call from Mrs K, stating that TK was not taking his medication. He had smashed furniture, and two days before had thrown washing down and ground his heels into it. He was talking incessantly to himself, was up all night screaming, was deluded that men were in his room talking to him, had smashed all the coffee cups, and cut his mother's hand when she tried to control him. He had been sexually disinhibited in his abuse to her.

2.3.12 Ms KC tried to contact Mrs K by telephone, but being unable to do so, wrote to her on 2nd October asking her to call in at the office to discuss any problems.

2.3.13 Housing interview records of 5th October 1996 note that TK had come into the office stating that he had argued with Mrs K and been removed from the house by Police. TK claimed to have a 'mental imbalance'. The Duty Social Worker was called and agreed TK needed to be seen by the Mental Health Team. Mrs K stated she would only allow TK back into the house to collect his clothes if there was a police escort.

2.3.14 The following morning, TK informed Housing staff that he had not gone to the reception centre that he had been advised to, and had instead stayed in an empty squat. New temporary accommodation was arranged. The file note reports that TK 'was heard by other staff to be talking to himself loudly and in an aggressive manner ... then jumped up saying he felt like beating somebody up.'.

2.3.15 On 15th October, Ms KC was contacted by the out-of hours drop-in service at 18 Highbury Grove, who were concerned about TK's mental state and felt he needed follow-up support. As a result, Ms KC wrote to TK offering an appointment for 18th October but TK did not attend, nor did he attend a further appointment for 21st October.

2.3.16 On 28th October, TK again visited his GP complaining about insomnia. TK denied drug use apart from 'occasional cannabis'.

2.3.17 Also on 28th October, Ms KC received a further call from Highbury Grove saying that TK now appeared to be extremely paranoid, saying that cameras were chained to him. He was more aggressive and angry, talking about taking revenge on women.

2.3.18 As a result of this conversation, Ms KC telephoned TK and asked him to come into the office, which he did. In her notes of the interview that followed, she noted that 'He told us he was thinking about bad ways towards people. Feeling aggressive and angry towards people.'. At the end of the interview, she telephoned TK's GP, and made an appointment for him for that evening. TK attended the appointment and was given a repeat prescription of anti-psychotic drugs and a prescription for temazepan. The locum GP also wrote to Dr NH on 5th November expressing his concerns about TK.

2.3.19 On 29th October, Ms KC received a telephone call from Mrs K, saying that TK had been arrested at 2.00am in connection with the theft of a motor vehicle. TK had two screwdrivers on him when arrested.

2.3.20 TK was seen by the Forensic Medical Officer (FME) who said that he was not mentally ill. Ms KC visited TK in police custody, and was present during an examination by a different FME. TK was detained under Section 3 of the Mental Health Act and for a second time was admitted to the Waterlow Unit.

2.4 Second Admission to the Waterlow Unit - 29th October 1996 to 9th January 1997

2.4.1 There were no free beds on Jafar Kareem Ward, and so TK was initially admitted to Samuel Coleridge Ward, also part of the Waterlow Unit. On admission, he was noted to be suffering paranoid delusions and psychotic ideation. He was started on anti-psychotic treatment, and it was noted that he had been 'non-compliant with medication and services.'.

2.4.2 At 10.00pm on 4th November, TK absconded from the ward and went to Sunnyside Road, requesting a crisis bed. He was returned by the Police.

2.4.3 On 6th November 1996, TK set off the fire alarms on the Ward by holding lighted paper under the alarm. He absconded when the doors were opened.

2.4.4 Also on 6th November, he tested negative for cannabis.

2.4.5 TK was transferred to Jafar Kareem Ward on 8th November 1996 under the care of Dr NH, at which time he was found to have a large amount of cannabis resin on him, as well as pornographic magazines. It was noted that he displayed disturbed behaviour and suspicious ideas about his social worker and felt that people were talking about him.

2.4.6 On 10th November, TK was placed on a high-dependency nursing regime following an assault on a fellow patient. Nursing notes record the reason as being 'displaying sexually inappropriate behaviours and being physically aggressive and intimidating towards patients'.

2.4.7 TK tested positive for cannabis on 11th November.

2.4.8 On 12th November, Ms KC telephoned the ward, to be informed that TK had absconded. TK went home for a few hours and then returned to the ward.

2.4.9 On 14th November, it was noted that TK was being sexually disinhibited towards women on the ward.

2.4.10 On the same day, Ms KC visited TK on the ward to prepare a report for the Mental Health Review Tribunal, as TK was appealing against his section. TK refused to speak to her in any detail.

2.4.11 Extra-dependency nursing was discontinued on 25th November, when TK's mental state was felt to be more stable.

2.4.12 On 5th December 1996, there was a meeting pursuant to Section 117 of the Mental Health Act. Section 117 requires health and local authorities to provide after-care services for persons who have been detained in hospital under Sections 3, 37, 47 or 48 of the Act, until they are jointly satisfied that this is no longer necessary. Present at this meeting were Ms KC, the primary nurse, Dr NH, and TK. Mrs K had been invited, but did not attend. At this meeting, TK admitted he had taken cannabis, which he claimed helped him relax and suppressed his unpleasant thoughts. TK asked for home leave and Dr NH agreed, providing he had a urine test on his return. TK asked to be again considered for Sunnyside Road. The plan, written by his primary nurse, was recorded as 'Weekend leave agreed - Sat/Sun. Assess. If successful increase. Agreed supply urine sample on return. Requesting his own flat. But Ms KC apply hostel accommodation (Sunnyside Road). Monitor sleep pattern. Medication reviewed. Attend OT activities.'.

2.4.13 On 9th December, Ms KC telephoned Mrs K who confirmed there had been no problems over the weekend visit, but stated she did not believe TK was ready to leave hospital yet.

2.4.14 On 12th December, TK was reviewed in a ward round by Dr NH. It was noted that he was more co-operative during interview than he had been earlier in his admission. He denied auditory hallucinations and asked for further home leave. Plans were made to increase his periods of leave, with a view to discharge if these went well.

2.4.15 Ms KC's Mental Health Review Tribunal report, dated 13th December 1996, recorded 'Mr TK is reluctant to accept that he has a mental illness and has little insight into his condition ... He agreed to take his medication when he is discharged from hospital and said he realised now he cannot cope in the community without support.'. She concluded 'It seems clear that Mr TK may not co-operate with the care plan once in the community. There appears to be a lot of unresolved issues between him and his family. It seems unlikely that he would be willing to give up his illicit drug use. If this pattern of behaviour continues, it would seem inevitable that Mr

TK will end up in a pattern of going in and out of hospital. However, I will endeavour to work with him to look at and provide him with the support he needs.'.

2.4.16 On 23rd December, Dr JB (SHO to Dr NH from September 1996) reviewed TK on the ward. TK had just returned from leave and said that it went well. He was talkative and described an incident in which he alleged he had stolen a car, driven away at high speed and hit a pedestrian. TK stated that he thought he might have killed her.

2.4.17 On 2nd January 1997, a urine test was positive for cannabis. TK was counselled by doctors and nurses about his behaviour.

2.4.18 On 6th January, TK again set off the fire alarms, leading to the ward being evacuated.

2.4.19 On 7th January, Ms KC again visited TK, who reported feeling a lot better. He stated that he had been home over Christmas and Dr NH had said he could be discharged later in the week. He said he still wanted to go to Sunnyside Road, and wanted to stay with his mother until a place became available. He did not want to go to Southwood Hospital. Ms KC prepared a Community Living Assessment Statement of Need, concluding that TK needed a community facility which provided twentyfour-hour on-site staffing and support.

2.4.20 TK tested positive for cannabis on 7th January 1997.

2.4.21 Nursing notes of 7th and 8th January report continuing concerns about sexually disinhibited behaviour. The clinical record of 7th January states 'sexually disinhibited ... would seem to be personality in origin rather than psychotic or organic. Not willing to go to Southwood. Social worker happy for discharge. She will visit at home and discuss Sunnyside Road with him as an out-patient.'.

2.4.22 Ward round notes of 8th January 1997 (contained in Social Work files) state 'Ms KC ... has booked slot on Referral Allocation Group Panel for Sunnyside (though waiting list full). Ms KC considers that B&B will lead to rapid relapse.'. The Referral Allocation Group was the method of referral to Sunnyside Road. Ward round notes of 9th January 1997 state 'SW (Social Worker) happy with discharge'.

2.4.23 A pre-discharge CPA meeting was held on 9th January 1997. TK's address was recorded as 287 Packington Square, the Consultant was recorded as Dr NH and the key worker as Ms KC. The form was dated 9th January, and TK was again placed on Level 2. The date of next review was 'To be arranged by key worker'. The diagnosis was given as 'personality disorder, drug-induced psychosis', and the risk category was

'drug taking'. Risk behaviour was described as 'sexual disinhibition and aggressive talk'.

2.4.24 The three steps in the care plan were specified as:-

1. To attend Dr NH's out-patient clinic two weeks after discharge (nurse responsible for making appointment)

2. To work with Social Services towards placement at Sunnyside Road - to be put before the RAG next week (Ms KC to action)

3. Will look into attending Day Centre (probably Corsica Street) with advice from Ms KC

The medication was risperidone 4 mg BD. The form was signed by Dr NH and TK, but not by a social worker. Ms KC stated to the Panel that she was not present at this meeting, and a colleague attended in her place. She did, however, become aware of the care plan on 14th January 1997, when the Social Services file records that she received a copy.

2.4.25 Nursing notes of 9th January state 'Seen and discussed in ward round. Had CPA meeting. Discharge from Section 3 ... Copies of CPA sent to carers. Discharged to home address.'.

2.4.26 There is no copy of the care plan in the GP notes, and no discharge summary in any of the files or notes, although Dr JB stated to the Panel that one was dictated and passed to secretarial staff for typing. On the other hand, a Court Report produced by Dr JB was in the medical notes. This had been produced following a request from TK's Solicitors in connection with a charge against TK for breaking into cars.

2.4.28 On 9th January 1997, TK went home to his mother.

2.5 TK's Discharge into the Community – 9th January 1997

2.5.1 On 14th January 1997, Ms KC attended the Referral Allocation Group (RAG) for Sunnyside Road, which was the appropriate referral method for Sunnyside. The outcome of this was that the RAG did not feel that Sunnyside Road was suitable, as TK was still very young and because of his drug habit, and in any case, the waiting list was closed. The RAG put forward two alternative suggestions - Richmond Fellowship and Barnsbury Road.

2.5.2 Also on 14th January 1997, Ms KC received a copy of the care plan, listing her as key worker.

2.5.3 According to the care plan, TK should have been given an appointment with Dr NH two weeks after discharge. The internal inquiry report conducted by C&ICHST concludes that 'there is no evidence of any outpatient appointment being booked. The recall of the nurse allocated with the task of arranging the appointment is that he made the appointment but there is no written record.'. The Panel have not felt able to reach a conclusion as to whether or not an appointment was booked and, if not, whose fault that was. Whatever went wrong with this part of the care plan, TK was not again seen by Dr NH after his discharge into the community.

2.5.4 On 6th February, TK saw his GP complaining that he was not sleeping. He was prescribed temazepan. The following day, TK apparently took an overdose and an ambulance was called but he refused to be taken to hospital.

2.5.5 On 13th February, Ms KC sent a letter to TK asking him to attend for an appointment on 18th February. He did not attend.

2.5.6 At some point in March (no specific date recorded in the file), Ms KC saw TK in the street. She called out to him, but he ignored her and walked away.

2.5.7 At one point during the night of the week 7th to 13th April, TK came onto Jafar Kareem Ward at approximately 12.30am requesting admission. At the time, he appeared dishevelled and agitated. He was advised by staff to present himself at the Whittington Hospital Accident & Emergency Department, which could arrange for admission if needed. TK left the ward five minutes later and there is no record of him ever having attended Accident & Emergency. The Senior Nurse was verbally informed of the event, but no written record was made.

2.5.8 On 7th April, Ms KC sent a further letter to TK stating she would be happy to visit him at home on 11th April, and asking TK to confirm this would be convenient.

2.5.9 On 10th April, Ms KC again saw TK in the street. She noted that he looked clean but in distress. She called out to him, and TK shouted back and swore at her.

2.5.10 As a result of this second sighting, a home visit by Ms KC was arranged for 11th April, together with Ms MF. When they arrived, they pressed the intercom and were informed by a young man's voice that TK was in bed.

They then spoke to a woman, explained they were social workers, and asked to be let in. The door was buzzed open and they went upstairs to knock on the door. TK opened the door wearing a tee-shirt and shorts. He kept repeating that they could not come in and that they should go away, became increasingly agitated, and then closed the door on them. As they walked away, TK opened the door again and swore at them.

2.5.11 Ms MF and Ms KC discussed the situation, and a decision is noted on the file that Ms MF would discuss TK at the next referral meeting with Dr NH. They said to the Panel that they decided to contact Dr NH, but were informed that he was just about to go on two weeks' study leave, and they decided to wait until his return before taking any action. Dr NH states that he was not contacted before he went on leave, nor was he made aware of any attempt to do so.

2.5.12 In the evening of 11th April 1997, TK arrived by ambulance at the Accident & Emergency Department at the Whittington Hospital and was assessed by a nurse at 11.37pm. He had caused a disturbance and damage to his mother's house and Mrs K had called an ambulance. The Accident & Emergency notes state 'Patient did not want to stay in department. I advised him that he was going to be seen shortly but he did not want to wait. 12.30pm not in cubicle.'. The triage nurse assessment reads '19 year old known psychiatric patient destroyed mother's house this p.m. Not eating, not taking meds. blaming mother for condition. Very violent at intervals. Not maintaining eye contact, looking at floor, answering questions with short curt answers.'.

2.5.13 TK was not seen by any doctor or anyone from the psychiatric services. He returned home two hours after the ambulance was called.

2.6 The Incident – 22nd April 1997

2.6.1 On 22nd April, the police arrested TK in connection with the death of NB from stab wounds. TK was examined by two forensic psychiatrists and was assessed as fit to appear in court. He was charged with murder and remanded to Feltham Young Persons Institution.

2.7 Post-Incident

2.7.1 At a meeting on 25th April 1997 between Dr ST (Medical Director), Dr JD (Head of Medical Services), Mr PW (Personnel Manager) and Dr NH, it was agreed to suspend Dr NH from duties whilst an internal investigation was completed. This was not intended as a disciplinary act or to imply misconduct. Dr NH was released from his duties whilst receiving full pay.

2.7.2 On 15th May Dr NH tendered his resignation, which was accepted.

Chapter 3: The Findings of the Independent Inquiry

3.1 Diagnosis

3.1.1 A different diagnosis of TK's condition was made at his trial from that made at the time of his discharges from the Waterlow Unit. The Panel therefore felt it appropriate to consider whether Dr NH was justified in reaching his diagnosis of personality disorder and drug-induced psychosis, and also whether it would have made any difference to the tragic outcome of events if a diagnosis of schizophrenia had been made on discharge.

3.1.2 Dr NH states that at the time of both admissions to the Waterlow Unit, TK exhibited psychotic symptoms. These lasted about four weeks on his first admission and two weeks on the second. What he believed he saw subsequently were the effects of drug taking, with TK becoming sexually disinhibited and describing bodily distortions. TK was seen smoking cannabis on the ward, and presented with symptoms of cannabis use - psychosis of medium-term duration that cleared during treatment, followed by intermittent periods of cannabis intoxication lasting three to four hours. Because the psychotic symptoms on his second admission were of shorter duration, Dr NH believed he was seeing the tail-end of a drug abuse episode.

3.1.3 TK's management whilst on the Waterlow Unit was based on what was known of him by the medical team prior to the fatal incident. He was perceived as a young man with a history of delinquency and drug taking within a criminal sub-culture. Dr NH believed his problems were compounded by a drug-induced psychosis, continued drug taking whilst an in-patient, and variable compliance with anti-psychotic medication. TK described third-person auditory hallucinations and hyponchondriacal delusions, which were consistent with a diagnosis of drug-induced psychosis. It was also noted that TK had been emotionally deprived as a child, and that his behaviour reflected a personality that was significantly disturbed. Personality disorder therefore formed the second axis of the diagnosis. Dr NH agreed that in the longer term, it might well have been necessary to consider a diagnosis of schizophrenia.

3.1.4 On TK's second admission, he initially reported that people were watching him and that there were cameras in his flat. There was also evidence of delusions regarding the radio and television. His diagnosis remained one of drug-induced psychosis, and at one point, a large amount of cannabis was confiscated from him. Whilst on the ward, TK's behaviour was erratic; he complained of bodily distortion typical of ongoing cannabis abuse and appeared to be talking to himself at times, but

consistently denied other psychotic symptoms. Throughout his stay on Jafar Kareem ward, TK would bully and sexually harass other patients, and was verbally abusive to the ward staff. He was not, however, physically violent, other than pushing a patient on one occasion.

3.1.5 Dr NH states that by the time of his discharge, his behaviour had become less bizarre and more co-operative. His personality difficulties remained in evidence, and his diagnosis was therefore personality disorder with episodes of drug-induced psychosis.

3.1.6 At no stage while under Dr NH's care did TK express homicidal thoughts. Dr NH's aim was to monitor him regularly as an in-patient, and then, through the care programme, to provide community care which would help him improve mentally, achieve social stability and become less disruptive generally.

3.1.7 Dr NH stated that he certainly did not expect TK to commit murder and that, on the basis of knowledge available to him, it would not have been possible to predict the offence.

3.1.8 The Panel considers that Dr NH and the staff team had taken appropriate measures to assess TK's mental state and to arrive at a working diagnosis of his condition. The Panel's view is that on the evidence available to Dr NH and his team, a reasonable view was adopted of TK's medical condition. A diagnosis of personality disorder with drug-induced psychosis did not preclude a later diagnosis of schizophrenia.

3.1.9 On the basis of the facts available, the Panel has no criticism to make of Dr NH's judgement in relation to diagnosis.

3.2 Risk Assessment

3.2.1 The internal inquiry report prepared by C&ICHST states that 'The panel believe that it is important to state at the outset that we are agreed that there was nothing in TK's history that could have predicted that he would have committed such a crime of violence. The [members of the internal inquiry] believe that the most reliable predictor of future violence is past violence and noted that TK did not have a past conviction for any serious violent offences.'.

3.2.2 The Panel accept that the best predictor of future violence is past violence. In other words, the assessment of risk that patients pose is linked to their history, particularly any aggressive or threatening behaviour, as well as their current mental state.

3.2.3 The Panel acknowledge that risk assessment is a difficult and inexact process and it is therefore important not to expect more than is reasonable, taking into account the circumstances and standards in place at the time. At the time of the incident, risk assessment on the Waterlow Unit had not been formalised as a procedure, though staff were using such principles in their work.

3.2.4 The Panel considered what information was available to ward staff about TK's potential for violence. At the ward round on 18th April 1996, a record was made of the social work presentation of TK's background. His forensic history was noted as stealing cars, criminal damage and burglary. The ward staff therefore felt that his violence was mostly directed at property, as they had no knowledge of a background of offensive weapons and assault.

3.2.5 On Jafar Kareem Ward, TK's violence was limited to one incident of pushing another patient. He did not stand out as being particularly violent, and ward staff did not feel that he posed any special risks.

3.2.6 The Panel noted that at one point during his admission, TK had talked to Dr JB about an incident when he alleged he had stolen a car and hit a pedestrian as he drove away, and TK believed that he may have killed her. Dr JB said to the Panel that, in this conversation and others, TK made statements that were possibly in keeping with an anti-social personality disorder. The incident as described did not strike her as necessarily being true, and she recalled that there had been a lot of bravado in this conversation. She had, however, been sufficiently concerned to repeat the details of the incident to Dr NH.

3.2.7 Social Services staff had more information about TK at their disposal, but this was contained in a variety of files from different sections, and no appropriate summary was available to either Ms MF or Ms KC when they took the case over.

3.2.8 In their thinking about TK, both Ms MF and Ms KC stated that they considered him as one of the more, but not the most difficult of their clients. His potential for violence was primarily considered in terms of safety issues for social services staff - it was decided that Ms KC should always be accompanied if visiting him at home, and if TK came into the office she would ask someone to keep an eye on him.

3.2.9 On the basis of the facts actually known to Dr NH, we consider that the decision to discharge TK and the level of risk specified for the purpose of the CPA were not unreasonable. However, more information about previous incidents of violence was available within the Local Authority

files, and if it had been accessed and shared between Social Services and the medical team, a different approach might have been taken.

3.3 Sharing of Information

3.3.1 In studying the files from Social Services and Housing, a picture is built up of an increasingly disturbed young man, with a number of convictions and a lifestyle indicative of a capacity for violence.

3.3.2 The essentials of this information were available in Social Services, Housing and in particular Youth Justice files, which indicated a greater level of violence than the medical team were aware of.

3.3.3 The Panel are aware of at least seventeen files relating to TK in the possession of Islington Council, the majority of which were Social Services and Housing. These files were previously dispersed between a number of different sections of the Neighbourhood Services Department, and collected together for the purpose of the two internal inquiries. The Panel had the advantage of oversight not available to Social Workers or Dr NH at the time of his psychiatric care.

3.3.4 Both Social Services and Dr NH indicated that if they had had a fuller picture, they might have responded differently to the management of TK on discharge from the Waterlow Unit.

3.3.5 Some previous violence was known to the medical team but, in this respect, TK was similar to other patients on the ward. Only with access to the full contents of Social Services and other Council files, as well as forensic records from the Police, could ward staff have had their best chance of making an accurate assessment of risk and deciding on optimal management. The Panel do, however, acknowledge the difficulties experienced by staff in gaining prompt information from other relevant agencies and in particular in gaining access to criminal records.

3.3.6 Dr NH told the Panel that if he had been aware of any previous convictions for assault, he would have considered a Level 3 discharge, which applies to patients who present a serious risk to themselves or others and require a high level of supervision in the community. He might also have considered a supervised discharge, which indicates that the patient is, or is liable to be, at significant risk of serious harm to themselves or others.

3.3.7 In terms of Social Services, Ms MF stated that she did not know TK had convictions for possessing offensive weapons and for assault. If she had known, she might have allocated TK's case to a different social worker

who had experience of working with young people with a history of offending. The key worker might have followed him more closely in the community.

3.3.8 Ms KC states that she did not read all of the old TK files available to her, and this is regrettable in that a number of opportunities for a greater understanding of TK's capacity for violence were thereby missed.

3.3.9 There were plenty of opportunities for sharing of information. A ward round was held every week and social workers would attend on a three-monthly rota basis. Additionally, Ms MF would attend meetings with Dr NH every Tuesday morning to pass on concerns about any patients in the community. If there was a CPA or Section 117 meeting, the named social worker was invited to it. The Panel considers that the necessary mechanisms were in place for the two-way passage of information.

3.3.10 The Panel have come to the conclusion that the co-ordination of Local Authority files and appropriate sharing of information, both within the Local Authority and between Social Services and health services, were not adequate. If they had been, this would probably not have resulted in a longer stay in hospital. It would, however, probably have made a difference in terms of better community supervision.

3.4 Discharge and Sexually Disinhibited Behaviour

3.4.1 The C&ICHST Internal Inquiry Report concluded that TK was 'discharged in part because he was a disruptive influence on the ward and not solely because it was felt to be an adequate time to release him'.

3.4.2 The Panel do not support this view.

3.4.3 Ms MF expressed surprise that TK had been discharged so soon and put it down to pressure on beds, noting 'as soon as patients were settled they wanted them back in the community.'

3.4.4 Undoubtedly there was a pressure to move people out into the community, given that there were a number of patients in costly private beds waiting for admission and others in the ward waiting to move into sheltered accommodation in the community. We do not, however, consider that this played a significant part in either of TK's discharges.

3.4.5 In the days preceding discharge, TK had been demonstrating sexually disinhibited behaviour. The Panel considered whether this should have delayed TK's discharge.

3.4.6 In responding to this, Dr NH noted the relevance of TK repeatedly taking disinhibiting drugs, in particular cannabis. TK was not committed to stop taking cannabis and a longer admission was not considered at all likely to change this. TK's sexual disinhibition was judged by Dr NH to be secondary to taking cannabis, the effects of which lasted about three hours. TK's pattern during his second admission was of sustained psychotic symptoms at the beginning, which then resolved. However, they were followed by other times when he would suddenly become very disturbed or sexually disinhibited for a short period. Following this, a cannabis test would come back positive. As such, Dr NH ascribed the incidents of sexual disinhibition to the short-term effects of cannabis use, rather than a recurrence of his drug-induced psychosis.

3.4.7 The Panel consider that neither of TK's discharges was inappropriate, and reject the suggestion that he was discharged because he was a nuisance on the ward or directly because of pressure on beds. Dr NH considered that TK was no longer psychotic and had stabilised in terms of his mental health. To have kept TK much longer on the ward would have served no useful purpose. In considering TK's discharge, Dr NH relied heavily on the knowledge that a key worker was in place whose responsibility it was to relay any possible concerns about relapse to the medical team, who could then act as appropriate.

3.5 Out-Patient Appointment

3.5.1 In our inquiries, we built up a picture of TK's increasing disturbance once he had been released into the community. One potential safety valve that failed was the action in the care plan for an out-patient appointment with Dr NH two weeks after his release.

3.5.2 In interview, Dr NH said that usually the system worked better, with a number of checks in place to ensure arrangements were made, including a pre-discharge checklist for nursing staff to complete, which would be checked by the ward manager. If, however, an appointment had slipped through the net, it was considered that the key worker would pick the matter up.

3.5.3 The internal inquiry conducted by C&ICHST accepted that this vital appointment was never made. The Panel heard that the practice in place at the time was that nursing staff attempting to make an out-patient appointment would leave a message on an answering machine. The nurse with responsibility for making TK's appointment states that he did leave such a message. Whatever happened, no appointment was made. The

Panel does not know whose fault this was, but responsibility must lie with the C&ICHST.

3.5.4 The Panel feel that this method of making appointments was very unsatisfactory.

3.5.5 If the GP had received a discharge letter, it is possible that he might have enquired about follow-up measures, including the out-patient appointment. Mr DS submitted to the Panel that the failure to send a discharge summary in the case of TK was an isolated incident. On the other hand, we were informed that as part of the Islington Review carried out in November 1997, an audit was undertaken of the number of days between discharge and the date of the discharge letter being sent to the GP. This audit indicated that 76% of discharge summaries were being sent to the GP within a week of discharge. These statistics do not indicate to the Panel that it was an isolated incident.

3.6 Care Programme Approach (CPA)

3.6.1 The CPA was introduced on 1st April 1991 by the Department of Health as a cornerstone of the Government's mental health policy. It was designed to improve the co-ordination of care for all people referred to mental health services.

3.6.2 Since the introduction of the CPA, a number of independent inquiries have concluded that ineffective compliance with the requirements of the CPA was at the heart of the incidents of violence carried out by mentally ill people.

3.6.3 C&ICHST introduced a revised CPA policy document in October 1994, and this was replaced by the multi-agency Camden & Islington Joint CPA Operational Policy in January 1997. The stated purpose of this policy was to provide guidance on the process of CPA and to promote close and effective inter-agency working. It was envisaged that the policy would be used as a point of reference by staff involved in planning community care.

3.6.4 NHS Circular HSG(94)27, issued in May 1994, states that the essential elements of an effective care programme are:-

- systematic assessment of health and social care needs (including accommodation) bearing in mind both immediate and longer term requirements

- a care plan agreed between the relevant professional staff, the patient, and his or her carers, and recorded in writing

- the allocation of a key worker whose job (with multi-disciplinary managerial and professional support) is:-

  - to keep in close contact with the patient

  - to monitor the agreed programme of care is delivered

  - to take immediate action if it is not

  - regular review of the patient's progress and of his or her health and social care needs.

3.6.5 Dr NH placed TK on Level 2 of the CPA, which he believed was commensurate with the complex needs that were then evident.

3.6.6 Level 2 is defined in the Camden & Islington Joint CPA Operational Policy in place at the time of the incident as applying 'primarily to patients who require significant treatment and support where typically a range of interventions from two or more health care workers is provided. These patients will often require more than one type of after care service and their needs are less likely to remain stable.'.

3.6.7 The mechanisms for intervention, review and discharge for Level 2 clients are defined as:-

	Complex Needs (Care Programme Level 2)
Range of Intervention	Intervention requires the provision of rehabilitation, treatment and support on a longer term basis. This also involves the monitoring and support of the patients mental state and the provision of support to family, friends and other carers involved with the patient. More than one member of a CMHT may be involved in the provision of treatment and rehabilitation.
key worker Activity	Requires the co-ordination and usually the direct provision of treatment, support and rehabilitation. It will also involve a close relationship between the key worker and patient, and may include responsibilities under S.17, Care Management and Supervised Discharge.
Frequency of Contact	Frequency of contact with the key worker will vary according to the needs of individual patients. It would normally not be less than one contact per month. Contact may be more frequent at times when increased input and monitoring is required.
Mechanism for	Reviews should be initiated by the key worker according to the

Review	needs of the patient. The key worker will discuss with or involve other relevant professionals and carers. Where possible this should be done in an established clinical review meeting but it is recognised that this might not always be possible or indeed relevant. The review should take place not less than 6 monthly. A copy of the CPA review form should be circulated to all relevant people including the GP within 5 working days.
Action to take if a patient loses contact or does not accept the Care Programme	When a patient withdraws from treatment or otherwise loses contact with the service, the key worker must try and make contact with the patient through home visits, letters, telephone or whatever means appropriate to the patient. The key worker should discuss the circumstances of the situation with the consultant and other involved professionals and carers, so that an appropriate way forward can be agreed.
Action on Discharge from CPA	Patients to be discharged from this level or moved to another level should be subject to a MDT review. A discharge summary should be provided and the patient should either be discharged off the CPA or the change of level recorded on the CPA form.

3.6.8 The conclusion of the internal inquiry report by Islington Council is that the Team Manager and allocated social worker followed the procedures current at the time, both in terms of departmental policy and those associated with the CPA. The Panel do not agree.

3.6.9 What actually happened to TK in the period 9th January 1997 to 22nd April 1997 can be summarised thus:-

	Complex Needs (Care Programme Level 2)
Range of Intervention	TK received no rehabilitation, treatment or support. He had no out-patient appointment to monitor his mental health and Mrs K was not contacted to see if she needed support.
Key Worker Activity	The key worker wrote two letters to TK in the period 9th January to 7th April. The key worker did not contact any other agencies to establish whether or not they had had contact with TK.
Frequency of Contact	TK was discharged on 9th January. The first letter to TK was sent on 13th February, and the second on 7th April. The key worker failed to keep in touch when he failed to respond to these letters, and did not see TK until an accidental sighting in the street sometime in March. A home visit occurred on 11th April, following which it was decided to contact Dr NH when he returned from study leave two weeks later.
Mechanism for Review	No review was carried out by the key worker, and no other professionals were contacted for input.
Action to taken if	A home visit was arranged for 11th April, three months after

a patient loses contact or does not accept the Care Programme	TK's discharge. The key worker and her manager failed to respond adequately when faced with evidence of TK's mental distress, in the knowledge that there had been no contact with him for three months. No other agencies were contacted to agree an appropriate way forward.

3.6.10 We believe that neither Ms KC nor Ms MF, although well intentioned, operated the CPA in accordance with the terms set out in HSG(94)27 or local operational policy. The Panel noted, however, that if Ms KC had received a discharge summary, she might have been prompted to check whether TK had attended an out-patient appointment.

3.6.11 The Panel believe that Ms KC's chosen method of keeping in contact with TK by writing letters offering appointments at her office was not the most effective method of attempting to engage with him, given his history of non-compliance with services and medication. Ms KC said she chose office-based appointments because of a concern that he could be aggressive, so that undertaking home visits would have meant including another social worker.

3.6.12 When TK did not respond to the letters, Ms KC talked over the case with Ms MF at her regular supervision session, and as a result, it was decided to undertake a home visit. By this time, Ms KC had not had any contact with TK for three months. She commented that the reason for the delay was that she had not received any reports of concern from other agencies, as she had after TK's first discharge. Because no concerns were raised by other bodies or Mrs K, she believed everything was satisfactory and she decided to 'give him space'.

3.6.13 The Panel consider this to have been a most regrettable attitude to adopt, given the requirements of the CPA and the reality of what was actually happening.

3.6.14 The Panel believe that both Ms KC and Ms MF greatly underestimated the extent of TK's disturbance, and since (without fault of their own) they were unaware of TK's visits to the Waterlow Unit and Accident & Emergency, had missed the vital clues. When Ms MF and Ms KC visited TK at his home on 11th April, they were armed with no information about his behaviour in the community since discharge on 9th January.

3.6.15 TK's response to their visit, when he refused to let them enter and swore at them, was perceived as him being difficult and juvenile, rather than being in a state of chronic disturbance. Ms MF and Ms KC noted that TK did not directly threaten them, although they admitted feeling unnerved and intimidated by him.

3.6.16 Because of limited knowledge of his potential for violence and of his attempts to get help in the preceding weeks, the Panel believe the key worker and her team leader misread this situation.

3.6.17 The Panel considered whether it was a reasonable decision to wait for Dr NH to return from study leave before attempting a psychiatric assessment. The Panel accept that the key worker was acting without knowledge of TK's visit to the Waterlow Unit and Accident & Emergency, and the fact that he had not had an out-patient appointment. However, it was the key worker's role to be in receipt of all this information. Ms KC said they decided to wait for Dr NH because they believed TK was able to mask his symptoms and they wanted someone who knew him well to make a psychiatric assessment. This, they felt, could wait for two weeks. In the Panel's view, this was an error of judgement.

3.6.18 The Panel heard from TK that he was aware that Ms KC was his Social Worker, but he did not see either her or Social Services as particularly relevant to his needs. Although he felt that his condition was deteriorating in the community after his discharge on 9th January 1997, he did not regard Ms KC as a person he could turn to. Equally, Mrs K did not regard Social Services as relevant to the needs of TK, and indeed she could not recall either Ms KC or Ms MF.

3.6.19 Could the failure of Social Services to follow-up TK in the community be attributed to excessive workload on the department? Ms MF stated she would have benefited from another social worker on the team, noting that the area they were working in had a lot of problems. However, the Panel were informed that the caseload of the key worker at the time did not indicate that it was in any way excessive.

3.6.19 Both Ms KC and Ms MF confirmed they had seen circular HSG(94)27, and had received training in the CPA. Ignorance was not, therefore, the reason for any related problem.

3.6.20 The Panel conclude that in key respects the care programme fell apart. The key worker did not keep in close contact with the patient, nor did she monitor the agreed package of care. The failure of TK to respond to letters should have been a trigger to co-ordinate information from all the agencies to establish what was happening. At this point, the failure of the outpatient appointment would have come to light.

3.6.21 To put these failures in context, the key worker had not received a discharge summary and she was not fully aware of all the details in other files. She was also operating in the knowledge that after TK's first discharge, she had been notified of increasing concerns about his mental state by a number of other bodies. Nevertheless, against the background

of previous independent inquiries, this was a serious failure to comply with the CPA.

3.7 Housing

3.7.1 The C&ICHST's internal inquiry found a lack of effective planning, particularly with regard to TK's housing needs. On each occasion, the multi-disciplinary team was said to have had three months to plan appropriate accommodation and yet, at the last moment, TK ended up in Bed & Breakfast or his mother's home.

3.7.2 The Panel, however, did not feel that such criticism was justified. During both admissions, TK frequently changed his mind with regard to his housing needs, and Mrs K was not consistent in her approach in terms of providing accommodation for her son.

3.7.3 On his first admission, TK refused to accept any supported accommodation for people with mental illness and wanted Bed & Breakfast accommodation near his mother's home. This was arranged as requested, and TK reported to Dr NH at his out-patient appointment that he was happy with it. On his second admission, he wanted to be discharged to his mother's house and to attend Sunnyside Road when a place became available.

3.7.4 Ms KC was aware that the waiting list for Sunnyside was then closed. Therefore, she was conscious that in pursuing this as an option for TK upon his discharge, it would inevitably involve a lengthy period of living with his mother, which she accepted was not an ideal solution.

3.7.5 Both Ms KC and Dr NH felt Sunnyside was an appropriate option, because of the one-to-one work with clients there and its ability to cope with his aggressive behaviour. Dr NH noted that he had sent other patients there who were similar to TK, and because they could be given intensive staff input, he felt the staff might be able to work with TK to get him away from the drug culture on the estate. Dr NH felt there were no other hostels in Islington that would have taken on board TK's drug-taking and disturbed behaviour.

3.7.6 The decision of the Referral Allocation Group not to admit TK to Sunnyside Road was a surprise to both Dr NH and Ms KC, particularly on the basis that he was too young, because the operational policy in place at that time did not have a lower age limit.

3.7.7 The Panel conclude that Sunnyside Road was never a viable option, and in some respects served to complicate the picture by delaying consideration of other possibilities.

3.8 Visit to The Waterlow Unit

3.8.1 It is evident that TK had some insight into what was happening to him after his second discharge.

3.8.2 Sometime during the period 7th to 13th April 1997, he attended Jafar Kareem Ward in the night and asked to be readmitted. In response, he was referred to the Accident & Emergency Department. The incident was not recorded in any of the ward notes.

3.8.3 The Panel conclude that the manner in which this attendance was managed was extremely unfortunate, particularly given that TK was demonstrating clear signs of disturbance and was asking to be readmitted.

3.9 Attendance at Accident & Emergency Department, Whittington Hospital on 11th April 1997

3.9.1 The Panel consider that another opportunity was lost to prevent the tragic occurrence on 22nd April, when TK was taken by ambulance to Accident & Emergency on 11th April 1997. TK was seen and assessed by the nurse, but left before being seen by a doctor.

3.9.2 If TK had been seen by the psychiatric services that night, he may well have been readmitted. TK explained to the Panel that he left because he was kept waiting. The Panel feel it was unrealistic to expect TK to have waited for a long period to be seen, and that the out-of-hours arrangements for psychiatric patients in place at the time of the incident were not adequate.

3.10 Jafar Kareem Ward and the Waterlow Unit

3.10.1 Dr NH was a diligent consultant working under extremely difficult conditions typical of an in-patient acute inner-city psychiatric ward, and attempting to do his best for his patients. The Panel do not accept that any blame is to be attributed to Dr NH for what happened to TK in the community.

3.10.2 Dr NH and Dr JB described a medical staff on the Unit which was over-stretched, with a range of responsibilities which appear excessive, compounded by the absence of a Specialist Registrar or Clinical Assistant. They also mentioned a number of problems with other staff areas - inadequate administrative staff to cover the CPA, insufficient secretarial support, and a large number of agency nurses on the ward.

3.10.3 The internal inquiry report produced by the C&ICHST quoted Ms KC as expressing 'some concerns that ward rounds were at times rushed, sometimes started late, and did not focus on patients close to release. Ms KC reported that she had not had very much discussion with staff at the Waterlow Unit regarding TK's ongoing treatment.'.

3.10.4 Ms KC clarified to the Panel that she felt the relationship between Social Services and the Waterlow Unit was quite good, with social workers attending ward rounds on a three-month rotation. Social workers would also attend Section 117 meetings and Mental Health Act Tribunal meetings. Ms KC agreed she did have access to Dr NH if she needed to talk to him about a particular patient.

3.10.5 Ms KC did, however, comment that ward rounds were rather unorganised and that on occasion, there would be long delays before they started. She also felt it was sometimes confusing to have to differentiate between a ward round and a CPA meeting and that sometimes cases were not dealt with thoroughly. Ms MF stated that Social Services staff did not always get an appropriate handover, that sometimes patients were discharged without a discharge meeting and that frequently discharge summaries had to be chased. Dr JB also commented that the ward rounds were rushed, due to the high workload and pressure of time.

3.10.6 Dr HH told the Panel that no such criticisms as mentioned above had ever been raised with him by either Ms KC or Ms MF. He stressed that, in his view, the Social Worker representative always played a crucial role in determining how much time was given to discussing patients at ward rounds and he would always clarify which patients they wanted to discuss. Ward rounds were preceded by a community meeting on Jafar Kareem Ward, led by Dr NH, which could sometimes result in slight delays. Also, in the event of a clinical emergency, longer delays could occur, but this was rare. Dr NH also told the Panel that at no stage did he receive any

indication that Ms KC wanted to discuss TK with him, nor did she take up any of the available routes to do so.

3.10.7 The Panel notes that neither TK nor his mother expressed to them any criticism of his care or treatment whilst in the Waterlow Unit.

3.11 Primary Care

3.11.1 The Panel invited Dr T, a partner at the St Peter's Street Medical Practice in Islington, to give evidence. TK was registered as a patient of this practice during the critical period between discharge from the Waterlow Unit on 11th January 1997 and NB's death on 22nd April 1997. On the information in the possession of the Panel, it appears that primary care did not play any material part in the management of TK's mental health crisis during that period. It would have been helpful to the Panel if they had had the opportunity to discuss this issue with Dr T.

Chapter 4: Summary of Conclusions And Recommendations

4.1 General Summary of the Principal Deficiences in the Care and Treatment of TK

4.1.1 The Panel's detailed investigation into the care TK was receiving up to and including 22nd April 1997 has led the Panel to conclude that his care was not in all respects suitable in view of his history and assessed health and social care needs. Nor did that care correspond with statutory obligations or local operational policies in relation to the CPA.

4.1.2 We have no criticism to make of the clinical professional judgement in the diagnosis of TK or the decision to discharge him from the Waterlow Unit on 9th January 1997.

4.1.3 The Panel have no criticism to make of the content of the care plan on TK's discharge on 9th January 1997, but its monitoring by the key worker was deficient in critical respects, leading to a loss of contact between TK and relevant services for a substantial period during which his mental health seriously deteriorated.

4.1.4 Collaboration and joint working between health and local authority services were hampered, and consequently deficient, by reason of the absence of systematic and organised collation of relevant information relating to TK within the different departments of Islington Council and within the different sections of Social Services. This deficiency undermined the ability of the mental health teams of Social Services to make a full assessment of TK's social care needs and also the ability of Social Services, in conjunction with health services, to arrive at a proper risk assessment for CPA purposes.

4.1.5 These deficiencies on the part of the Council were compounded by the failure of C&ICHST to make and distribute a discharge summary on TK's discharge on 9th January 1997, and to make the out-patient appointment specified in the CPA, and also by the inadequate response to TK's presentation at the Waterlow Unit during the period 7th

to 13th April 1997 and at the Whittington Hospital Accident & Emergency Department on 11th April 1997.

4.2 Conclusions and Recommendations on Particular Issues

4.2.1 Diagnosis

Conclusion

The Panel have no criticism of the diagnosis of TK by Dr NH (Paragraph 3.1).

4.2.2 Records Relevant to Risk Assessment

Conclusions

The effective management of a case such as TK's requires the fullest possible exchange of information within and between agencies. Within the different departments of Islington Council, there were records that could have been used to compile a fuller picture of TK's needs and potential for violence.

If there were procedures and systems within Islington Council for the systematic and organised collation of relevant information, they were not effective in the case of TK. The Panel are, for example, concerned that there was no appropriate summary of TK in the files when the case was transferred from one team to another.

If a fuller picture of TK had been available, Social Services and health staff might have taken a different course of action in relation to the CPA, for example in terms of discharge on Level 3 or a supervised discharge (Paragraphs 3.2.9, 3.3.6, 3.3.7, 3.3.10).

Recommendation

Islington Social Services should ensure proper arrangements exist for the mental health teams to have access to, and be in possession of, all relevant information within different departments of the Council, as well as within Social Services itself. Islington Social Services should also ensure that all

relevant information in the possession of the Council is shared with health agencies.

4.2.3 Discharge

Conclusion

On the basis of the information available to the medical team, the Panel have no criticism of the decision to discharge TK into the community on 9th January 1997 (Paragraphs 3.2.9, 3.4.7).

4.2.4 Care Programme Approach

Conclusion

The requirements of the CPA, particularly in respect of the functions of the key worker, were not satisfied, with the consequence that both Social Services and health staff lost touch with TK for a period of time when his mental health was seriously deteriorating (Paragraphs 3.6.20, 3.6.21).

Recommendation

As already stated by so many other Independent Inquiries, it is a critical responsibility of all relevant agencies to ensure that the requirements of the CPA are fully understood by their staff and properly implemented. C&ICHST and Islington Social Services must therefore satisfy themselves that the arrangements for the CPA are sufficiently robust and failsafe.

4.2.5 Administrative/Procedural Failings by C&ICHST

4.2.5.1 Out-Patient Appointment Following Second Discharge into the Community

Conclusion

The out-patient appointment for TK, as outlined in the care plan, was never made (Paragraphs 3.5.3, 3.5.4).

Recommendation

The C&ICHST must satisfy itself that the arrangements for making out-patient appointments are reliable and effective. We understand that a revised procedure for the booking of out-patient appointments has been implemented since March 1998. The C&ICHST should satisfy itself that these arrangements are sufficiently robust and failsafe.

4.2.5.2 Discharge Summary

Conclusion

No discharge summary was prepared and distributed on TK's second discharge into the community (Paragraph 3.5.5).

Recommendation

The C&ICHST should ensure that arrangements for the preparation and distribution of discharge summaries, on the discharge of patients from hospital, are reliable and effective.

4.2.5.3 Visit to the Waterlow Unit

Conclusion

The response to TK's visit to the Waterlow Unit in the week 7th to 11th April was inadequate. Although the response followed customary practice at that time, it proved to be seriously inadequate in relation to the management of TK's case and represented a significant lost opportunity (3.8.3).

Recommendation

The C&ICHST should ensure that any psychiatric patient who presents for help should have access to professional assessment at any time.

The Panel note that C&ICHST issued new guidance on the management of patients who present at their in-patient sites requesting admission or similar services in June 1999.

The C&ICHST must ensure that these arrangements are reliable and effective.

4.2.5.4 Visit to the Accident & Emergency Department on 11th April 1996

Conclusion

The manner in which TK's visit to the Accident & Emergency Department during the night of 11th April 1997 was handled was inadequate (Paragraphs 3.9.1, 3.9.2).

Recommendation

Any person presenting at the Accident & Emergency Department with a mental health problem and requesting assistance should receive speedy professional assessment.

The Panel note the introduction of the South Islington Resolution Service, available 24 hours a day, 365 days of the year, to provide immediate assessment and support to residents of South Islington. This team will see patients waiting in the Accident & Emergency Department.

The C&ICHST should ensure that these arrangements are reliable and effective.

4.2.6 Primary Care

Conclusion

It appears that primary care did not play any significant part in the management of TK's mental health crisis in the period between TK's discharge on 9th January 1997 and NB's death on 22nd April 1997 (Paragraph 3.11.1).

Glossary

C&ICHST	-	Camden & Islington Community Health Services Trust
CPA	-	Care Programme Approach
RAG	-	Referral Allocation Group

Appendix A – List of Documents

Camden & Islington Community Health Services NHS Trust

a) Report of the Serious Incident Investigation Regarding Mr TK (5th August 1997)
b) Joint Care Programme Approach Operational Policy (January 1997)
c) South Islington Crisis Resolution Service Operational Policy – September 1999
d) Annual Report 1997/98

Camden & Islington Mental Health Services

a) Guidance Booklet, The Assessment and Management of Risk (September 1997)
b) Protocol for Referring to Local Borough Risk Management Meetings (September 1999)

Camden & Islington Area Mental Health Committee

a) A Guide to Member Agencies
b) First Year Review 1998-1999

Camden & Islington Joint Care Programme Approach Operational Policy

Islington Mental Health Forum User Survey 1999 'It Makes You Worse'

London Borough of Islington

a) Seventeen files on TK and K family
b) Report of Internal Investigation into the Care and Treatment of TK by Islington Neighbourhood Services

NHS Executive HSG(94)27 issued in May 1994 Guidance on the discharge of mentally disordered people and their continuing care in the community

Press cuttings, both local and national

TK medical records

a) GP
b) Waterlow Unit, Whittington Hospital
c) Accident & Emergency Department, Whittington Hospital

Transcript of Old Bailey Trial - Regina v TK on 22nd December 1997

A Mental Health Strategy for Adults aged between 18 and 65 years in Camden and Islington - Implementation Plan. Issued by a partnership of Camden & Islington Health Authority, London Borough of Camden, London Borough of Islington, Camden & Islington Community Health Services NHS Trust and The Royal Free Hampstead NHS Trust in August 1998

Mental Health Act Commission visit reports to the Waterlow Unit, 22nd March 1996, 31st January 1996, May 1995

The Islington Review Summary Report of Review of Operational Management of Islington Mental Health Services, Camden & Islington Community Health Services NHS Trust October 1977

The Report into the Care and Treatment of Martin Mursell – March 1997

Learning Lessons: Report into the events leading to the incident at St John's Way Medical Centre in December 1995 – December 1996