Lambeth, Southwark and Lewisham NHS
Health Authority

Report of the Inquiry into the Care and Treatment of Wayne Matthew Hutchinson

A report commissioned by Lambeth, Southwark & Lewisham Health Authority

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INTRODUCTION

On 5th January 1996 at the Central Criminal Court, Wayne Matthew Hutchinson was convicted of two counts of manslaughter on the ground of diminished responsibility; one count of attempted murder and three counts of wounding with intent, contrary to s.18, Offences Against the Person Act 1861.

The offences were committed just after Christmas 1994. On 1st February 1996 he was sentenced to life imprisonment on each count. He was then aged 21. He had never previously been convicted of any criminal offence

The psychiatrists who gave evidence at the trial were unanimous in their opinion that when he committed the relevant offences he was seriously mentally ill, and that since the latter part of 1994 he had been a grave danger to the public.(1)

On 12th November 1996 the Court of Appeal, Criminal Division, quashed the sentences of life imprisonment and substituted a Hospital Order under section 37, Mental Health Act 1983, to which was attached a Restriction Order under section 41. Wayne Hutchinson remains in Broadmoor Hospital.

For a short period during late 1994 Wayne Hutchinson had been treated for suspected mental illness at St. Thomas' Hospital and at South Western Hospital. Following his arrest for these offences in January 1995, West Lambeth Community Care NHS Trust, who were responsible for the operation and management of both hospitals, set up an Internal Inquiry to examine whether existing protocols and the training of staff needed to be improved, urgently, in the light of these serious and tragic events. In June 1995 the Inquiry's findings were presented to the Lambeth, Southwark and Lewisham Health Commission and to the Trust Board. In a number of important respects we have reached different conclusions from those reached by the Internal Inquiry. That may be explained by the limitations of the Internal Inquiry. That investigation was not as extensive as that which has been carried out in the course of the present Inquiry. Questioning of the relevant witnesses was limited: the evidence was not, in our opinion, sufficiently tested. Despite these constraints, we agree with and adopt the recommendations which were made by the Internal Inquiry. They are reproduced and reformulated in the Summary of Recommendations.

On 5th January 1996, the same day that Wayne Hutchinson was convicted of these offences, the Health Commission announced that an independent inquiry into his care and treatment would be set up under the terms of Department of Health Circular HSG(94)27.

Although the three members of the Inquiry Panel were formally appointed during 1996 it was not until Brian Morden was appointed as Inquiry Coordinator, in January 1997, that the Inquiry was able to begin its work. As soon as independent administrative arrangements were made he set about obtaining all the relevant documents from the individual agencies. Accommodation for the formal sittings of the Inquiry was, in due course, arranged and after a very lengthy delay Wayne Hutchinson eventually gave the necessary consent to allow the Inquiry access to the relevant clinical and social services notes.

The Inquiry Panel heard evidence from selected witnesses on various occasions between September 1997 and October 1998. The hearing dates are set out in Appendix 4. Those witnesses who gave evidence are identified at Appendix 3. The procedure adopted by the Inquiry is set out in Appendix 2, and broadly followed the approach adopted by the *Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford (1998)*. Members of the Panel visited the rebuilt South Western Hospital in October 1997 and also visited Wayne Hutchinson at Broadmoor Hospital in July 1997 and January 1999.

The Terms of Reference are set out at page iv. We have endeavoured to confine the ambit of the Inquiry within those Terms.

We attempted to invite relatives of those who had been killed and those persons who had been attacked by Wayne Hutchinson to contribute to the Inquiry process. Mrs. Hutchinson and her daughter Christine gave evidence before us. **WE RECOMMEND THAT the Terms of Reference of an inquiry such as this should require the Panel as a matter of principle to invite the primary**

and secondary victims and their relatives to contact the Inquiry Panel.

We are conscious that we have been investigating and reporting on events that occurred nearly five years ago. Since then, South Western Hospital has been demolished and a new hospital has arisen on the same site. Nonetheless, the results of our analysis of the clinical management of Wayne Hutchinson is still relevant today.

We acknowledge that we have focussed our attention on one part only of the hospital and have considered the activities of only a limited number of health service staff. Consequently we are in no position to suggest that the circumstances we describe in this report were typical of the hospital as a whole.

We received evidence during the course of the Inquiry which suggested that primary and secondary victims may not have received appropriate support from various agencies. **WE RECOMMEND THAT the Trust should offer to provide appropriate therapy as a matter of course to all those who may have been directly or indirectly affected following events such as these.**

We have adopted the same approach to the appraisal of the professional conduct of individuals as was adopted in the *Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford (1998).*

The findings of the *National Confidential Inquiry into Homicides and Suicides by Mentally Ill People (1994),* which have been confirmed by a significant number of local inquiries commissioned under the terms of HSG(94)(27), have described repeated shortcomings in the management of the mentally ill. Poor communication between professionals and agencies and a failure to recognise warning signs have been the hallmarks of those inquiries. It is disappointing to have to report that those failures occurred in this case, too.

The major findings of this Inquiry are also reflected in *"Modernising Mental Health Services".*[(2)] This recognised that treatment of mental illness is made more difficult by substance misuse and acknowledged that in some parts of the country, particularly London, there are simply not enough acute or secure beds to meet patient demand. It is to be hoped that the review of beds which is currently being carried out in the National Health Service will lead to a targeting of investment to those local communities with the greatest needs. In 1994 Lambeth was one such community.

Following the publication of a Report such as this there is a real risk of intrusive media coverage which may cause distress to many of those who were closely connected with the events at the material time **WE RECOMMEND THAT all primary and secondary victims and those centrally concerned with the relevant events should be given advance warning of publication.**

We gratefully acknowledge the substantial administrative contribution made to the Inquiry by the Coordinator, Brian Morden, and the skilful compilation of the drafts of the Report by our secretaries, Christine Chambers and Marion Barnes. We also record the valuable assistance provided to us by Broadmoor Hospital and by the medical and nursing staff at St. Thomas' and South Western Hospitals.

Kieran Coonan, Q.C.

David Tidmarsh, MD, FRC Psych.

Patricia Hayward, RMN, RGN, Health Ed. Cert. DMS

June 1999
revised June 2001

TERMS OF REFERENCE

Lambeth, Southwark & Lewisham Health Authority

Terms of Reference of the Inquiry into the Care and Treatment of Wayne Hutchinson

1. To examine and review the report of the Internal Inquiry into the care and treatment of Mr. Wayne Hutchinson, to determine:

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

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

a) his assessed health and social care needs;

b) risk assessment of potential harm to others;

c) any previous psychiatric history;

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

e) the nature and extent of any previous criminal involvement or Court convictions;

iii) the extent to which his care corresponded with statutory obligations, in particular the Mental Health Act 1983, relevant guidance from the Department of Health (including the Care Programme Approach (HSG(90)23/ LASL (90)11), discharge guidance (HSG(94)27) and local operational policies).

2. To examine, in the light of the Internal Inquiry report, the circumstances surrounding the decisions to give Mr. Hutchinson leave of absence while subject to section 2 of the Mental Health Act 1983.

3. To examine the adequacy of local arrangements for absconding, their effectiveness in practice and the exercise of individual responsibilities in respect of Mr. Hutchinson's absence without leave.

4. To examine to what extent the recommendations of the Internal Inquiry have been implemented.

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

6. To produce a report and make recommendations to the Board of Lambeth, Southwark and Lewisham Health Authority.

MEMBERSHIP OF THE INQUIRY PANEL

Kieran Coonan, Q.C. (Chairman)
A Recorder of the Crown Court.

David Tidmarsh, MD, FRC Psych.
Formerly Consultant Psychiatrist, Broadmoor Hospital.

Patricia Hayward, RMN, RGN, Health Ed. Cert., DMS
Formerly Director of Clinical Services, Foundation NHS Trust.

CHAPTER ONE

The Index Offences

1. Just after Christmas 1994, Wayne Matthew Hutchinson brought terror to parts of Brixton, in south London.

2. In the early hours of 26th December Delroy Thomas, aged 20, was sitting in the living room of his home on the Stockwell Park Estate, watching television. He heard a gunshot and the sound of smashing glass. He heard a second bang, and when he went to his bedroom window he saw that there was a hole about four inches wide in the glass. When he was later arrested Wayne Hutchinson, who knew Delroy Thomas, admitted intending to kill him.

3. The next day, Wayne Hutchinson went to a club called *Mixes* in Stockwell Road. He had a double-barrelled sawn-off shotgun with him. It was the same gun which he had fired at Delroy Thomas' window. Anthony Kellman worked at the club as a doorman. Wayne Hutchinson waited outside until the door opened. He jammed his foot in the doorway, pushed the gun into the gap between the door and the wall and fired it, twice, at point-blank range at Anthony Kellman, saying *"Remember me?"*. Mr. Kellman was fatally injured. (See also paragraph 116).

- On 29th December, Marlon Snape was visiting a relative on the Cowley Estate in Brixton. Wayne Hutchinson arrived with some other young men and a young woman. During general conversation he suddenly drew a knife, slashed Marlon Snape on both sides of his face, and stabbed him in the back of the neck. Fortunately Mr. Snape survived the attack but he required 53 stitches in his face, neck and forearm. When Wayne Hutchinson was subsequently arrested he told police officers that Marlon Snape had previously taken *"great liberties"* and that he had stabbed him because Marlon Snape had not been listening to what he had been saying. When Marlon Snape was interviewed by police officers he alleged that Wayne Hutchinson had been smoking "crack cocaine" shortly before the incident.

- On Friday, December 30th, police officers went to Wayne Hutchinson's home address as part of their routine enquiries into the murder of Anthony Kellman and the attempted murder of Marlon Snape. He denied any involvement in either offence. He was not arrested (see Chapter 12).

- On 31st December at about 9 p.m., Paulo Pereira was walking along Stockwell Road. As he passed the offices of Bluebell Cabs, Wayne Hutchinson stepped out from a doorway. He was holding a knife in his right hand. He stabbed Mr. Pereira in the left side of the chest and then ran away. Fortunately, the wound was not fatal. When he was later interviewed by police officers about this incident, Wayne Hutchinson admitted that he had stabbed Mr. Pereira but claimed that he had been insulted by him on an earlier occasion. Mr. Pereira told the police officers that although there had been no conversation between them on 3rd December he recognised Wayne Hutchinson as someone who had supplied cannabis to him on ten or more occasions in the past, in the Stockwell Road area.

- Just after midnight on 1st January 1995, Mr. Clifton Mitchell was standing outside a shop in Landor Road, drinking a can of beer. Wayne Hutchinson appeared and suddenly began to stab Mr. Mitchell in the back of his neck and head, and struck him in the face. When he was interviewed about this incident after his arrest, Wayne Hutchinson said that he stabbed Mr. Mitchell because he believed that he had *"bad-mouthed"* him and had not shown him *"any respect"* on an earlier occasion. Fortunately, the attack was not fatal

- Immediately after the attack on Mr. Mitchell, Wayne Hutchinson entered the shop. He was still carrying the knife. Marie Hatton was one of the customers there. She was a crack and heroin user and had been a small-time dealer in drugs. (It is believed that they knew each other because of mutual dealing in drugs.) Wayne Hutchinson went up to her and, without any warning, stabbed her in the head and chest and through her wrist. Without pausing, he turned and walked out of the shop wiping the blade of the knife on his sleeve. One of the other customers demanded to know why he had stabbed her. He replied, simply, *"Cool"*. Marie Hatton died from the stab wounds to her chest(3)

- Wayne utchinson was arrested at his mother's address on the Stockwell Park Estate a few hours after he had killed Marie Hatton. Police officers found him asleep in an armchair. He was interviewed in the presence of a legal representative from a local firm of solicitors, Fisher Meredith, who thought that an appropriate adult(4) might be necessary during further interviews. Later that day he was examined by Dr. Jacqueline Howitt, Forensic Medical Examiner, who found him to be rational and cooperative. He told her that he had smoked "weed" (cannabis) and "coke" (crack cocaine) the night before but had not taken any alcohol. She found no signs of inebriation by drugs or alcohol. She considered him fit to be detained in police custody and fit to be interviewed, but in view of his psychiatric history (he told her he had been a patient at South Western Hospital), only in the presence of an appropriate adult. She did not find any psychotic symptoms. A urine specimen taken in the police station tested positive for cannabis and cocaine (5) Following her advice, an appropriate adult was present during subsequent interviews. After initially denying the offences, he eventually admitted them. He asserted that he had a gift of knowing when people were *"taking the piss"*. He said: *"they all deserved whatever happened"*.

COMMENT

- During these lengthy interviews he also made what was undoubtedly a false confession to the killing of another man in a car-wash, in December 1994. **This false confession was a reflection of his disturbed mental state during the interviews.**

- On 11th January 1995, police officers searched an address in Streatham which he said he had recently been using. They found a shortened double-barrelled shotgun which he admitted had been used to kill Anthony Kellman. They also found fifty-nine live cartridges of the same type as those used in that attack, and a quantity of 9 mm ammunition. He told the police officers that the 9 mm ammunition was for a gun which he had *"lent to someone"*. A quantity of .38 ammunition was also seized, which he admitted was associated with the gun which he had fired outside *Mixes* nightclub on November 4th (see paragraph 116).

- He was remanded in custody by Camberwell Green Magistrates' Court and was detained, at first, in Feltham Young Offenders Institution.

- When he was admitted to the Health Care Centre at Feltham YOI he told the healthcare officer that the only drug he used was cannabis, and denied suffering from any psychiatric illness. He admitted that he had been in South Western Hospital but he said he did not know why. The medical officer considered him to be rational, and not obviously thought-disordered

- On 4th January 1995 he carried out an unprovoked assault on an inmate and was transferred to the segregation unit. On 5th January he was seen by the Medical Officer,Dr. P. E. Browne. His opinion was that Wayne Hutchinson was not mentally ill and was fit for ordinary location within the YOI.

- On 16th January he was transferred to HMP Belmarsh where he was admitted to the Healthcare Centre for psychiatric assessment.

- He was examined the next day by Dr. M. Leigh-Howarth, Senior Registrar. He admitted taking cannabis daily and using cocaine occasionally. His thought content was described as "paranoid". He complained that he was being poisoned and that he was being given heroin and other drugs in his food. He alleged that the television and radio were making references to him and that he was able to influence what was shown on television. He admitted having heard voices which were saying *"mad things"* to him. He claimed that he was a GP. Dr. Leigh-Howarth felt that he was exhibiting signs of a paranoid illness, which was possibly drug-induced, and concluded that he was a very dangerous individual. He refused to take any medication.

- On 18th January, after Wayne Hutchinson had attempted to walk out of the prison hospital, Dr. Leigh-Howarth wrote to Broadmoor Hospital asking for an assessment to be carried out and also referred him to Dr. Janet Parrot, Consultant Forensic Psychiatrist to the Bracton Clinic at Bexley Hospital, and to HMP Belmarsh.

COMMENT

- It is unfortunate that when, on 4th January, the Healthcare Centre staff at Feltham YOI, and on 18th January the staff at HMP Belmarsh, attempted to obtain information about Wayne Hutchinson from South Western Hospital they were told that there was no record of such a patient having been in the hospital at all.

- The next morning, during a visit by his mother and brother, he hit a member of staff with a chair. On 29th January he refused to eat because he believed that his food was poisoned, and complained that his legs and arms were broken.

- Dr. Parrot saw him on 7th February and prepared a report dated 9th February 1995. She requested that he be transferred to Broadmoor Hospital under section 48, Mental Health Act 1983. By this time she had been able to obtain the notes from South Western Hospital.

- She noted that he had been cautioned in January 1993 and in August 1994 for the possession of cannabis. He told her that although he smoked cannabis regularly he had not resumed regular cannabis use following his admission to South Western Hospital in October 1994. He said he used to take crack cocaine at "raves" but had only used crack on one occasion in 1994 -- during the Christmas period. He maintained that he had not taken alcohol or drugs prior to the commission of the offences in late December.

- An extract from her report graphically illustrates his mental state in early February 1995:

> *". . . He was restless, constantly turning towards the door and trying it. His talk was somewhat disjointed, e.g. "I'd died. I tell you, I remember escaping. I see things when I am in bed". At first he described seeing an eagle and later said the eagle controlled him: "It hooks onto your brain with its claws". He said he heard voices, people telling him to do things. He felt he was doing good in the long run. He added that the eagle told him to do things,*

> *such as saying "defend yourself". When asked specifically about command hallucinations to harm or kill others he did not reply. He said that "When you don't do what you're told, they call you a pussy. Then your arse turns into a pussy". He went on to say that the eagle had gone now and he was now a moose. He said there was something in his back that received communications from the officers' radio (when we could not hear it) and that he heard these voices on top of his head. He then said "I am the police. I've got the radio in my back".*

- Dr. Parrott concluded her opinion in this way:

> *"Mr. Hutchinson developed a first episode of psychosis during the summer of 1994. He had a history of auditory hallucinations, delusions of reference, delusions of control and bodily change, and paranoid ideation. It seems most likely he is developing a schizophrenic illness, although the history of drug use requires further clarification. He is currently psychotic and poses a risk to staff and himself. He requires urgent transfer to hospital under section 48 of the Mental Health Act. In view of the seriousness of the offences, maximum security is essential."*

- On 8th February he was seen by Dr. Baxter, Senior Registrar, Broadmoor Hospital, who agreed that he was in urgent need of medical treatment and recommended his transfer to Broadmoor. He was admitted to Broadmoor on 13th February under the provisions of section 48, Mental Health Act 1983, with a restriction on discharge under section 49.

- On admission to Broadmoor he was extremely suspicious, hostile and aggressive. He maintained that he could hear voices and said that he was *"a tiger, number one in the jungle"*, and that people were tampering with his food. He was given intramuscular antipsychotic medication which led to a rapid improvement in his symptoms and behaviour although delusions about his food persisted and he did not gain any insight into the fact that he was ill. However, his medication was gradually reduced and by June 1995 his symptoms were no longer apparent.

- In November 1995 he was seen by Dr. G. H. Gudjonsson, Consultant Clinical Psychologist -- who had been instructed by his own solicitors -- in connection with the admissions which he had made during interviews with the police. Dr. Gudjonsson noted a very wide variety of psychotic symptoms present at that time but did not elicit any during his own interview with Wayne Hutchinson. He was unable to come to a firm conclusion about the reliability of the admissions which he had made but found no evidence that Wayne Hutchinson had been unfairly interviewed by the police.

- The medication induced remission continued until his trial. In February 1996, after he was sentenced to life imprisonment at the Central Criminal Court, he was immediately returned to Broadmoor Hospital under the provisions of Sections 47 and 49 of the Mental Health Act. At that time he was able to acknowledge that he had committed the offences, although initially he justified or minimised them. In March 1996, medication was stopped. By June of that year his symptoms, including his sexual delusions, had returned, which indicated that there was an underlying psychosis that had, until then, been controlled by medication. Antipsychotic medication was restarted, this time orally

- On 12th November 1996 the Court of Appeal substituted a hospital order for the life sentences. At the end of 1996, despite medication, there was a recurrence of psychotic symptoms. He had been taking cannabis whilst in detention.

- In July 1997 he refused medication and again his symptoms relapsed, resulting in two assaults -- one with a knife -- on other patients. Thereafter, his symptoms responded to medication.

- In March 1998 his case was considered by the Mental Health Review Tribunal which declined to discharge him.

- Later that year, because there were still some doubts about the reasons for his relapses and because Wayne Hutchinson himself insisted that all his symptoms had been due to illegal drugs, medication was again withdrawn. Frequent tests for illegal drugs were carried out, all of which proved negative. Within weeks he had relapsed, which indicated that the relapse was indeed due to the illness alone.

- On 22nd October a further Mental Health Review Tribunal hearing took place. Again, discharge was not recommended. The Tribunal's reasons were as follows:

> *". . . we accept that the RMO has now resolved his earlier ambivalence with regard to the diagnosis following a drug free period when the patient relapsed into a psychosis with florid delusions indicating a schizophrenic illness. Those delusions are still present and the patient informed us that he wished to be absolutely discharged in order that he could follow his instructions from the government and clear the streets of drug dealers if necessary by killing them. The RMO expects the patient's mental state to stabilise on medication and confirms that at such times he presents as an amiable and obliging patient".*

COMMENT

- There is now a consensus that the diagnosis is paranoid schizophrenia. The onset of this illness was in August 1994 and its symptoms became increasingly disturbing over the next two months. It is probable that they were exacerbated by the use of cannabis which he took in a vain attempt at self- medication. Wayne Hutchinson's brief admission to hospital in October 1994 and the antipsychotic medication he was given over those few days probably had little effect on the progress of his illness. However it is likely that the cannabis and crack cocaine which he took after leaving South Western Hospital, again in the hope that his symptoms might be controlled, exacerbated them and disinhibited his behaviour to a disastrous degree. Any rational motives he may have had for his offences were totally distorted by his psychosis; his violence was caused by psychotic processes fuelled by both the illness and the cocaine. His progress in Broadmoor has shown that his multifarious symptoms which have included hallucinations in various modalities and grandiose, persecutory and sexual delusions can, for the present at least, be controlled by medication. However, it is also clear that symptoms return within weeks of medication being stopped and may still lead to violence. These relapses occur without the help of cannabis or other illegal drugs. It is also probable that even when medication is controlling his symptoms, the taking of cannabis can cause a relapse. The ultimate prognosis remains uncertain. The subject of substance misuse is dealt with in more detail in Chapter Six.

The Panel members who saw him in Broadmoor Hospital confirm that he presents very well when his illness is in remission.

- It is to the events leading up to the commission of these offences and to Wayne Hutchinson's involvement with health and social services that we now turn.

CHAPTER TWO

Family and personal history

- Wayne Hutchinson has, for a variety of reasons, been a poor historian. The following summary is therefore based on the notes of Chris Strahan, Approved Social Worker at St. Thomas' Hospital, supplemented by what has been learned since by Mr. W. R. Jackson, Senior Social Worker at Broadmoor Hospital. Mrs. Hutchinson and her daughter, Christine, have also provided helpful information to the Inquiry.

- Wayne Hutchinson's father, who came from Jamaica, died soon after he was born. His mother was also born in Jamaica. She came to this country when she was 19 and married soon afterwards. She had four children, three boys and a girl. She did not go out to work while the children were growing up. Later she obtained formal educational qualifications and has since done part-time clerical work. She has been a member of the Pentecostal Church since childhood and has received a great deal of support from the Church in recent times.

- The family initially settled in Bedford but before Wayne Hutchinson was born they moved to Brixton. They acquired accommodation on the Stockwell Park Estate. Wayne Hutchinson lived there with his mother until his admission to hospital in 1994.

COMMENT

- The Stockwell Park Estate was described in Lord Scarman's report on the 1981 Brixton disorders, as follows:

> ***"The estate which is of a multi-racial character, houses some 1,050 families, about 40 per cent of them being single-parent families. The Tenant's Association described the estate as one in which a combination of design faults and social problems had turned a planner's dream into a nightmare. The design of the estate with low-rise blocks of flats with exterior walk-ways and inter-connecting bridges, made the control of crime a problem. "Muggings" and burglaries were of particular concern, although since the introduction of a Home Beat Officer with responsibility for the Estate, the overall level of crime had been reduced by about 50 per cent. High unemployment and the lack of social and recreational facilities in Brixton, however, provided a seed-bed for continuing problems among the youth of the estate."***

We were given no reason to doubt that this is an accurate description of the environment in which Wayne Hutchinson grew up.

- Wayne Hutchinson was born on 10th November 1974. There were no birth complications, or any developmental delay, or significant illnesses in childhood. His mother did all that could be expected of her: the social services were never involved with the family. He went to a nursery and then the nursery class of the local junior school. When he was nine his mother moved him to St. John's Church of England School because she wanted him to have a religious education; she was particularly concerned that he should attend Sunday school. At eleven he went to the Archbishop Michael Ramsey School in Camberwell where he stayed until he was sixteen.

- There is some dispute about his academic qualifications -- the school in Camberwell could provide no information for those assessing him at Broadmoor, either about his academic record or his behaviour. At some stage he had special tuition to help with reading and writing but he seems to have left school with six low-grade GCSE passes. He was said to be good with his hands, with an interest in woodwork and electronics. He was physically active, gaining certificates in BMX and cross-country running. He did not truant and was never in any

disciplinary trouble.

- After leaving school he found work as an apprentice carpenter but left this after six months because he did not think he was learning enough. He then obtained a place at a college in Paddington but it was conditional on his finding a placement in industry and this he was unable to do. Then for about a year he worked three or four days a week for a demolition firm. In 1993 he started work for a telephone company on commission. He gave this up in August or September 1994 with the onset of his illness.

- He has been described by others as being concerned about his family and friends, considerate and altruistic. Although he was the life and soul of the party he was also able to keep his high spirits under control. He had a good relationship with his mother.

- He had a number of casual relationships with girlfriends, the last of whom gave birth to their daughter on 27th December 1994 -- the same day that he killed Anthony Kellman.

- He was cautioned by police for possession of cannabis in January 1993 and August 1994 but had no previous convictions.

- He had no previous psychiatric history before July 1994, nor is there any known family history of mental illness.

COMMENT

- This otherwise unremarkable personal history masked a gradual breakdown in mental health from mid-1994. It is in stark contrast, too, with the apparent ease with which a young man was able to acquire lethal weapons and ammunition and, in a disturbed mental state, use them with such tragic consequences. **It is now known that during 1994 Wayne Hutchinson was able to acquire possession of at least four firearms: a sawn-off shotgun; a 6.35 mm self-loading pistol; a .38 revolver and a .9 mm pistol.**

CHAPTER THREE

Arrest for firearm offences: the onset of mental illness

- In the early hours of 27th July 1994, Wayne Hutchinson and another man were stopped by police officers in the King's Cross area of London. The officers believed that they were involved in drug dealing. As both men ran off, Wayne Hutchinson threw a loaded pistol over a wall. Although both men were soon arrested, the other man managed to escape by wrenching off the door handle of the police car to which the handcuffs had been attached.

- At the scene of his arrest the police recovered a JT Sauer model VP, 0.25/ 6.35 mm self-loading pistol together with seven rounds of 0.25 calibre ammunition(6) Six rounds of ammunition were in the magazine, and one round was in the breech.

- Shortly after being taken to Islington police station, he accompanied officers to a house in Gypsy Hill, south London, which he said was his home address. Although nothing incriminating was found, the address proved to be that of his sister, Christine: it was obvious to the police officers that he had not been living there. He was then taken to Tottenham Court Road police station where he was later seen by a representative from Fisher Meredith, a firm of solicitors, and by his mother.

- When he was interviewed in the presence of his solicitor he denied all knowledge of any gun and ammunition, and refused to answer any further questions.

- The next day, 28th July, he appeared at Clerkenwell Magistrates' Court. Bail was opposed by the Crown Prosecution Service representative on the grounds that he would fail to surrender to bail and that he would be likely to commit further offences. It was felt that since he had been charged with three serious offences under the Firearms Act he would be unlikely to attend Court if granted bail: he would probably receive a custodial sentence if he was eventually found guilty.

- The CPS representative at Court relied on the contents of Form MG7 which had been completed by DC (now DS) Loudon, who was in charge of investigating the firearm matter:

> *"This man was arrested after having been seen by police to discard a .25 semi-automatic pistol which contained seven rounds of ammunition, one of which was in the breech. It cannot be emphasised strongly enough the injuries, if not fatalities, that such a weapon would cause in an area where similar incidents appear to be heavily on the increase. At this stage, one can only speculate what this firearm was intended for in the hands of a 19 year old man who apparently has no convictions. The area is well-known for its drug activities and in the last few weeks a murder was committed where a pistol was used.*
>
> *It is felt that this individual, who has given no account for having this firearm and ammunition in his possession, is more than likely to ignore any bail conditions set by the court, resulting in him failing to appear at further hearings. The address given by Hutchinson apparently is his sister's, who I am led to believe stated that he does not reside there."*

  In the concluding passage, which is not only accurate but chillingly prophetic, he said:

> *"Bearing in mind the seriousness of the charges preferred, it must be suggested that should he be granted bail it would afford him the possibility of obtaining a further firearm and the resulting actions could lead to even more offences, including violence. In essence, the public has a right to be protected from such individuals."*

- Despite these forceful and justified objections the Court granted bail on condition that:
  i. his brother stood as a surety in the sum of £5,000;
  ii. he resided at his brother's address in Croydon;
  iii. he was subject to a curfew between 9 p.m. and 7 a.m.;
  iv. he was prohibited from coming within five miles of the King's Cross area except for the purposes of attending Court or seeing his solicitors;
  v. he reported to Croydon police station daily between 6 p.m. and 7 p.m.

- On 13th August he attended Croydon police station in order to comply with his bail conditions. Because he was kept waiting he became abusive, and as a result was detained in a cell for a short time. A small quantity of cannabis was found on him. He was cautioned. While he was in the cell he became convinced that there had been a dead body in it and that he had been *"harmed by the fumes"*.

- Over the next few weeks Wayne Hutchinson became depressed; he had a poor appetite; he lost weight; his sleep was disturbed and he suffered from headaches. He took analgesics and increasing amounts of cannabis. He told the Inquiry that he stopped taking crack cocaine at this time. He became withdrawn , played loud music and became verbally aggressive towards his

mother. He started hearing voices which told him to *"look up or down"*. He obeyed them.

- Between 28th July and 8th September he appears to have complied with his bail conditions.

- On 8th September 1994 he appeared at Clerkenwell Magistrates' Court and was committed for trial on the firearm charges to Middlesex Guildhall.(7) Bail was renewed on the same terms, save that he was required to report to Croydon police Station on Monday, Wednesday and Friday only.

- By early September he was unable to work. His mother attributed his malaise to stress caused by the arrest and the pending criminal proceedings. He became convinced that his mother was contaminating his food and was trying to poison him. He took to boiling the tap water before drinking it, and stopped eating the food she cooked for him; he ate take-away food instead. When he attended the genito-urinary clinic at King's College Hospital complaining of a urethral discharge, he refused to let any male nursing staff examine him. By this time he believed that his teeth and feet were infected and that his body was physically deteriorating.

- On 19th September he visited the GPs' surgery at the Stockwell Group Practice with his mother. He complained of headaches and depression. The GP thought that his mental state was *"odd"*. Analgesics were prescribed. On 7th October he saw another doctor from the same practice. Again he was thought to be behaving strangely. He was given analgesics and a medical certificate for three months on the grounds of *"nervous debility"*. Until this time he had never complained of any significant medical problems.

- On 11th October he told Dr. J. Hitchens at the surgery that he had not been able to attend Croydon police station on 5th October because he was suffering from diarrhoea.

- On 17th October his mother again informed Dr. Hitchens that he was unwell and that he had failed to keep an appointment with his solicitor (in connection with the firearm charges). Mrs. Hutchinson telephoned Croydon police station and told the custody officer that her son's failure to report to the police station since October 12th was due to *"depression"*, and said that a medical certificate would be forwarded.

- She brought her son to the surgery again the next day. For the first time he revealed that he was hearing voices and that he believed his head was *"expanding"*. Dr. Hitchens suggested that he see a psychiatrist, but he declined to do so. Very sensibly, Dr. Hitchens then telephoned Wayne Hutchinson's solicitor and suggested that a psychiatric report should be obtained. He followed this up with a letter, in similar terms. He also wrote to Croydon Police Station:

> *"I have seen Mr. Hutchinson today and believe him to be mentally ill. He will not accept this. I understand he has not been attending the police station as required. I think this is part of his mental illness".*

- Dr. Hitchens did not believe that detention under the Mental Health Act 1983 was appropriate at this stage.

COMMENT

- Dr. Hitchens could not have done more to alert the police and Wayne Hutchinson's own solicitor to his condition. His approach to the application of the Mental Health Act at that stage of the development of the illness was reasonable.

- Wayne Hutchinson saw Dr. Hitchens again on 27th October. On this occasion he gave a three day history of pain in his bottom. He said that it was turning into a vagina. Presented with these

symptoms Dr. Hitchens immediately arranged for him to be seen at the out-patient department at St. Thomas' Hospital. On this occasion, Wayne Hutchinson agreed. Dr. Hitchens' referral letter -- which proved to be an important document -- reads as follows:

> *"Thank you for seeing Matthew. He has been unwell for a month or so. Initially he just seemed a bit odd. Last week he had some definite psychotic symptoms and he says he was hearing voices and his mother's food was giving him trips. Today he tells me he has a pain in his bottom and it is turning into a vagina. He sounds a little more aggressive.*
>
> *He is also on bail at present, for carrying a firearm, but has refused to see a solicitor. His mother is having to take care of this.*
>
> *These are all, I am sure, symptoms of a psychotic illness ? stress induced. He does not use drugs heavily".*

COMMENT

- Dr. Hitchens' referral was thoroughly justified. His letter alerted the hospital staff, in the clearest possible terms, to a pending allegation of a serious criminal offence committed by a person who was suffering from a psychotic illness. The public safety implications were, or should have been, obvious.

CHAPTER FOUR

Admission to St. Thomas' Hospital

- Mrs. Hutchinson escorted her son to St. Thomas' Hospital immediately. He was seen by Dr. Onyanga, the duty Psychiatric Registrar, in Scutari, the out-patient department. Dr. Onyanga elicited a similar history, but when Mrs. Hutchinson said that he probably used cannabis, her son became verbally aggressive and suspicious of the notes that Dr. Onyanga was writing. This rapidly developed into physical and verbal aggression. He shouted that the hospital staff were going to kill him. He was eventually restrained by members of the nursing staff and given an intra-muscular injection of Lorazepam, as a sedative. Dr. Onyanga thought he might be suffering from a drug-induced psychosis.

- Shortly afterwards he was seen by Dr. Maria Fotiadou, Senior Psychiatric Registrar, who completed the medical recommendation for compulsory admission for assessment under section 2, Mental Health Act 1983.(8) She believed that he ought to be detained under the Act, not only in the interests of his own health and safety but also *with a view to the protection of other persons*.

COMMENT

- Even though the section 2 procedure was not completed until the next morning, it was correctly invoked and executed.

The violent incident in Scutari occurred before the section 2 admission procedure could be completed. The medication, which was forcibly given at this stage, was administered to safeguard the patient and members of staff. There was a proper clinical basis for its administration.

- Dr. Fotiadou told the Inquiry that she was aware that a firearm offence had been mentioned in the referral letter from Dr. Hitchens and that this had influenced her opinion about Wayne Hutchinson's level of potential dangerousness. This early assessment was, as events were to demonstrate, fully justified. Regrettably, insufficient attention was subsequently paid by other medical and nursing staff to the quite separate ground for detention under the Act, namely, that he represented a risk to *others* as well as to himself.

- While he was waiting for Wayne Hutchinson to calm down, Chris Strahan, an Approved Social Worker who was based at St Thomas' Hospital and employed by Lambeth Social Services, was able to talk to his mother and thus gain some knowledge of his family background. She told him that her son had been arrested for possession of a firearm in July, but she insisted that he was innocent and contended that the arrest was the cause of his depression and disturbed behaviour. She said that he had been complaining of pain in the right buttock and that a vagina was growing there. He had told her the devil was responsible for it.. Chris Strahan felt that Mrs. Hutchinson had little understanding of her son's illness.

- At 2.30 p.m. he was admitted as an emergency to Lloyd Still ward, which is an open ward, under the care of Dr. Henry Oakley, Consultant Psychiatrist. Although by this time he had calmed down considerably, he insisted on leaving the ward and it needed two hours' negotiation to persuade him to go to his room. Chris Strahan was then able to make a more detailed assessment of his symptoms. He was agitated, disorientated, and seemed to be responding to hallucinations. He frequently requested cannabis but when he was asked how much he used he said he only smoked *"a little grass"* and denied using other drugs. He was convinced a vagina was growing on his body and was *"accusatory towards family members"*. Mr. Strahan compiled an extensive hand-written report which incorporated all this information and concluded:

  > *"Matthew is demonstrating thought disorder. He is obviously concerned about the forthcoming Court case and I think he feels he faces a prison sentence. My own particular feelings are that he may well have an underlying mental health problem, which has been exacerbated by cannabis, and now by the threat of prison/criminal record. I think he is a typical young black south Londoner who is reacting to possibly unfair treatment by the State and for future prospects. I do not think he is trying to avoid prosecution by pretending to be mentally unwell."*

  He did not believe that Mrs. Hutchinson was in any danger from her son.

- On admission to the ward an information sheet was completed by nursing staff. The reason for his admission was recorded as follows:

  > *"Psychotic episode. Abnormal belief that his bottom is turning into a vagina".*

- On the reverse of this form the initial nursing assessment referred to the fact that he was on bail for carrying a firearm. The diagnosis entered on the medical admission form was *"paranoid psychosis"* with *"psychotic depression"* as the differential diagnosis. He was prescribed Chlorpromazine (Largactil) 200 mg twice a day and at night and was nursed under 15 minute close observation. He was asleep for most of the day. That evening the second medical recommendation was signed by Dr. Kamal Gupta, who considered -- unlike Dr. Fotiadou -- that Wayne Hutchinson's *own* health and safety were the only relevant grounds for detention under the Act.

- During the course of the next day, Friday October 28th, Chris Strahan completed the application for his admission to hospital under section 2 of the Mental Health Act 1983.

- Chris Strahan told the Inquiry that he had been informed that Wayne Hutchinson had dealt in heroin and crack cocaine, but did not take either substance himself. He had immediately contacted Dr. Oakley and passed on this information to him. He told the Inquiry that this information had persuaded him that there was, now, real evidence of potential dangerousness to others.

COMMENT

- **Chris Strahan's hand-written report was very comprehensive and an excellent example of how such a report should be compiled. Regrettably a copy was never included in the medical notes or sent to South Western Hospital. The report remained in his own files at St. Thomas' Hospital and was not seen by anyone else. This reflected local social work practice at that time. This document, and the information within it, should have been available to others so that it could play a role in any subsequent comprehensive assessment of risk. It should also have been available so as to influence the structure of any treatment plan for this patient.**

- That morning, October 28th, Wayne Hutchinson became verbally and physically aggressive. He tried to leave the ward and had to be restrained by nursing and security staff. He was seen by the duty doctor and was given an intramuscular injection of Zuclopenthixol acetate (Clopixol acuphase), an antipsychotic, and an intravenous injection of Benzodiazepine (Diazepam), an anxiolytic, after which he slept. When he woke up at midday he appeared to be responding to auditory hallucinations. He said he was hearing voices which were telling him to drink water, but which he believed to be poison. At 12.25 p.m. he kicked open the door of the ward and ran off pursued by nursing staff. They managed to stop him on the main road trying to get into a taxi. They brought him back to the ward. He was persuaded to take Chlorpromazine (Largactil) orally but he remained restless, pacing up and down He became disturbed once again and was seen by a junior doctor who found him to be *"actively hallucinating"* and recorded that he was "*asking to see his child upstairs"*. This doctor then made an entry in the medical notes, which read:

> *"Pt will be transferred to South Western Hospital as soon as possible. (Dr. Lawrence's SHO contacted)"*

COMMENT

- At that stage Wayne Hutchinson's child had not been born.

The transfer to South Western Hospital was planned because his home address fell within that hospital's catchment area, and also because Lloyd Still ward was an acute ward serving a busy A&E Department.

- He was then prescribed a further intramuscular injection of Lorazepam in preparation for his transfer to South Western Hospital.

- The nursing notes recorded that arrangements had been made for transfer to *"Nelson ward"* at South Western Hospital. Nelson ward is an open ward.

- At about 5 p.m. Wayne Hutchinson was seen by Dr. Oakley who had received additional information from Chris Strahan (paragraph 76). He also talked to Wayne Hutchinson's mother, but not to Wayne Hutchinson himself, who by that time was asleep. He was unable to conduct a detailed mental state examination. He observed:

> *"The history is of schizophrenia which may be drug-induced. Awaiting*

transfer to Eden ward @ South Western Hospital. Advise oral neuroleptics when he wakes".

Eden ward was a locked ward which contained five beds and accommodated disturbed patients from both St. Thomas' and South Western Hospitals.

- Dr. Oakley felt that he needed to be nursed in Eden ward because of the level of aggression and violence which he had displayed in Scutari; the degree of hallucinosis and confusion; his apparent involvement with firearms; and his attempt to abscond from the ward.

- Dr. Oakley understood that when a patient is transferred to South Western Hospital he or she would come under the care of another consultant who would be responsible for ensuring that an assessment would be carried out and for deciding where the patient would be nursed. However, it was a commonly-held view amongst medical and nursing staff at St. Thomas' Hospital that Eden ward was always full.

COMMENT

- By late afternoon, on Friday 28th October, a significant amount of information was available to the medical and nursing staff at St. Thomas' Hospital about Wayne Hutchinson's behaviour and potential dangerousness. Dr. Oakley's working diagnosis was justified. He was also correct to conclude that Wayne Hutchinson would need to be nursed in a secure environment. Eden Ward would have been appropriate.

- The discharge summary set out the reason for admission to St. Thomas' Hospital as:

  "Psychotic episode. Believes that his bottom is turning into a vagina. Paranoid about his mother poisoning his food".

- At St. Thomas's Hospital an initial nursing care plan had been drawn up by Mr. Lemince, RMN, as soon as Wayne Hutchinson had been admitted to Lloyd Still ward. If Wayne Hutchinson had remained at St. Thomas' Hospital, both Mr. Lemince and Chris Strahan would have expected enquiries to have been made, as soon as possible, so as to obtain accurate information about the firearm allegation. This would have been relevant for the purposes of completing the assessment under section 2 of the Act, and for the purposes of carrying out a proper risk assessment. As it was, he was transferred to South Western Hospital before those steps could be taken. The responsibility for carrying out those enquiries rested, thereafter, with South Western Hospital.

COMMENT

- Although the arrangements governing the disclosure of or access to Chris Strahan's report were unsatisfactory (see paragraph 77 and Chapter 8) and the preliminary nursing care plan at St. Thomas's Hospital omitted relevant detail (see paragraph 213) the clinical and nursing management of Wayne Hutchinson at St. Thomas' Hospital was otherwise in accordance with good practice.

CHAPTER FIVE

Admission to South Western Hospital

- In the early evening of Friday 28th October Wayne Hutchinson, heavily sedated, was

transferred by ambulance to South Western Hospital. He was admitted to Nelson ward, which is an open ward, under the care of Dr. Robin Lawrence, Consultant Psychiatrist. He was seen by Dr. Ojo, the Psychiatric Registrar on duty, who noted that he was soundly asleep and recorded:

> *"Psychotic, not insightful, absconding risk. For review over the weekend. For reassessment by Firm next week. DV."*

Chlorpromazine (Largactil) 200 mg was prescribed twice daily and Dr. Ojo requested that special observation should be continued. His mother stayed with him while he slept.

- A considerable amount of documentation accompanied the patient to South Western Hospital. It consisted of:
  - Dr. Hitchens' referral letter.
  - The notes written in the out-patient clinic (Scutari).
  - The Lloyd Still ward information sheet (which by now included the address of Wayne Hutchinson's solicitor).
  - The Adult Mental Health Admission Form partially completed. (This proforma is designed for the systematic recording of social and psychiatric information).
  - The medical notes.
  - The nursing notes and initial nursing care plan.
  - The statutory documents.
  - The discharge summary from St. Thomas' Hospital.
  - Chris Strahan's report remained at St. Thomas' Hospital.

COMMENT

- We were unable to discover what, if any, arrangements had been made between medical and nursing staff at the two hospitals so as to effect a transfer to Eden ward. Dr. Oakley's note (paragraph 82) was probably more an expression of hope rather than evidence of a concluded agreement. Nor could we discover whether any initial assessment was ever carried out at South Western Hospital in order to determine whether Wayne Hutchinson should be admitted immediately to Eden ward, or even that the nursing staff on Nelson ward knew that such an initial assessment should have been carried out. **WE RECOMMEND THAT clear procedures governing transfers between St. Thomas's Hospital and South Western Hospital should be established.**

- The bed occupancy schedule which was supplied to the Internal Inquiry demonstrates that Eden ward was full on 28th October and that only leave beds were available on Nelson ward, and it was to one of these that Wayne Hutchinson was admitted. He was then heavily sedated.

- As Eden ward was full, a vacancy would have had to be created so as to provide a secure environment for Wayne Hutchinson. If a bed had been available in Nelson Ward or one of the other open wards, a patient could have been transferred to it from Eden Ward. This was a comparatively simple matter but was dependant on the suitability of such a patient for an open ward. If no bed was available on one of the open wards, a patient would have had to be transferred to another hospital so as to create a vacancy on Nelson Ward for the patient from Eden Ward. This would have meant organising an Extra Contractual Referral which was notoriously difficult to achieve in the public sector, in London. Transfers to the private sector were, and are, expensive, and were virtually impossible in the case of a disturbed patient with a history of violence: any such patient would have had to be more settled and be from an open ward. No request for an ECR was made then or at any other time and, as far as is known, the question of transfer of a patient to another hospital so as to accommodate Wayne Hutchinson on Eden Ward was never raised.

- The transfer to South Western Hospital took place on a Friday evening when only out-of-hours medical cover was available. Even though this was unavoidable, it meant that the patient was not seen by his catchment area team until Monday, 31st October. Thus the opportunity for a full assessment was delayed.

- It is an inescapable conclusion that the level of concern which had been registered by Dr. Oakley and by Dr. Fotiadou at St. Thomas' Hospital was not adequately appreciated when he was admitted to South Western Hospital on October 28th. Such lack of appreciation was a significant feature throughout Wayne Hutchinson's admission to South Western Hospital.

- The medical and nursing staff at South Western Hospital were not, however, placed at a disadvantage by not having access to Chris Strahan's hand-written report. At the outset they knew, or should have known, from the available documentation that he was deluded; that he might be suffering from drug-induced schizophrenia; that he might have committed a serious criminal offence; and that he had assaulted nursing staff at and absconded from St. Thomas' Hospital. The contrary view was expressed in the Report of the Internal Inquiry. We do not share it.

- Saturday 29th October was uneventful. Wayne Hutchinson was asleep most of the morning. When his mother visited, she complained about the state of his room. The nursing staff (and possibly Mrs. Hutchinson) hoovered and cleaned it. Sometime during the day the initial nursing care plan, which had been commenced at St. Thomas' Hospital, was reviewed. He was not given any of the prescribed medication and slept throughout the night. On Sunday 30th October he refused his morning dose of Chlorpromazine. At times he was agitated and restless, and tried to leave the ward. He was thought to be suffering from visual hallucinations.

- On Monday, 31st October, Dr. Lawrence saw him for the first time. He was so drowsy that he was barely able to answer questions. It was clear, though, that he was still deluded. The care plan involved halving the dose of chlorpromazine but continuing with special observation. That afternoon Dr. H. B. Dewan, Dr. Lawrence's Psychiatric Registrar, was able to interview Wayne Hutchinson's mother and complete the remaining parts of the Adult Mental Health Admission Form. On this he recorded, under the heading Forensic History,

  > *"Currently on bail because of possessing a gun (police saw him throwing a gun but mum said he never had). On another occasion he received bruises when he resisted police"*

  In the evening his mother brought him some food, which he ate.

COMMENT

- Neither this ward-round -- nor any other ward-round -- was minuted. There are considerable advantages for all members of the clinical team if the names of those who attend, the decisions taken, and the identity of those who are to carry them out, are all recorded in a single document.

- The question whether Wayne Hutchinson should be nursed on Nelson or Eden ward should have been -- but was not -- discussed at this ward-round.

- On Tuesday 1st November he slept until breakfast time. During the morning he was described by nursing staff as cheerful, calm and pleasant. He explained that *"weed"* made him feel good and relaxed. He was not given his lunch-time dose of Chlorpromazine. That afternoon he told the nurses that he wanted to go home and insisted he could smell perfume. The nurses noted *"paranoid ideas and hallucinating"*. He refused the night-time dose of Chlorpromazine.

- Michael Andrews, his "named nurse" - who had been allocated in his absence whilst on leave - saw him for the first time that night. Mr. Andrews wanted to talk to him, but because he said he was tired no conversation took place. Mr. Andrews noted in the care plan review that Wayne Hutchinson remained deluded, was not taking all the medication prescribed for him and was a potential absconding risk.

- On Wednesday 2nd November, Wayne Hutchinson was interviewed again by Dr. Lawrence. He made only a brief note of this meeting and did not record any symptoms, save that Wayne Hutchinson denied hearing voices. Dr. Lawrence recalled, in evidence, that he had asked Wayne Hutchinson about the firearm allegation, but that he had denied all knowledge of it. He was able to recall that Wayne Hutchinson was not aggressive and not, at that time, thought-disordered. Dr. Lawrence thought that these features suggested that his mental state had changed, and that it was possible that he had been suffering from a drug-induced psychosis. When Wayne Hutchinson said he wanted to go home, Dr. Lawrence offered him two hours' leave. After an initial refusal he accepted. He also asked the nursing staff to contact his mother to see if she was willing to have him home overnight. Dr. Lawrence thought that he presented as an interesting case of dysmorphophobia and would be a suitable clinical subject for the membership examination which was due to take place in a few days time.

- At this point one-to-one nursing was stopped. Wayne Hutchinson went home for lunch and returned with his sister, on time, and in a stable condition. He did not take his lunchtime medication. Later that day he was restless and still delusional about his bottom. He refused his evening medication. Mr. Andrews tried to talk to him once again but he was uncommunicative. This was Mr. Andrews' last contact with Wayne Hutchinson.

- On Thursday 3rd November, Mrs. Hutchinson attended Dr. Lawrence's ward-round. She expressed anxiety about her son's use of cannabis but indicated that she was willing to have him home for the weekend until Monday 7th November. He was given a supply of Chlorpromazine to take at home and left the ward with Dr. Lawrence's consent.

COMMENT

- The role of the named nurse was described at that time in a local policy document and, as such, it represented good practice. However, although the nursing care plan identified a number of nursing interventions which were to be undertaken, the named nurse was not able to establish any therapeutic relationship with Wayne Hutchinson. This was, in part, due to his unco-operative and drowsy state over the weekend, but mainly because the named nurse was on a permanent night duty roster throughout his admission to South Western Hospital. This should not have been allowed to happen. (See paragraph 225).

- This meant that day-to-day nursing care was divorced from the care planning process: the named nurse was unable to determine the appropriate nursing interventions or assess their results. He was unable to provide a direct link to the consultant in the multi-disciplinary setting. The contribution of a well-briefed named nurse on November 2nd, during a busy ward-round, would have been invaluable. He was unable to communicate adequately with other relevant nursing and medical staff and with other external agencies, such as the police, the GP or the patient's solicitor.

- Although it should have been a multi-disciplinary responsibility to ensure that all information relevant to the clinical assessment was obtained, neither the consultant nor the named nurse sought to obtain any information about the firearm allegation and the extent of Wayne Hutchinson's drug-taking. The task of making any enquiry about the allegation of a serious criminal offence was not even noted in the nursing documentation until November 11th. **In the absence of the named nurse the Consultant should have shouldered this burden.**

- **We do not accept that the named nurse or the consultantwas materially disadvantaged by not having access to Chris Strahan's report: the relevant information was available from other documentary material on the ward.**

- **An opportunity was lost on November 2nd, when Wayne Hutchinson was calm and cooperative, to undertake the first full assessment for the purposes of section 2, Mental Health Act 1983. This should have included a review of his background, social functioning and past behaviour, together with an investigation of the firearm allegation and his use of drugs.**

- **Although there had been some objective improvement in Wayne Hutchinson's mental state by November 3rd, and Dr. Lawrence believed that this improvement would continue, the granting of leave was, even without the benefit of hindsight, premature. Although the ultimate goal was a long-term therapeutic alliance - and Dr. Lawrence felt that a short period of leave would help to achieve that goal - much greater caution should have been exercised. No comprehensive assessment of his mental state had been carried out by this time. This patient could not, sensibly, be assessed while he was away from the ward. He had been subject to one-to-one nursing care and his stability without it had not been adequately tested. He was *still* delusional (see paragraph 104) and Dr. Lawrence admitted in the course of his evidence that he did not think that his patient's symptoms were adequately controlled at that time.**

- **We do not accept the contrary view, as expressed in the Internal Inquiry Report, that an apparently successful period of two hours' leave on 2nd November provided a reasonable basis for the more extensive grant of leave on 3rd November.**

- **By November 3rd no general assessment of risk had been carried out by Dr. Lawrence. Dr. Fotiadou had expressed the view that he *did* represent a risk to others. The firearm allegation had not been investigated. Dr. Lawrence was influenced by the fact that he had been granted bail. This was unfortunate: the grant of bail should not have suggested that he was not a risk to others; nor did it remove the need to seek details of this serious allegation as soon as possible. No contact had been made with his solicitors or with the police. Nor had the question of risk to his mother been addressed. That this grant of leave was unjustified and unwise was vividly demonstrated by the potentially fatal firearm attack the following day, November 4th (see paragraph 116).**

- **It is likely that Dr. Lawrence was persuaded to grant leave on 3rd November for three main reasons. There was pressure on the availability of beds, even in Nelson ward; Mrs. Hutchinson seemed to be a responsible parent, able to look after his patient; and the general state of the ward meant that the more patients there were, the less would be the optimal therapeutic input for other patients (see paragraph 309).**

- **At that time there was no standard document available for completion by the medical staff when leave was granted under section 17, Mental Health Act 1983. This has since been rectified (see paragraph 292). Good practice demanded that the plan of such leave of absence, including any special conditions and supervision arrangements, was recorded clearly in the case notes or in a standard document. No such record was ever made in respect of this patient.**

- **On 4th November, the day after he had been granted leave by Dr. Lawrence, Wayne Hutchinson went to a club called *Mixes*, in Stockwell Road. After drinking there for a time he went outside, sat in his car smoking cannabis, and waited. As three men came out of the club he fired a .38 revolver at them. Fortunately, he missed, and they ran off. A few**

minutes later, when he attempted to re-enter the club he became involved in an argument and scuffle with the doormen, one of whom was Anthony Kellman. During the incident Wayne Hutchinson suffered a black eye and his revolver was seized. (The incident rankled. On 27th December he returned to *Mixes* and shot Anthony Kellman dead with a sawn-off shotgun: see paragraph 3.)

COMMENT

- **This incident demonstrates that within a short time of being released on bail, on 28th July, Wayne Hutchinson was able to acquire another handgun. It also illustrates his underlying mental state and level of dangerousness when he was granted leave. This had not been recognised by the medical and nursing staff by this time. The incident emphasises, too, the accuracy of Dr. Fotiadou's initial assessment and provides justification for Dr. Oakley's expectation that Wayne Hutchinson would be nursed on a locked ward.**

- **Wayne Hutchinson failed to return to hospital on Monday 7th November as directed. Instead, his sister attended the ward-round. She reported that, although he had been sleeping well without medication, he had been staring into the mirror for lengthy periods. Dr. Lawrence was concerned about this. He felt he would have to be brought back to hospital. Nursing staff telephoned Mrs. Hutchinson and asked her to return her son to the ward *"as a bed is available"* (i.e. on Nelson ward).**

- **The next day, 8th November, the nursing staff informed Brixton police station that he had failed to return to hospital. Eventually, at 5 p.m., police officers brought him back to hospital in handcuffs. He was very argumentative, extremely paranoid, and refused to stay in the ward. While he was still handcuffed, he was persuaded to take Droperidol, an antipsychotic, by mouth. Then he calmed down. His black eye was noted and he admitted having been involved in a fight the previous Friday. The eye specialist at St. Thomas' Hospital was contacted. Droperidol was prescribed in addition toChlorpromazine. Special one-to-one nursing was restarted. Dr. Dewan noted *"Clearly psychotic. High absconding risk"*.**

COMMENT

- **Wayne Hutchinson did not give any details of this fight to Dr. Dewan. His named nurse did not talk to him about it, either that evening or later. The hospital therefore knew nothing of the *Mixes* incident. In failing to establish any details of the fight, an important opportunity was lost for assessing Wayne Hutchinson's capacity for violence. Indeed, the details only emerged during interrogation by police officers following his arrest in January 1995.**

- **When he was brought back to the hospital by police officers on November 8th he should have been admitted to a locked ward, even though the staff did not know about the *Mixes* incident. But Eden ward was full. Dr. Dewan told us that if a bed *had* been available he would have been admitted to Eden ward. Nonetheless, attempts should have been made to provide a bed for Wayne Hutchinson in Eden ward, either by the transfer of another patient to Nelson ward or by arranging for an ECR. No such attempts were made. Nor was he fully re-assessed on 8th November as he should have been.**

- **On Wednesday morning, 9th November, he made repeated attempts to leave the ward. There was then a period of calm after he had been encouraged to take his medication. Despite that, he tried on numerous occasions, during the course of the afternoon to leave the ward. Eventually at 2.40 p.m. he succeeded in pushing past two members of the nursing staff who were standing guard at the unlocked door to the ward. He was pursued**

by the ward staff, but managed to elude them.

- **The ward staff immediately informed Brixton police station and Mrs. Hutchinson. She promised to inform the ward if her son made contact with her.**

- **Dr. Myers, the duty Psychiatric Registrar, had been on the ward when Wayne Hutchinson absconded on November 9th. He made an important note in the medical records:**

> ***"When he returns he will need sedation. To continue 1:1 observation (there are no available beds in Eden ward)."***

- **At 11 p.m., Mrs. Hutchinson telephoned the ward and informed nursing staff that he had been to her home, taken some medication, and was staying at a friend's house. She was asked to encourage him to return for the ward-round the next day.**

COMMENT

- **The hospital staff acted correctly in alerting the police, and his mother, when he failed to return on the 7th, and when he absconded on the 9th.**

- **At 12.30 p.m. the next day, Thursday November 10th, Mrs. Hutchinson brought her son back to the hospital. Dr. Dewan was on leave so Dr. R. F. Saxena, a locum Psychiatric Registrar, was called to the ward. He told the Inquiry that the medical notes were not made available to him and he was therefore unaware of what Dr. Myers, in particular, had written the day before. He wrote his own note of this encounter on a loose sheet of paper (the word "file" appears on the top of this sheet of paper). Before seeing the patient he talked to nursing staff who told him, simply, that Wayne Hutchinson had returned from leave. No-one advised him that he had been absent without leave. He maintained in his evidence to the Inquiry that he was not alerted to any factors which would have suggested that Wayne Hutchinson was a risk to others; and, crucially, he was wholly unaware that Wayne Hutchinson was a detained patient. Having noticed that Wayne Hutchinson had an injury to his left eye he carried out a general physical examination. No other injuries were found. Dr. Saxena told the Inquiry that Wayne Hutchinson had explained that the injury was the result of a friendly punch-up. His psychiatric examination seems to have been brief, as his initial note reads:**

> ***"Return from holiday. Accompanied by mother. Well behaved at home. Taken medication at home. History of injury to left eye in a fight. Does not look depressed. Good flow of speech. Poor eye contact. Continue medication. Observe".***

- **He initially intended that Wayne Hutchinson should return to the ward but, after a further conversation with Mrs. Hutchinson who wanted to take her son home and bring him back to the hospital on Monday 14th November, he changed his mind. She told Dr. Saxena that he had been well-behaved while *"on leave"* at home. Dr. Saxena's note reflects this change of plan. Dr. Saxena recalled that while initially Wayne Hutchinson was content to stay in hospital he then became reluctant to do so. Since Dr. Saxena assumed that Wayne Hutchinson was an informal patient, he saw no reason to consult Dr. Lawrence. He allowed him to leave the ward until Monday, 14th November. He was given medication to take at home. Dr. Lawrence was unaware of this action at the time.**

COMMENT

- **This was a catastrophic error with fatal consenquences. Although Dr. Saxena had never**

previously met Wayne Hutchinson or his mother, he was too easily persuaded to agree to a further period of leave. However, he did not know that Wayne Hutchinson had been detained under the Mental Health Act, nor did he know the relevant background. No section 17 document existed. Had he been aware of these details he accepted that he would not have allowed him to leave the ward. He acknowledged that he had no authority to grant leave to a detained patient, although he had granted leave to informal patients in other hospitals. Nonetheless, even though the medical notes were not available he should have asked the nursing staff for the essential details and refused to make a decision until he obtained them. He should have asked to see the nursing notes. They would have revealed the true picture to him. In any event, the nursing staff should have provided him with a summary of the relevant details, including the important fact that he was a detained patient who had absconded from the ward on November 9th. Dr. Saxena's management of this patient and that of the nursing staff on this occasion fell well below the standard to be expected. WE RECOMMEND THAT medical staff who have no first-hand or contemporary knowledge of a patient's circumstances should not take clinical decisions without first scrutinising the relevant case notes.

- **Dr. Lawrence accepted that if he had been called to see Wayne Hutchinson that morning, November 10th , he would not have allowed him to leave the ward. Even though there was still no bed available in Eden ward, he would have had to be nursed on Nelson ward (where a bed *was* available at that particular time of day), until an out of district placement could be found. However, the stark reality is that if he had been admitted to Nelson ward he would probably have tried to abscond again - and may have succeeded - despite the best efforts of the nurses who were guarding the door to the ward.**

- **At 4.30 p.m. that afternoon police officers, who were still acting on the information which they had been given by the hospital the previous day, brought Wayne Hutchinson back to the hospital. Dr. Lawrence, who had by this time discovered Dr. Saxena's error, was informed that Wayne Hutchinson had arrived. On hearing this welcome news he made his way to the ward. But before he reached it, Wayne Hutchinson had disappeared.**

- **Dr. Lawrence told us that he had asked the nursing staff to hold Wayne Hutchinson until he was able to reach the ward, and was very dismayed to find that he had left by the time he arrived there. By this time of the afternoon there were no beds available, either on Eden or Nelson wards.**

COMMENT

- **It is not clear why the nursing staff did not act on Dr. Lawrence's instructions. However, if he had managed to see Wayne Hutchinson on the ward in the afternoon and had countermanded Dr. Saxena's decision -- which, he told us, he would have done -- he would have faced the very real problem of finding him a bed. There is little doubt that this patient not only needed to be in hospital but, given his absconding record, he needed to be in a locked ward. An out of district placement would have had to be found.**

- **There was a profound breakdown in communication between nursing and medical staff on November 10th. This allowed Wayne Hutchinson, who by now was very dangerous, to remain at large in the community. It allowed him to gain access to yet another firearm and use it, with fatal consequences, six weeks later. WE RECOMMEND THAT a medical and nursing handbook for full-time and temporary staff should be produced which identifies and explains existing policies, protocols and procedures and which summarises the legal framework of the Mental Health Act.**

- **Ominously, Wayne Hutchinson did not return to the hospital on Monday 14th, in breach of the leave arrangements sanctioned by Dr. Saxena. His circumstances were discussed at the ward-round that day. Dr. Dewan recorded in the medical notes that Nick Raghoo, Community Psychiatric Nurse, would telephone his mother and ask her to bring him back to the hospital and would request the assistance of the police, if necessary. However the nurse who compiled the ward-round documentation for that day interpreted the situation rather differently:**

"When a bed is found, inform family then Matthew **[Wayne]** ***should come to hospital. Michael*** **[Andrews]** ***or nurse in charge ring mother and ask if Matthew wants to come to hospital. CPA planned for 15.12.94. Michael to send invitation letters."***

There is no suggestion in that note that any role had been allocated to the Community Psychiatric Nurse.

- **Letters of invitation were sent later that day to the GP; social worker; case manager; the outreach team; to Wayne Hutchinson himself, and to his mother and sister. It was assumed that he would have returned to the ward by 15th December.**

137. At 4.50 p.m. the police at Brixton were informed for the first time by the ward staff that Wayne Hutchinson had been missing from the ward since November 10th . However they were not told that he was on bail for a firearms offence: nor were they told that he was potentially dangerous.

COMMENT

It is regrettable that Dr. Lawrence took no steps prior to 14th November to countermand Dr. Saxena's action and cause this dangerous patient to be returned to hospital. Dr. Lawrence failed to appreciate - as he should have done - the real risk posed by this patient.

- **Shortly before 8 a.m. on Tuesday, 15th November, Mrs. Hutchinson telephoned the ward to say that her son had just left home. Half an hour later, Sgt. Marshall from Brixton police station informed the ward by telephone that the police had visited Mrs. Hutchinson's address, only to discover that he had indeed disappeared.**

Mrs. Hutchinson told the Inquiry that this was the last time the police came to her home before he committed the index offences.

- **The nursing note for 15th November records that the police *"will now wait for his mother to contact Brixton police whenever he comes home".***

- **On the evening of 15th November, the named nurse, Michael Andrews wrote:**

"CPN Nick Raghoo was contacted to ring mother and persuade her to return him to the ward for assessment."

COMMENT

- **The nursing note made on 14th November suggests that there were, now, no beds available on either Eden or Nelson wards: the bed situation was thus as difficult as it had been on November 10th. This is confirmed by the bed occupancy levels (see Appendix 5). If Wayne Hutchinson had returned to hospital on the 14th as anticipated, the hospital would have faced exactly the same problem in finding him a bed as the nursing and medical staff would have faced on the 10th.**

142. Dr. Lawrence conceded, in his evidence to the Inquiry, that if Wayne Hutchinson had returned to the hospital on Monday (14th November) his mental condition was such that he would have required a bed in Eden ward. He admitted that he had never asked for a bed to be made available for Wayne Hutchinson on Eden ward -- or suggested a transfer to another hospital -- at any time.

- **Despite Dr. Lawrence's candour, the reality is that the medical staff did not recognise or suspect -- as they should have done -- that this patient was potentially dangerous. There was no real sense of urgency about returning Wayne Hutchinson to hospital: insufficient concern was expressed by members of the multi-disciplinary team that this detained patient, who had never been properly assessed, was at large. Crucially, the hospital failed to brief the local police on the relevant facts.**

- **In 1994 there was no written policy concerning the admission of patients to Eden ward, either following transfer from St. Thomas's Hospital, or generally. The situation has since been clarified and a policy document, which we commend, was published in June 1996.**

- **The pressure on Eden ward was such that Dr. Z. Atakan, Consultant Psychiatrist at South Western Hospital, was moved to express her concerns in writing to the Secretary of State,**

in May 1994. One paragraph of her letter illustrates the serious nature of the problem:

". . . on Thursday 19th May as a team in our intensive care unit we had all decided that none of the five patients could be transferred out as they were all highly disturbed, three of them waiting to be placed in private secure units. Today (23.05.94) there are 4 new patients who had been admitted to our unit over the weekend as they were even more disturbed than those who we wanted to keep in the unit. Those patients who were transferred out are in open wards being specialed, continuing to present danger to society and staff. This is not good practice; this is against my clinical judgement; it is not fair on those individual patients who are being shifted from one unit to another and it is not fair on us, as staff, who have all had continuous serious concern for our own safety."

The situation she described in May 1994 remained essentially unchanged during Wayne Hutchinson's short-lived admission to South Western Hospital.

- **There is overwhelming evidence that during 1994 there were too few beds in Eden Ward to meet the needs of patients from the relevant catchment area. The pressure on these beds was such that only the most disturbed patients could be admitted, and then only with difficulty. Nevertheless, in Wayne Hutchinson's case the combination of delusions, disturbance, absconding and a potential association with firearms, made treatment on an open ward unacceptable: he should have been admitted to Eden ward from St. Thomas' Hospital as Dr. Oakley originally expected. The evidence also demonstrates that there was an inadequate number of beds in Nelson ward, too.**

- **Had Wayne Hutchinson been admitted to Eden ward it would have been easier to assess him, control his illness, and manage his treatment in the long-term. It would have allowed a more cautious approach to his management. His return to the community whilst still psychotic would probably not have been permitted, and, crucially, Dr. Saxena would not have been placed in a false position on November 10th. WE RECOMMEND THAT the number of beds in the locked ward should be maintained at an adequate and realistic level.**
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- **In normal circumstances, the Community Psychiatric Nurse would be the ideal person to visit a patient's home to investigate the reason for the patient's failure to return to hospital. However, the wisdom of a single CPN confronting a disturbed patient suffering from schizophrenia who had already been charged with the possession of a firearm, is debatable. In any event, Mr. Raghoo, the CPN who might have been otherwise involved, denied in his written response to the Internal Inquiry that he had ever received a referral from the ward to assist with Wayne Hutchinson, despite Michael Andrews' note dated 15th November. Mr. Raghoo never made any visit to Mrs. Hutchinson's house or had any contact with her, or with the police. It is regrettable that Mr. Raghoo did not accept an invitation to give evidence before this Inquiry.**

- **Even though there was some confusion in mid-November as to who should do what, Dr. Dewan phoned Mrs. Hutchinson on 16th November and warned her about the risks if her son did not take medication. She told him that he was not at home and that he *"came and went".* She promised to contact the police if he returned. Dr. Dewan telephoned her**

again on Friday 18th, and was told that he had not returned. On Monday 21st his absence was mentioned at the ward-round and it was agreed that a deadline for his return to

hospital would be imposed, otherwise he would be discharged. His detention under section 2 was due to end at midnight on 26th November, i.e. twenty-eight days after his original admission. His mother was telephoned by the ward staff on several further occasions.

- **On Monday 28th November, by now technically an informal patient, Wayne Hutchinson was again discussed at the ward-round and formally discharged in his absence against medical advice. No out-patient appointment was arranged; nor were any arrangements made for the Community Psychiatric Nurse to follow him up.**

- **Dr. Dewan completed a discharge summary the same day. The clinical part of the discharge summary reads:**

"Diagnosis. Schizophreniform Psychosis (Acute Psychotic Reaction).

Care Plan. Patient was admitted on Sec. 2, after an assessment at A&E. Went home and refused to come back. We could not get him back in spite of strenuous efforts. No follow up. Discharged against medical advice."

- **The handwritten discharge proforma referred to the *"harmful effects of cannabis"* as a subsidiary diagnosis. The medication which he had been given was not mentioned in either of these two documents. The proforma ends by saying that if a full length summary is required, Dr. Lawrence's secretary should be contacted. In fact such a summary was not written until 2nd February 1995. The catalyst for that appears to have been a request for information from HMP Belmarsh after he had been remanded in custody. WE RECOMMEND THAT full discharge summaries should be completed as soon as possible after a patient's discharge from hospital and the time taken to do this should be audited.**

- **Having been admitted to hospital under section 2 of the Act, Wayne Hutchinson did not fall within the provisions for aftercare provided by section 117 but, as with all psychiatric in-patients about to be discharged from hospital, he did qualify for assessment under the Care Programme Approach. Dr. Dewan partially completed a Care Programme Approach pre-discharge checklist and indicated on it that Wayne Hutchinson was not**

subject to sections 3 or 37/41 of the Act. It included the observation: *"Patient absconded from the ward, and remained out in spite of strenuous efforts"*.

COMMENT

- **A brief resume of his recent psychiatric history should have been set out on the reverse side of the pre-discharge checklist. It should have referred to paranoid schizophrenia; the delusions about his mother; that he had absconded from**

hospital; that he posed a risk to others and that he would probably need to be admitted to hospital again in the future.

- **The CPA conference had already been scheduled for Thursday, 15th December. The Inquiry was unable to find any record of this meeting, and Dr. Lawrence told the Inquiry that he could not remember whether such records were made. What he did remember was that neither Wayne Hutchinson; his mother; the CPN; nor the social worker attended, and in the circumstances he could see no point in formulating a care plan or identifying a keyworker.**

COMMENT

- **After Wayne Hutchinson was formally discharged on 28th November, and particularly when he and his mother failed to attend the CPA conference on 15th December, no further steps were taken to locate and engage him, either directly or through his mother or sister, despite the real and continuing risk that he represented to the community. Further steps could have been taken: the GP could have been invited to help; the CPN or social worker (preferably in pairs) could have been invited to visit the family home. His solicitor could have been approached. The hospital staff could have reinforced their concerns by communicating directly with the police at Brixton: the last contact with them had been on 15th November. WE RECOMMEND THAT whenever a patient has absconded from hospital his case should not be closed, even though the relevant period of detention under the Act has expired and no plan for aftercare has been formulated: further attempts should be made to locate and persuade the patient to return to hospital.**

- **Attempts to persuade a potentially dangerous schizophrenic to return to hospital which are limited -- as here -- to a series of telephone calls to his mother, does not justify the accolade that *"strenuous efforts"* were made to achieve that objective. The hospital's response whilst he was still subject to detention under the Act, was particularly inadequate. The hospital should not have relied solely upon his mother's protestations that she was ignorant of his whereabouts and should have been far more pro-active in seeking his cooperation.**

- **The underlying problem was that the hospital had never fully appreciated just how dangerous Wayne Hutchinson might be. No proper risk assessment had ever been carried out. There is no reference to the question of dangerousness in the clinical notes. As the psychiatrists at his trial explained, Wayne Hutchinson had become a serious danger to the**

community by early November 1994. Had the medical staff realised the extent of the potential danger, the efforts to being him back to hospital would probably have been greater, and may well have been successful. If so, he would have been prevented from killing and injuring members of the public in December 1994.

- **We do not agree with the conclusion of the Internal Inquiry that there was *"frequent contact with both police and his family . . . if the police were unable to trace him and return him, there was nothing further for health care professionals to offer . . ."*. The hospital had no idea what steps, if any, the police were taking. Furthermore, there**

***were* steps that the health professionals could have taken (see paragraph 156). Equally, we disagree that *"It is unlikely that any further efforts on the part of the community nurses or the GP would have proven fruitful"*. They were never asked.**

- **On 30th November Mrs. Hutchinson obtained from another GP in the Stockwell practice a medical certificate for six months, on the grounds that her son was suffering from a "*Psychotic illness*".**

- **On Christmas Day he visited his mother and behaved very oddly. After a short time he suddenly spat on the floor and walked out abruptly.**

- **According to Dr. Baxter at Broadmoor Hospital, it seems that after he left South Western Hospital on November 10th he continued to have headaches and *"visions of his life passing in front of him"*. To relieve his symptoms he apparently smoked double his usual amount of cannabis. Later in November he went to see his church pastor to discuss his experiences. He was offered a drink of Tiger Balm and honey by the pastor's Chinese wife and from that moment he felt *"special"* and knew that something good was going to happen to him. He believed that his backache signified that people were *"taking the piss"*. He told Dr. Baxter that he had been hearing voices, in the latter part of the year, telling him to *"explain things"* to other people. He told members of the Inquiry Panel that in addition to cannabis he was taking crack cocaine at this time to relieve his symptoms. He said that the television and people in the street had been talking about him and that he had heard voices from God and the Devil telling him to do *"horrible things"* to people, especially to Delroy Thomas. He believed that his friends, and even his mother, had turned against him. This was the reason he began to carry a knife in December 1994. At the same time he had what he described as *"weird thoughts"*, for instance that he was *"invincible"*. Mrs. Hutchinson described her son's demeanour after he left South Western Hospital as moody, angry, and disinhibited.**

COMMENT

- **These symptoms were described months, and in some cases years, after they occurred.**

Although they are consistent with the development of a severe psychotic illness, it is impossible to verify that they occurred in exactly the way they were described.

- **Between 15th November 1994 and his arrest on 1st January 1995, it is not known precisely where Wayne Hutchinson was living. The medical and nursing staff suspected that he visited his mother's or his sister's home from time to time. If he did so, Mrs. Hutchinson did not alert the police or the hospital as she had undertaken to do. It subsequently transpired, although it was not known at the time, that he had a girlfriend who gave birth to his child on December 27(9): it is possible that he stayed with her occasionally. Alternatively he may have stayed at his brother's home in Croydon (as was required by the terms of his bail) -- although his mother had told the ward staff that he was not there either. He may also have stayed at the address in Streatham where the police later found the shotgun and ammunition (see paragraph 11).**

CHAPTER SIX

Substance Misuse

- **Drug misuse has featured from the very beginning of what is now a series of homicide inquiries(10) Thus, in the case of *Buchanan*(11) the use of crack cocaine was an important factor in the development of his mental condition and in *Clunis*(12) a misdiagnosis of drug-induced psychosis prevented the proper treatment of the underlying schizophrenic disorder.**

Cocaine

- **Cocaine is a cerebral stimulant. Crack cocaine is a preparation which can be smoked or inhaled and it produces an immediate but short-lived feeling of intense euphoria followed by a period of profound depression and a craving for the drug, which may be severe. Some of those who take it become as dependent on it as heroin addicts or alcoholics and therefore increase their intake, thus incurring a risk, not only to physical health, but also, occasionally, of sudden death. There is also a risk that a brief paranoid psychosis may be produced which usually remits within twenty-four hours(13) These medical risks of cocaine have been known to the medical profession for a long time(14) In 1989, shortly after the emergence of crack cocaine in the United States, the House of Commons Home Affairs Committee produced a somewhat emotive report which highlighted, in particular, the crime and violence associated with it (Home Affairs Committee 1989).**

- **In 1993 a comprehensive review article on cocaine in the UK was published in the British Journal of Psychiatry, although no mention was made about its ability to cause violence in those who take it.(15) However, one of its conclusions was that the general psychiatrist**

now needed to have a knowledge of the psychopathology directly and indirectly related to cocaine abuse. Although the authoritative British Crime Survey[(16)] showed that in 1994 fewer than 1% of young people had ever tried cocaine and even fewer had tried crack, the use of these substances was increasing considerably in some areas and in some populations. Thus in 1995 a "*particularly dramatic increase*" was reported in the use of crack amongst contacts of GPs and other health agencies in the South East London Health Authority, part of which is served by South Western Hospital;[(17)] while at the Maudsley Hospital the proportion of substance abusers attending a community drug team who had used cocaine rose from 13% to 29% between 1987 and 1989, and of these the proportion using crack had risen from 15% to 75%.[(18)] Most of these were heroin addicts who had added cocaine to their repertoires. They would have come from the area adjoining the catchment area of South Western Hospital and which shared its social characteristics.

Cocaine, crime and violence

- **Crime and violence are associated with cocaine in three ways. First as a means of providing the funds to pay for the drug. For this, hundreds of pounds a week may be needed, far more than can possibly be provided from the kind of work addicts are capable of, still less from what they can obtain from Social Security.[(19)] The immediacy of their needs means that robbery may be preferred to burglary, and dealing is always an option. The second association is with the turf wars which are an inevitable result of the extremely profitable illegal trade in drugs. The third association, of more relevance to psychiatrists, is with the pharmacological effects of cocaine on the brain and behaviour.**

- **In many cases, careers of crime and violence start well before the abuse of drugs. This led to the belief that drug abuse and criminality were unrelated products of the same adverse social factors. However there is now sound criminological evidence that abuse of crack cocaine is associated with, and probably causes, increased levels of violent crime -- including homicide -- over and above the levels that can be explained by socio-demographic determinants alone[(20)]. This is in agreement with the findings of the highly acclaimed and more conventional household study of the Epidemiologic Catchment Area Surveys into the associations between psychiatric disorder and violence, albeit somewhat minor compared with the facts revealed by this Inquiry. This showed how the use of any substance increased the risk of violence: this risk increasing as one ascends the scale from cannabis to alcohol and on to hard drugs.[(21)] It is probable that crack cocaine not only amplifies the risk of violence but can also initiate it.**

- **The relationship between cocaine and violence in the individual is a complex one, mediated by the pharmacological effects and dosage of the drug, the psychological and biological characteristics of the individual and the situational context.[(22)] The direct effect of the drug in promoting violence, even without the development of psychotic symptoms, was described in 1987[(23)] and has been confirmed by interviewing users themselves[(24)]. But a crack psychosis is also possible[(25)] as was shown in 1991 in this country by two cases: one a murder and the other a case of false imprisonment and making threats to kill.**

Dual diagnosis or co-morbidity

- **An existing propensity for violence is one such characteristic, but another characteristic is the presence of a major mental illness. Alcohol and cannabis were the first to attract attention in the context of dual diagnosis, or co-morbidity, but more recently cocaine has come to the fore. Research into dual diagnosis has mainly been carried out in the United States. What has to be explained is why the rate of substance abuse in schizophrenics is often higher, and sometimes very much higher, than in the normal population, and in particular among the young. Rates have been found ranging from 51% in young chronic patients admitted to a private hospital, to 94% in prison populations. In one study in the United States urine tests showed that 37% of the schizophrenic patients were taking cocaine or amphetamines but a quarter of them denied this, and clinicians, presumably well aware of the possibility, missed the diagnosis in a third of these patients. Routine urine tests for all psychotic patients was therefore recommended(26). Leaving aside the still controversial issue of whether drugs can cause chronic (as opposed to acute) psychosis, the commonest and most powerful motive for taking them is probably self-medication, in the hope of relieving the distressing symptoms of the disease. However the disadvantage is that in addition to their euphoriant properties these drugs can also cause acute psychotic symptoms and, almost inevitably, accelerate social decline. Not surprisingly dual diagnosis patients present with more severe symptoms, have more social problems, stay in hospital longer and are readmitted more frequently.**

- **The drugs, the concept, and the research arrived in this country a little later but it is rapidly becoming clear that the problems are similar, though perhaps not yet as severe as in the USA. In 1994, in an area adjoining the catchment area of South Western Hospital, a survey by interview of psychotic patients showed that a third had misused substances, mostly alcohol or cannabis, and, although only 6% were thought to be using cocaine, 50% in the 20-29 age group had used drugs of some kind.(27)**

- **The question of whether dual diagnosis patients are associated with a higher risk of violence has now been answered by research. Thus, in San Francisco, individuals with schizophrenia who abused multiple substances were twelve times more likely to be violent during a three-month follow up period than those who did not abuse substances. Alcohol and marihuana on their own were not associated with violence.(28) These results have now been confirmed in this country, again from an area adjoining the catchment area of South Western Hospital. These studies have been based on small samples over short time-scales, and again, compared with the present context, the violence has not been particularly serious.(29)**

Treatment services

- **A treatment programme for dual diagnosis patients was described as long ago as 1986,(30)**

and the services set up for them in the United States were reviewed in 1994.(31) All seem to be agreed that these patients tend to be rejected by both the mental illness services and the substance abuse services, and that unless special efforts are made they are not treated or, at best, shuttled from one service to another. The situation is bedevilled by differing philosophies, different funding sources, and at times by outright institutional denial. In-patient treatment is needed for detoxification and to clarify the diagnosis, and thereafter intensive out-patient or community outreach follow-up. It is thought that the psychiatric services rather than the addiction services are more likely to be successful, as the latter may be too confrontational for the mentally ill. Denial of drug taking is a recurring problem and frequent drug screening is recommended.(32) Better stabilisation of the psychosis, reduction in the need for in-patient treatment, and fewer social problems are realistic goals. It is too early to say whether violence can be reduced.

- **In their report for 1993-1995 the Mental Health Act Commission drew attention to the growing problem of illicit drugs in the mental health services and felt that *"It may be the appropriate time to give special consideration to the complex legal, ethical and medical issues raised by the misuse of drugs in psychiatric services"*. Some of these issues are beginning to be addressed at local level. Thus the North East Essex Mental Health NHS Trust has produced a Treatment Agreement, to be signed by patients, which covers the issues of bringing alcohol and illegal drugs into the ward; the searching of patients, and the provision of samples for drug testing. Rather less has been implemented at the centre. Thus at a ministerial review held in July 1996 the Commission recommended the setting-up of a multi-disciplinary working party under the auspices of the Department of Health to produce guidelines for good and consistent practice. We are informed that no such working party has been set up, although we are aware that in March 1998 the Department held an "Expert Seminar" on dual diagnosis.(33) There are no departmental guidelines on the management of dual diagnosis patients in hospital, and we know of no services in this country set up specifically for them.**

- **The precedents for setting up effective services for an unpopular clientele are only moderately encouraging. In London, the failure of an attempt to set up a particular service for addicts has been described in depressing detail,(34) but services for abusers of crack cocaine present greater and more daunting difficulties. The report of one outreach project described how traditional drug services had favoured opiate users over users of stimulants and refused to respond rapidly by day, and not at all at night, to the urgent needs of crack addicts. They were not experienced at working in an environment where debts generated fear, threats and intimidation, sometimes backed up by the use of firearms.(35) An undated report by the Social Services Inspectorate of the Department of Health showed how little had been achieved by 1994 for the general run of substance abusers in a sample of five social services departments. Despite these gloomy omens, a national study of services for cocaine users has shown that, at the very least, treatment can reduce criminal behaviour and improve social functioning.(36) These findings were quoted in the report of the independent task force set up by the Department of Health, which made recommendations not only about the treatment of cocaine misusers but also about the need for purchasers and providers to *"ensure that people working in both drugs and mental illness services are aware of the need to identify and respond to problems of combined psychiatric illness and drug misuse"*.(37) This theme has also been endorsed by Keith Hellawell, the Anti-Drugs Coordinator, who said that the Government's ten-year strategy for tackling drugs misuse would *"provide an integrated, effective and efficient***

***response to people with drugs and mental health problems"*.[(38)] Exactly how this policy is to be put into practice remains unclear. A recent leading article in the British Medical Journal calls for the training of a skilled workforce, research into the extent and nature of co-morbidity and the development and testing of new treatment models.[(39)] It is only too clear that there are more pious hopes than easy answers.**

Wayne Hutchinson and substance abuse

- **It is clear, in retrospect, that Wayne Hutchinson gave a very incomplete account of the nature and extent of his substance abuse to the staff of St. Thomas', and South Western Hospitals, to the doctors who saw him on remand, and even to the staff of Broadmoor Hospital. We accept that those who take or deal in illegal drugs are often unreliable witnesses, and we are only too well aware that the additional information Wayne Hutchinson has given us may be no more reliable than the information he has given to others. However, it is convenient to look at what was known about his misuse of substances when he was in hospital, before describing the wider picture.**

- **Dr. Hitchens' referral letter ended by saying "*He does not use drugs heavily"*. In Scutari, Dr. Onyanga recorded that his mother said that "*probably he uses cannabis*". He ended his note with a tentative diagnosis *"? Drug induced psychosis"*. On admission to Lloyd Still ward it was noted that he was a *"heavy cannabis user"*, and this was repeated on the Admission Form, but the diagnosis recorded on it did not include anything about cannabis.**

- **He told Chris Strahan, in Scutari, that he only smoked *"a little grass"*, which, of itself, would not have 'rung any bells'. But the next day Chris Strahan spoke to Wayne Hutchinson's sister, and noted in connection with the Kings Cross episode:**

"She scoffs at the idea of Matthew being an innocent wrongly charged with gun offences. She says that he is used to guns, is involved in drugs and dealing and has 2 cars purchased by drug money".

Chris Strahan told the Consultant, Dr. Oakley, about this, and he then recorded:

"Social worker says he is a crack and heroin dealer on bail for possession of a firearm"

He therefore wrote: *"the history is of schizophrenia which may be drug induced".*

- **After Wayne Hutchinson's transfer to South Western Hospital a note about his cannabis smoking was made at the first ward-round, and on 3rd November his mother expressed her concern about his cannabis-taking to Dr. Lawrence. Thereafter, there are no further references to substance abuse in the medical notes and none at all in the nursing notes. At the end of his stay in hospital, Dr. Dewan did include *"Harmful effects of cannabis"* as a subsidiary diagnosis, on his hand-written Discharge Advice Form , although for some reason this note was omitted from the type-written discharge summary. The full-length Discharge Summary written in February includes, under Drug History, the unequivocal statement:**

"He has been using cannabis on regular basis. No other history of illicit drug use or alcohol abuse"

COMMENT

- **The most likely diagnosis by the time he left South Western Hospital was schizophrenia exacerbated by cannabis abuse. This has now been confirmed by the course of his illness in Broadmoor Hospital. We note that there is no evidence that any attempt has been made to discuss with him the harmful effects of his use of cannabis.**

- **Since he committed the index offences, information has emerged which throws an altogether more serious light on Wayne Hutchinson's involvement with drugs.**

- **Whilst he was on remand at HMP Belmarsh, Wayne Hutchinson told the doctors there that he had been smoking cannabis since he was thirteen. He told Mr. Jackson, Senior Social Worker at Broadmoor Hospital, that while he was at school he had also started dealing in cannabis, and had made considerable sums of money from it. In January 1993 he was cautioned for being in possession of cannabis. In August 1994, when he reported to Croydon Police Station, cannabis was found on him. He was cautioned once more. This episode marked the onset of his psychosis. He told doctors *after* his arrest -- but not before it -- that he had tried to treat his symptoms by taking painkillers and increasing amounts of cannabis. This contrasts with the story he originally told Chris Strahan, *"a little grass"* being all he would admit to. However, it was noted at St. Thomas' Hospital that he was a heavy cannabis user, although it is doubtful if it was realised quite how much he was using. He took cannabis while he was on leave from South Western Hospital and continued to do so after he absconded. at a cost, he claimed, of up to £30 a day. It is of interest that on one occasion when his illness relapsed in Broadmoor, his urine tested positive for cannabinoids.**
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- **Wayne Hutchinson's intake of cocaine is more debatable. What is certain is that a urine sample taken a few hours after he killed Marie Hatton tested positive for both cannabinoids and cocaine. One of his victims, Marlon Snape, told police that he had heard that he had been smoking crack and had become unstable. Wayne Hutchinson gave**

varying accounts to the doctors who saw him before his trial, telling one that he had taken none at all but to another saying that he had taken it five times over the Christmas period.

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- **The story he gave to members of the Inquiry Panel was very different. He said that he had been taking crack in his teens but had managed to stop. He had had withdrawal symptoms but his mother did not realise what was happening. Later, he started taking crack again regularly, perhaps three or four times a week. The drug made him hyperactive, lively and cheerful. Then, not long after the King's Cross incident, he heard the pastor at his church say *"he started too young"* and, *"on realising that this meant him"*, stopped smoking crack. He claimed, therefore, that he was not smoking crack or taking any other drug apart from cannabis when he was admitted to St. Thomas' Hospital. However after he left South Western Hospital he said he resorted once again to taking crack three or four times a week in addition to increasing quantities of cannabis, although by then it was making him feel sick and aggressive rather than euphoric.**

COMMENT

- **If what he told the Inquiry Panel is true, Wayne Hutchinson misled the hospital staff in October 1994 about his previous regular use of crack cocaine. Cannabis use was all he admitted to at that stage. If he had really stopped taking crack cocaine some weeks beforehand, it would not have been detectable even if his urine had been tested on admission. However the positive urine test after his arrest makes it certain that he was under the influence of cocaine when he killed Marie Hatton, and his own account makes it more than likely that he was under its influence when he committed the other offences. Nonetheless, even if what he told the Inquiry was true, the hospital cannot be blamed for failing to identify this particular risk factor. That said, his case does highlight the need for hospitals to do what they can to resolve diagnostic doubts in similar cases. In Nelson ward at the relevant time there were no such procedures in place. WE RECOMMEND THAT all patients admitted to the psychiatric wards at South Western Hospital should be tested for substance misuse.**

- **What he has said about drug dealing has also varied: from a complete denial to recent claims that he could earn up to £1,000 a day (although there could be an ulterior motive for this particular claim). When he was admitted to St. Thomas' Hospital his sister left Chris Strahan in no doubt that she believed that not only was he dealing in drugs but that he was familiar with firearms. Some of the witnesses who were interviewed by the police also implicated him in drug dealing. Indeed one of the motives he gave for his acts of violence when he was interviewed by the police was the need to re-establish his reputation on the street.**

Existing local services for substance abusers

- **The local drug dependence services originally had their in-patient unit at Tooting Bec Hospital, while their out-patients were dealt with at St. Thomas' Hospital. In 1990 the out-patient services were moved to the South Western Hospital site. Several witnesses were unhappy about existing service provision, and Dr. Dewan, the Psychiatric Registrar, was**

unaware of the existence of such a service. Dr. Oakley said the service would commonly take an inordinate time to see a patient of his, and he would then hear little more about him or her. Erville Millar, Chief Executive, Lambeth Healthcare NHS Trust, described a six-month waiting list, and Dr. Lawrence was unable to remember the name of the consultant responsible for the service. Dr. David Roy, Medical Director, Lambeth Healthcare NHS Trust, told us that the consultant had in fact left and they had not been allowed to appoint a replacement. In August 1994 the services were taken over by, and relocated at, the Maudsley Hospital, a move which was said to have created a certain amount of upheaval and dismay. Asked specifically about services for dual diagnosis patients, hospital witnesses told the Inquiry that at the relevant time they were just beginning to grapple with the concept of dual diagnosis and, because the waiting list for the drug dependence service was so long, they were developing their own skills in managing these patients.

- **Lorraine Hewitt, who managed the Stockwell Project, a service for substance misusers from Lambeth and South Southwark, told us that in 1994 there was little collaboration between the mental illness and the substance misuse services. She thought it possible that Wayne Hutchinson could have been referred to the Project if the hospital had recognised his cocaine misuse, but she admitted that in fifteen years she had seen only about four schizophrenics. She had had no contact with Dr. Lawrence.**

- **The evidence given by the witnesses was confirmed by the NHS Drug Advisory Service report on the services available for problem drug users in the Lambeth, Southwark and Lewisham Health District (HAS 1995). By coincidence, the field work for this was done in early 1995 and described the situation which existed soon after Wayne Hutchinson had left hospital. The report commented that there had been a great deal of disruption due to the recent reconfiguration of services, which had adversely affected the users of those services. Whilst commending the high level of enthusiasm, dedication and commitment in the health district in meeting the needs of drug misusers, the report said that there was no corporate strategy for substance misuse and that recent changes in management and personnel had led to confusion. Cooperation between health and social services was presenting its usual difficulties. At the clinical level there was no stated view about needs assessment. It was believed that there might be 11,000 cocaine users in the district and that specific treatment initiatives should be commissioned. The problem of dual diagnosis was recognised. It was recommended that unmet need should be identified and a protocol developed to provide for assessment and care management. We support these observations. WE RECOMMEND THAT:**

- **Policies should be drawn up for, and staff trained in, the treatment of dual diagnosis patients.**

- **Communication between South Western Hospital, the local Drug Dependence Services, the Stockwell Project, the Lambeth Social Services Department, the Police, and the local Drug Action Team, should be greatly improved and the responsibilities of each, for dual diagnosis patients, clearly defined.**

- **The Department of Health, in conjunction with the relevant professional bodies, should formulate guidelines for testing for substance misuse and for the management of dual diagnosis patients.**

CHAPTER SEVEN

Assessment and Treatment

- **Wayne Hutchinson was admitted to hospital under the provisions of section 2, Mental Health Act 1983. Such an admission is referred to in the Act as an "admission for assessment (or for assessment followed by medical treatment)". The Act does not in any way define what "assessment" means or say what its purpose should be.**

- **The Code of Practice issued under the provisions of the Mental Health Act 1983 summarises the criteria for admission under section 2 of the Act:**

where the diagnosis and prognosis of a patient's condition is unclear;

where there is a need to carry out an in-patient assessment in order

to formulate a treatment plan;

where a judgment is needed as to whether the patient will accept treatment on a voluntary basis following admission.

These criteria also effectively define what should be done while a patient is in hospital for assessment. They also represent the distillation of traditional good clinical practice.

- **The Royal College of Psychiatrists has no policy and has issued no guidelines on the question of assessment under section 2 of the Act. WE RECOMMEND THAT the Department of Health, in conjunction with the relevant professional bodies should formulate guidelines for the assessment of patients detained under section 2, Mental Health Act 1983. There were no local policies relating to this issue in 1994 at South Western Hospital. Clinicians therefore relied on their clinical training, custom and practice.**
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- **The Approved Social Worker has the overall responsibility for coordinating the process of assessment before admission. Chris Strahan had to decide whether it was in the interests either of Wayne Hutchinson's health, *or* safety *or* for the protection of others that he should be admitted to hospital and it was for him to arrange admission if at least one of these criteria was satisfied.**

COMMENT

- **There was no alternative to admitting Wayne Hutchinson to hospital. Chris Strahan managed the admission process very well.**

Medical assessment

- **Traditionally, the main elements of the assessment process are the psychiatric history and the mental state examination supplemented, if indicated, by more detailed history taking, information from relatives and other informants and special tests ranging from the standardised tests of the clinical psychologist to sophisticated forms of brain imaging. This has to be supported by the observations and records of skilled nursing staff. It must be stressed that for diagnostic purposes, in psychiatry as in medicine generally, it is not necessary to know and record everything one can discover about a patient, merely that which is essential. That is a matter of judgment.**
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- **Very little information beyond that which was contained in Dr. Hitchens' referral letter was obtained at St. Thomas' Hospital because Wayne Hutchinson was either too disturbed or sedated. Thus only the basic minimum of the Adult Mental Health Admission Form was therefore completed before his transfer to South Western Hospital. On Monday, 31 October the sections of the form relating to the history were completed by Dr. Dewan but the sections relating to mental state were not completed either then or later. No attempt was made to explore the full extent of his delusional system or the range of his symptoms. In particular we were unable to find any record of an exploration of the sexual aspects of his delusions or his attitude to his mother who figured so prominently in them. On the contrary, after he committed the index offences, a wide range of symptoms were recorded. It is likely that some at least of these were present in October and could have been elicited.**

COMMENT

A record of a mental state examination carried out when a patient is first in contact with the psychiatric services provides a baseline against which progress or deterioration can be measured. In this case the failure to make such a record constituted poor clinical practice.

- **However, in the present case a number of factors combined to make it difficult for the clinicians to obtain a complete picture of Wayne Hutchinson. There was very little therapeutic relationship between him and his named nurse, Michael Andrews. The hospital was unaware of some aspects of the family history, for example that his girlfriend was about to give birth to his child. The staff did not have an accurate account of the nature of his involvement with drugs and firearms. The suspiciousness caused by his**

psychosis, coupled with the plain fact that he was not in hospital for any significant period of time -- and even when he was in hospital he was either disturbed or heavily sedated -- hampered the task of assessment. Dr. Lawrence told us that *"the usual policy at that time would have been to continue the assessment while he was at home with his mother"*.

COMMENT

- **It was wholly unrealistic to contemplate the continuation of assessment in this patient's home. No arrangements were ever made for either the Community Psychiatric Nurse or a social worker to visit his home. It is not surprising that Dr. Lawrence accepted that by the time his patient left hospital in mid-November 1994 he had not been properly assessed.**

- **Observation during the period of Wayne Hutchinson's short admission confirmed Dr. Hitchens' diagnosis of psychosis, and the final diagnosis (as recorded by Dr. Dewan) of schizophreniform psychosis. Schizophreniform disorder is defined as an illness with the same symptoms as schizophrenia but with a history of less than six months.(40) Approximately a third of these patients recover. If symptoms persist for more than six months the criteria for a diagnosis of schizophrenia are met. In Wayne Hutchinson's case the symptoms had started in August and he left hospital at the beginning of November so the diagnosis was entirely appropriate. The diagnosis of schizophrenia with its connotations of chronicity and deterioration is considered stigmatising and there is now a general reluctance to use this diagnosis loosely particularly in patients from ethnic minorities. Clinicians are now well aware of the risk of confusing unfamiliar cultural beliefs with psychotic delusions.**

- **The empirical evidence however is that the diagnosis does carry a poor prognosis. Two thirds of patients do progress to a diagnosis of schizophrenia (or schizo-affective disorder) and schizophreniform disorder is therefore more often than not a provisional description of the onset of a serious illness. This means that a patient with this diagnosis will need long term treatment and aftercare with an expectation that only a third will make a good recovery. In fact the subsequent history has shown that Wayne Hutchinson was not one of the lucky minority with a good prognosis but is suffering from schizophrenia.**

COMMENT

- **To the diagnosis of schizophreniform psychosis Dr. Dewan attached the subsidiary diagnosis "harmful effects of cannabis" which, though more speculative, was also justified.**

However the diagnosis that was made and communicated to the patient's general practitioner was correct and has stood the test of time.

Treatment plans

- **Traditionally in psychiatry, as in medicine generally, the treatment strategy is formulated by the consultant and its progress monitored at ward-rounds at which all members of the clinical team are present and to which they contribute their expertise and their observations of the patient. Notes are made in the patient's case notes and members of the team take their own notes to remind them about what they should be doing. This arrangement works well with a close-knit team but does not do so if members of the team do not come to the ward-rounds.**

- **On Nelson ward, Dr. Lawrence held ward-rounds on Mondays and Thursdays. Wayne Hutchinson's named nurse, Michael Andrews, was on night duty and could not attend. Social workers were, by 1994, no longer allocated to clinical teams and attendance depended on who was on duty on the day. The Community Psychiatric Nurse apparently did not discuss Wayne Hutchinson with Dr. Lawrence, either at a ward-round or at any other time. The ward-round was not an ideal forum for the purposes of establishing a treatment plan: nor was the team particularly closely knit. This led to communication difficulties. This was to some extent obviated by the use of a ward-round Documentation Sheet which was completed by a nurse for each individual patient and kept available on the ward. This has sections headed *"Care plan discussed", "Action to be taken by", "Care plan outcome",* and space for the CPA meeting date and the name of the Case Manager. It was not distributed outside the ward.**

- **Consultants elsewhere find it useful to produce notes or minutes of ward-rounds which identify those who attended and which contain in one document the decisions made about all the patients discussed. Copies are then distributed to all the members of the team, whether or not they attended the meeting. WE RECOMMEND THAT consultants should be responsible for ensuring that ward-rounds are properly minuted and the minutes circulated to all members of the clinical team. WE RECOMMEND THAT there should be a single set of minutes which contain clearly identified plans and agreed actions, together with the identification of the persons responsible for their implementation.**

- **In 1990 the Code of Practice described Treatment Plans for patients being treated in hospital, as follows:**
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"These are essential for both informal and detained patients. Consultants should coordinate the formulation of treatment plans in consultation with their professional colleagues. The plan should be recorded in the patient's clinical notes.

A plan of treatment should include a description of the immediate and long term goals for the patient with a clear indication of the treatments proposed and the methods of treatment. The patient's progress and possible changes to the plan should be reviewed at regular intervals.

Wherever possible the whole plan should be discussed with the patient, with a view to his making his own contribution and saying whether or not he agrees with it. It is important to discuss it with the appropriate relatives concerned about a patient (but only with his consent)."

This was repeated in the 1993 edition of the Code. However it was silent about the distribution of these Treatment Plans but hospital policies usually indicate that all members of the team should have copies. None of the witnesses who gave evidence were aware of the requirement for consultants to coordinate the drawing up of treatment plans and the hospital's policies were and still are, at the date of this report, silent on this subject.

- **Treatment plans for patients in hospital are not referred to in the various Circulars which govern the Care Programme Approach. There is thus a gap between the Department of Health's recommendations which appear in the Code of Practice and those which appear in the CPA Circulars. There are clear advantages in considering a patient's long-term management early on in his admission, rather than waiting until shortly before discharge. It is not helpful to have two methods of planning treatment for the same patient. WE RECOMMEND THAT the Department of Health, the Mental Health Act Commission, and the relevant professional bodies should clarify and coordinate the policies relating to treatment plans for hospital in-patients and the CPA. In the meantime, until such changes are achieved, WE RECOMMEND THAT consultants should be responsible for drawing up and circulating treatment plans in accordance with the Code of Practice for all psychiatric in-patients so that all members of the clinical team are aware of the role they are to play in the patient's treatment.**

Nursing care

- **The nursing care plan was initially drawn up by the patient's named nurse at St. Thomas' Hospital and subsequently reviewed and revised by another named nurse at South Western Hospital. Different plan formats are used in each of the two hospitals.**

- **Two versions of the nursing care plan were devised by Mr. Lemince RMN at St. Thomas' Hospital on the day that Wayne Hutchinson was admitted. The first reads:**

"Problem/need Matthew seems to be hearing voices.

***Goal/objective** Matthew will be less troubled by the voices by mid-November.*

***Action/intervention** Nurse to spend time with Matthew to develop rapport and acceptance. Nurse to listen attentively paying attention to any suicidal ideation. Nurse to attempt to deviate Matthew's attention when he seems to be under the influence of auditory hallucinations."*

The second reads:

*"**Problem/need** Abnormal belief that his bottom is turning into a vagina.*

***Goal/objective** By the end of 10 days Matthew will be less troubled by his abnormal thought and will be in touch with reality.*

***Action/intervention** Nurse to spend time with Matthew to build therapeutic relationship. Nurse to observe Matthew's behaviour and report to doctor of their findings and also to maintain his progress notes. Nurse to ensure that Matthew does not jeopardise his safety when he is having his delusion. Nurse to listen to Matthew's complaints and be patient. Nurse to model calm behaviour when dealing with Matthew being aware of their own body language and tone of voice."*

COMMENT

- **These nursing care plans do not refer to the section of the Mental Health Act 1983 under which Wayne Hutchinson was admitted, nor to any provisional diagnosis. They do not refer to the accusation that his mother was poisoning him; to his need for medication; to his substance abuse; to the firearm incident or to his impending court case. Even though these references are to be found in the medical notes, in Chris Strahan's written assessment (which was not available to Mr. Lemince) and, later, in the South Western Hospital nursing care plan, it is unfortunate that they were omitted at this early stage from the care plan which had been drawn up at St. Thomas' Hospital. However, these were very preliminary nursing care plans and the omissions from them did not have any impact on the subsequent management of Wayne Hutchinson.**

- **The entries which were made in the nursing care plan at South Western Hospital are more comprehensive. The first entry, dated Saturday 29th October, mentions the risk of absconding and the risk of violence to staff. The second entry, dated 2nd November (the first by his named nurse who had, until then, been on leave) mentions Wayne Hutchinson as an absconding risk and refers to potential aggressive behaviour when he was prevented from leaving the ward. It also refers to the section under which he was detained; to his refusal to take medication and to the possibility of planned leave. Section 3 was also mentioned, which suggests the possibility of extending his detention, but this is difficult to reconcile with the possibility of planned leave. The entry dated 9th November noted that Wayne Hutchinson was absent from the ward without permission and recorded : *"Plan for section 3 on return to ward".* The possibility of extending detention under section 3 is not mentioned in the medical notes or in the ward-round documentation. As we have already remarked, Dr. Saxena was not provided with this information when he saw Wayne Hutchinson the next day, November 10th.**

- **The entry dated 11th November, which was written the day after Dr. Saxena granted him leave and, as it turned out, when he had left the hospital for the last time, records:**

"On return obtain further information on offences and court

appearance.

Liaise with relevant agencies."

This is the first time that liaison with the relevant agencies in relation to the firearm matters is suggested in the documentation.

- **On 15th November, the day after Wayne Hutchinson had failed to return from leave, the ward-round note recorded his failure to return and that *"CPN Raghoo was contacted to ring mother and persuade her to return him to the ward for assessment".***
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- **The nursing care plan entry for November 15th also contains a reference about the criminal charges that he was facing.**

"Reported to be on bail by mother - charges unknown. Talk to client and mother on return to hospital and find out what offence he has committed and date of court appearance. Liaise with court/probation."

COMMENT

- **The overall quality of the written nursing notes at South Western Hospital was poor and the standard of therapeutic provision was low. Important nursing interventions were either not considered, or not implemented.**

- **Even when the care plan first recorded that Wayne Hutchinson was on bail and that relevant information should be obtained, no action was taken. By then it was too late. Wayne Hutchinson had absconded from the hospital.**

- **There is no evidence that his drug use was fully enquired into or that he was offered any help to deal with it. The care plans and client care record do not refer to his drug use. Mrs. Hutchinson was never interviewed in private by nursing staff to ascertain the facts surrounding her son's admission, or to establish her own needs as a carer, or to discuss the importance of taking medication.**

- **The care plan, such as it was, merely acknowledged the existence of the symptoms already recorded in the case notes without attempting to explore the patient's own needs, and family and social background.**

- **Although regular ward-rounds were held, the medical and nursing staff wrote up the outcome separately: often there were important differences of emphasis and action. No record was kept of those who were invited or attended the ward-rounds.**

- **The role of the named nurse, Mr. Andrews, was, in this case, unclear and did not accord with the expectations of the existing nursing policy document. This uncertainty was transmitted to members of staff.**

- **Mr. Andrews' role as named nurse was diminished, largely because he was on permanent night duty. He also had a poor understanding of his role. WE RECOMMEND THAT if a nurse is allocated to permanent night duty, he or she should not be appointed as a named nurse.**

- **There had been a long-running dispute between the Ward Manager and Michael Andrews. Allocation to permanent night duty turned out to be a pragmatic but unsatisfactory attempt to deal with this problem. This was poor management. The Service Manager, Sue Lewis, was aware of this longstanding problem but decided to wait until the ward was moved to the new hospital site before tackling it. The dispute, however, was not**

confined to the two protagonists: all the staff were aware of the bad blood between them and felt

a need to take sides. This did not assist in providing a harmonious and cohesive body of nurses. Mr. Andrews' failure to establish a therapeutic relationship with Wayne Hutchinson was primarily caused by a failure of management.

- **The skill mix on Nelson ward mirrored that of many other acute psychiatric units in London at that time. However, the over-reliance on bank staff, agency staff, untrained and ill-trained staff, created a culture in which leadership and accountability were lacking, and awareness, knowledge and initiative were at a premium. WE RECOMMEND THAT two registered mental nurses should be on duty at all times on an acute psychiatric admission ward.**

- **However, the ability of the nursing staff to formulate and then implement a sensible and coherent care plan was severely compromised by the policy of using leave as a method of freeing beds for new admissions. The bed occupancy levels were constantly well over one hundred percent (see Chapter 10). Consequently there was inadequate time to build up trusting relationships with patients and to conduct assessments.**

The ward environment

- **Since 1994, the old South Western Hospital has been demolished and replaced by a new building. All the witnesses described Nelson ward in the old building as a poor environment for patients and staff alike. But that appears to have been something of an improvement on the previous situation. In 1990 the conditions on those wards which admitted patients from Tooting Bec Hospital were so inadequate that the Mental Health Act Commission was only six months away from recommending to the Secretary of State that the hospital's power to detain patients should be withdrawn. The admission of patients from Tooting Bec to different wards - including Nelson Ward - was a temporary measure until the new hospital could be built. For that reason these wards were not adequately maintained.**

- **Erville Millar described Nelson ward in 1994 as *"appalling"*. Dr. Dewan was more dramatic: *"The building was generally dirty and it appeared as, from . . . Haiti or Gambia or somewhere"*. It is not surprising that Mrs. Hutchinson asked the nursing staff for the appropriate materials to enable her to clean her son's room.**
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- **Patients had no secure facilities in which to store their belongings. Theft was rife. There was no privacy. It was very noisy. Dr. Lawrence described Nelson ward in these terms:**

". . . an old television room with the television in the corner, music blaring, people walking around, no structure. Nurses almost all used up on one-to-one, all guarding the door.we are talking about a warehouse, the most awful place you could imagine".

He told us that there was no occupational therapy, no garden, and that patients had very limited access to the gym. There was nothing to distract them or to provide them with any interests:

"The truth of the service was, in my experience, that the patients had nothing to do all day".

In November 1992, the MHAC criticised the lack of occupational therapy or other activities for patients on both hospital sites though, after their visit in June 1994, they did note that there was good occupational therapy input albeit usually by agency staff.

- **The difficulties caused by the lack of facilities were compounded by two other factors which had the effect of diverting the nursing staff from attending to existing patients. There was an influx of patients who were either on leave or had been discharged but who came back to the ward for various reasons, perhaps to get their medication or for a meal, or perhaps just for company. Others came with more reprehensible motives. We were told drug dealers came to the building, if not to the ward, usually to trade in cannabis but, according to one witness, crack cocaine was not unknown. Cannabis was heavily smoked on the ward and the nursing staff could do little to stop it.**

- **The ward environment was also influenced by the nature of the patients themselves. At the time Wayne Hutchinson was admitted to hospital a third of the patients were detained under a section of the Mental Health Act. Detained patients are more likely than informal patients to lack insight; to be disturbed in their behaviour and to be uncooperative. A few such patients may not have much effect on the ethos and running of a ward but, if the proportion is as high as a third, ward management tends to suffer.**

- **There is little doubt that the environment of Nelson ward reduced the quality of the care which was given to all the patients at that time.**

Morale

- **An influential report by the Clinical Standards Advisory Group on the quality of care given to patients with schizophrenia concluded that the most important single feature distinguishing the provision of good from poor care was staff morale. Clearly this is difficult to assess, particularly in retrospect, but the Inquiry heard that some of the staff were very unhappy in their work at the time Wayne Hutchinson was in hospital.**

- **After the publication of the 1990 MHAC Report, a team of consultant psychiatrists, which included Dr. Lawrence, was appointed to attempt to improve the service. However Dr. Lawrence told us that *"the five years I worked at the South Western were about the five worst years of my life".* He had no Senior Registrar and he felt that he had no power to implement improvements. In 1993 he took a sabbatical year and returned in mid-1994. By this time he had begun to work in private practice and in 1995 he resigned from South Western Hospital and from the NHS to devote himself full-time to private practice.**

- **We were told by Dr. Dewan that at South Western Hospital *"you would dread to go into that building. You would feel rather scared at night if you were on call."*. Amongst his colleagues on the registrar rotation scheme, South Western Hospital did not have a high reputation: *"none of us wanted to get a placement there . . . for everybody it was a nightmare having a placement at South Western".***

COMMENT

- **The quality of decision-making and therapeutic provision on this ward was severely reduced by a devastating combination of poor working relationships; a depressing working environment and low morale, coupled with the operation of an unacceptable policy of using leave as a method of freeing beds for new admissions. The ward team did not function as a cohesive unit. These factors contributed to the circumstances in which Dr. Saxena came to allow Wayne Hutchinson to leave the ward on November 10th and go someway towards providing an explanation for the lack of any real urgency associated with the attempts -- such as they were -- to seek his return to hospital after November 14th.**

Medical Treatment

- **The mainstay of medical treatment for mental illness of the kind that Wayne Hutchinson is suffering from is antipsychotic medication of which there is now a wide range of preparations with varying properties and side effects. Their effectiveness varies from patient to patient depending on the nature and stage of the illness. Patients vary in the side effects they experience and their reaction to these side effects. As with many chronic physical illnesses, patients may have to take medication for months if not years, or even for a lifetime. Patients also vary in their insight as to whether they are ill and need medication and many do not realise that the relief of their symptoms is due to the medication they are taking. In some cases patients actually blame their medication, or those that give it, for their psychotic symptoms. Consequently it is often no easy matter to persuade patients to take medication or to find the preparation which has the maximum effect on the symptoms and the minimum of side effects. Cooperation and a degree of**

insight on the part of the patient, a seductive rather than a confrontational approach on the part of the doctor and a certain amount of trial and error are necessary for best results. Nevertheless there is no doubt that medication does reduce psychotic symptoms even if it does not eliminate them, and this is particularly so in the early stages of a schizophrenic illness.

- **The first medication Wayne Hutchinson received was an intramuscular injection of Lorazepam given as a quick acting sedative when he became disturbed in Scutari. He was then prescribed oral Chlorpromazine, a sedative antipsychotic, at a dose of 200 mg twice a day. On 28th October on waking he became disturbed and this time given intravenous Diazepam to sedate him quickly, together with intramuscular Zuclopenthixol acetate (Clopixol acuphase), an antipsychotic which remains effective for a day or longer. Later that day he was again disturbed and was given a further injection of Lorazepam. This was the last time he received medication by injection.**
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- **The dose of Chlorpromazine was varied. It was initially increased and then, because he was over-sedated, reduced. However he did not take it as prescribed, either because he was drowsy or because he refused it, or for other unknown reasons. Altogether, of the twenty four doses prescribed, he took eleven or, to put it another way, of 3700 mg prescribed he took 1500 mg. On November 8th, towards the end of his admission, he was**

prescribed Droperidol, a less sedating antipsychotic, instead of Chlorpromazine. Of the four doses he was prescribed he took three. This analysis applies only to the time he was on the ward.

- **When he went on leave he was given a supply of medication to take at home. He told the Inquiry Panel that his mother made sure that he took it but this medication would not have been effective during the time he was absent without leave. He was not prescribed any anti-psychotic medication between leaving hospital and the commission of the offences.**

- **Although a start was being made to match the medication to the patient, his compliance was only partial and he was not therefore benefiting from the anti-psychotic effects of medication as much as he should have done. We accept that the time had not yet arrived, by November 8th, to attempt to embark on a regime of depot anti-psychotic medication. Nonetheless, Dr. Lawrence does not appear to have appreciated the extent of the non-compliance.**

- **Removing the patient from an environment which exacerbates his symptoms may be an important part of treatment. In this case Wayne Hutchinson's mother featured prominently in his delusions, but there is nothing in the case notes to suggest that any thought was given to the possibility that close contact with her might be inadvisable. Once in hospital the ward environment can in itself be therapeutic and should, in any case, encourage therapy. We heard of no therapeutic endeavours other than medication and in particular no counselling or other guidance about his cannabis intake as suggested in the hospital's policy document on substance misuse.**
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- **The effects of treatment should be monitored. The clinical team needs to know whether hallucinations are receding or getting worse, whether delusions are spreading or diminishing, how much the symptoms are troubling the patient and how much insight is being acquired. Ideally the patient will realise that he is ill, that his symptoms are not based on reality and that medication will reduce them and prevent them coming back. There are no records to show that the illness was monitored in this way and the failure to record a mental state examination to act as a baseline would have made this more difficult.**

COMMENT

- **We consider that the patient's symptoms and his response to treatment were inadequately explored and monitored. In determining whether a patient is well, it is not enough to observe his behaviour (which in this case had not stabilised), and rely on his own statements when they are unsupported by a mental state assessment.**
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Assessment for detention under section 3

- **In hospital, observation of a patient's behaviour, symptoms and attitudes allows the consultant to assess whether he needs further treatment and whether he will accept this**

voluntarily. If he will not, it may be necessary to detain him for a longer period under section 3 of the Act.[(41)]

- **As noted elsewhere, Wayne Hutchinson absconded from St. Thomas' Hospital, tried to leave Nelson ward, and then overstayed his weekend leave. When he was brought back in handcuffs by the police on Tuesday 8th November he had a black eye and had been in**

a fight. The next day he made continual attempts to leave and eventually absconded by pushing past the nurses. Clearly, he was reluctant to stay in hospital voluntarily and did not comply with his medication (see paragraph 240).

- **There is little evidence in the case notes of any attempt to monitor and record the progress of his symptoms, but it is probable that his disturbed behaviour was driven by the activity of his psychosis. It should have been obvious that his illness had not remitted and that he required continuing treatment. Events have demonstrated that he was not prepared to cooperate with this, and on these grounds alone -- quite apart from the question of dangerousness -- he should have been detained under section 3. Patients who are deluded, hallucinated, and only very recently disturbed, should not be permitted to be in the community. The importance of a risk assessment in the context of danger to the public is discussed in Chapter 11.**

- **We were unable to discover whether any decision had been made to extend Wayne**

Hutchinson's detention under section 3 of the Act. No reference is to be found in the medical notes, the ward-round documentation or nursing notes. The only reference is by the named nurse, Michael Andrews, in the care plan entry dated 9th November, the day on which he absconded from the ward, in which he observed:

"Plan for section 3 on return to ward"

and in his entry dated 11th November:

"Plan for section 3. Section 2 expires 26/11/94".

On 15th November he wrote:

"Section 2 expires 26/11/94. Review on return for Section 3."

- **This material indicates that at least one member of the clinical team had considered that further detention might be necessary. We are unable to say whether these views were communicated to or shared with others.**

- **To activate this section of the Act it is necessary that recommendations should be made by two doctors, one of whom is not a practitioner on the staff of the hospital in which he is detained. Both are required to examine the patient and to complete(42) the appropriate forms. In addition it is the duty of an approved social worker to interview the patient and, where he is satisfied that an application ought to be made and having regard to any wishes expressed by the relatives, to make the application for admission. This process needs some time to organise. There is nothing in the case notes or in the records of the social service department to indicate that the process was ever started.**

COMMENT

- **We consider that Wayne Hutchinson needed to be detained under section 3 of the Mental Health Act 1983 and that this need was inadequately assessed. He should have been detained under section 3, at the latest on Tuesday November 8th, on his return to hospital in handcuffs. Had he been detained under that section , these tragedies would have been avoided.**

- **It is ironic that the named nurse who, because of permanent night duty had failed to establish a therapeutic relationship with Wayne Hutchinson, should have correctly identified the future management requirements of this patient. The fact that section 3 was considered, on 15th November, to be the likely future management should have spurred the hospital on to locate him and thus return him to the ward. This is particularly so in the light of Dr. Fotiadou's opinion that he was a danger to others (see paragraph 68). That did not happen.**

CHAPTER EIGHT

Lambeth Social Services

Referral to Social Services

- **Until April 1993 social workers were attached to each consultant's clinical team at both St. Thomas' Hospital and South Western Hospital. Dr. Lawrence told us that this system had worked well. They provided a valuable input into the operation of the Care Programme Approach. Following reorganisation, attachments to consultants ceased at South Western Hospital (although not at St. Thomas' Hospital) and referrals were taken from a wide range of sources. Attendance at ward-rounds was solely for the discussion of specific cases. Patients were only seen or assessed following a formal referral and were no longer seen on a routine basis. Dr. Lawrence told us that when he returned from his sabbatical he saw different social workers according to which day he was doing his ward-round and who was the duty social worker for that day.**

- **Further reorganisation took place in 1995/96, which saw community health workers and social workers being co-located in local offices in order to bring together care management and CPA requirements through a single front door.**

COMMENT

- **Whatever its merits in other areas of social work, the 1993 reorganisation impaired the working of the clinical teams within the hospital setting.**

- **It comes as no surprise, therefore, that the only contact Wayne Hutchinson had with a social worker after his admission was in connection with his entitlement to sickness benefit. On Thursday 10th November, after he had been brought back to Nelson ward by his mother, the nursing staff asked the duty social worker, June Hogan, to investigate whether he was entitled to sickness benefit. (He had been advised by the agency that, since**

he had not paid any national insurance contributions, he was not entitled to this benefit.)

- **Owing to pressure of work she was unable to make any enquiry until Monday, 14th November. The agency confirmed that he was not entitled to any sickness benefit.**

- **June Hogan noted:**

"Mr. Hutchinson on Sec 2 as of 28.10 which expires on 26.11.94. He keeps leaving the hospital and not taking medication and his mother does not want him in hospital. Discussed at ward-round today when it was decided to contact his mother for him to be brought back. NFA at this time".

It is not clear how much more June Hogan knew about Wayne Hutchinson. There is no doubt that she did not have the benefit of Chris Strahan's report. However what is clear is that at that meeting, when it was still expected that Wayne Hutchinson would return to the ward, Dr. Lawrence did not make a specific request either for a social work assessment or for aftercare: no referral to social services took place.

- **The social worker was one of the intended recipients of the invitation to the pre-discharge section 117/after-care planning (CPA) conference on 15th December which was sent out on 15th November. The social work file presented to us does not contain a copy of the invitation and it is uncertain whether it reached its destination. Equally uncertain, as the meeting was not minuted, is whether any social worker attended. It is quite possible that no social worker was present since this was consistent with policies in operation at the time. The only policy document available from Lambeth Social Services is undated and unsigned. It is unclear from this document how patients were to be referred to social services for aftercare under section 117, or under the CPA. Wayne Hutchinson was detained under section 2 rather than section 3 and was not therefore covered by the provisions of section 117 of the Act. He had not been specifically referred to social services and no care plan had been drawn up. Both these elements appear to have been a necessary pre-condition before a patient was considered by social services. After 1993 it was rare for a social worker to be a patient's key worker. WE RECOMMEND THAT whenever social services have performed a statutory function under section 2 or section 3, Mental Health Act 1983, they should be advised of the outcome even if no formal referral of the patient has been made.**
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- **Accordingly, it is not surprising that after Wayne Hutchinson failed to return to hospital, social workers were not asked to visit his home to look for him, and that Lambeth Social Services were never involved in planning or providing aftercare.**

Pre-admission assessment

- **Except where a patient is admitted to hospital following an application by the nearest relative, the Approved Social Worker does not have any legal obligation to provide the hospital managers with a report on his or her social circumstances. The policy of the Lambeth Social Services Department at that time reflected this position. In this case, no report of a pre-admission assessment was submitted to the hospital managers. However it was Chris Strahan's practice to write extensive long-hand notes on the patients he dealt with and this he did in the case of Wayne Hutchinson. His notes contained a brief family and personal history from his mother and her account of the onset of the illness. There was also a description of Wayne Hutchinson's mental state and it incorporated his anxieties about drug dealing and access to firearms. This record was more extensive and better organised than those written subsequently by the medical staff.**

- **Chris Strahan told the Inquiry that it had never been his practice to arrange for copies of his social assessment or pre-admission notes to be included in the medical notes or for them to be sent to his social worker colleagues at South Western Hospital or elsewhere. His seniors had never discussed this issue with him and he knew of no policy indicating that he should do so. His evidence was confirmed by Irene Stiller, Manager, Lambeth Social Services.**

- **There are two main reasons for making a record of this kind. Firstly, it is a record of the circumstances which led to the compulsory admission; secondly, the assessment is an aid to clinical management. Such a preliminary assessment should also address the question of risk. However, the assessment can only assist clinical management if the clinical team has access to it, and in this case Chris Strahan ceased to be involved when Wayne Hutchinson was transferred to South Western Hospital.**
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- **It is here worth emphasising that confidentiality was not at issue in this case. In any event, the British Association of Social Workers has stated quite clearly that where there is a serious risk of danger to others, the client's right to confidentiality may be limited or overruled.**
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- **The Internal Inquiry noted the failure of important social work information to follow the patient to the new hospital setting and recommended that copies of Social Work assessments should be made available for insertion into the medical notes. This recommendation, if implemented, would amount to a change of policy, because at the time Wayne Hutchinson was admitted to hospital the formal procedural arrangements between the social work departments of the two hospital sites did not require the transfer of social work case notes between teams or to the medical records department when detained patients were transferred from one hospital to the other. Chris Strahan was complying with the policy of his department at that time.**

- **The implementation of this simple and sensible recommendation has taken a long time. In July and September 1995, Dr. Roy wrote to Lambeth Social Services Department asking for confirmation that copies of all social work assessments and other reports would be placed in the hospital case notes, since social work assessments were not being routinely made available. This also applied to MHRT reports and reports for managers' hearings. On 21st November 1995, Mr. Ballatt, Service Manager (Mental Health), declared that the**

reports would henceforth be made available.

- **In 1995/96 Lambeth Social Services reduced the numbers of its social workers. They were withdrawn from the hospitals and located together with community-based health colleagues in joint local offices. As with the earlier removal of social workers from consultant teams, this must have reduced the social work input for patients in hospital but, more importantly in the present context, this redeployment made it even more important that written information should be communicated to those who needed to receive it.**
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- **However in May 1997, following a visit to South Western Hospital the MHAC reported:**

"Commissioners could not find Approved Social Worker reports relating to the circumstances of admission on patients' files. Although it is not a statutory requirement to provide such reports, it is common practice for a report to be made and copied to the patient's file together with the section papers. In the MHAC's experience these reports provide valuable information about the events leading to an admission, especially where the patient is not previously known to the services."

and

". . . Commissioners saw very little evidence of Social Work involvement on the files apart from an occasional report to the MHRT."

- **In May 1997, Sue Lewis, Service Manager, was informed by Lambeth Social Services that a proper report form was to be introduced for this purpose. However further inquiries revealed that social workers were not then even being allowed to fax information to the hospital. This was in marked contrast to the practice of the probation service which routinely provided information to the hospital.**
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- **By this time the MHAC was becoming disenchanted with this muddle. In June 1997 ASW reports on patients' files were still absent. After their visit in October 1997 the Commission wrote:**

"The statutory documentation was completed to a high standard and scrutiny procedures appeared to be working well. However it was disappointing that despite written reassurances from Lambeth Social Services following the MHAC's last visit, there were few reports by ASWs following Mental Health Act assessments. Staff confirmed that it is rare to receive copy reports from ASWs although there are prominent reminders on Eden ward."

This was followed up in November by a letter from the Chief Executive of the MHAC:

"Issues raised with yourself, in correspondence, have arisen again and the Commission would be grateful for your comments. In particular it was very disappointing to learn that ASW reports are not being copied to the Trust. Your comments on these matters would be appreciated".

- **When Irene Stiller, Manager, Lambeth Social Services, and Sara de Witt, Team Manager, Mental Health, gave evidence to the Inquiry in November 1997, the picture remained unsatisfactory and confusing. It appears that some twenty years ago it was the practice to produce assessments on yellow paper so that they were easily recognisable in the medical case notes. Then *"somewhere along the line someone made a decision that assessments did not go on the medical files"*. In 1994 therefore there were no procedures whereby Chris Strahan's report would go either into Wayne Hutchinson's medical file or to the files of the social workers at South Western Hospital. We were told that there was some doubt as to whether Chris Strahan's hand-written document was a *"report"* or a *"running record"*. Sara de Witt and Irene Stiller believed it was a running record and running records would not, we were told, be routinely copied and distributed. Sara de Witt expressed herself *"horrified and surprised to see that they* [the Commissioners] *were not seeing the reports on files."***

COMMENT

- **If June Hogan, or any other social worker who attended Dr. Lawrence's ward-round, had had a copy of Chris Strahan's pre-admission assessment it is likely that she would have raised the question of Wayne Hutchinson's alleged firearm offences in the multi-disciplinary team setting simply because this was a social services document. This is likely to have triggered early liaison with the police and with Wayne Hutchinson's solicitor. Had these steps been taken, even after November 14th, real concern would inevitably have arisen in the light of the information which would have been received. Urgent steps would have been taken to locate him and return him to hospital. In those circumstances it is inconceivable that the police at Brixton would not have been fully briefed by the hospital or by social services. Although the absence of Chris Strahan's report in the hospital probably made little, if any, difference to the approach of the hospital staff - since they were aware of all the relevant information in any event - it did make, paradoxically, a significant difference to the potential response of social services to his absence.**

- **It was only in 1998, and after the Inquiry had received evidence from Irene Stiller and Sara de Witt, that a policy was agreed in writing between Lambeth Social Services and Lambeth Healthcare NHS Trust concerning the sharing of information. It is difficult to understand why it has taken so long to introduce this sensible policy. This policy appears to accommodate the concerns of this Inquiry. There is, nevertheless, an urgent need for it to be fully implemented and monitored. WE RECOMMEND THAT pre-admission social assessments carried out by social services should always be included in a patient's medical case notes.**

CHAPTER NINE

Absconding and the granting of leave

- **During his brief admission to hospital Wayne Hutchinson absconded on two occasions from the ward. The first occasion was on Friday 28th October when he kicked the door open and ran off Lloyd Still ward. Nurses chased and caught him on the main road as he was trying to get into a taxi. On the second occasion, Wednesday 9th November, he pushed past two nurses on Nelson ward, ran down the stairs and out of the hospital. This time the nurses were unable to catch him. The police were informed. He was brought back to the hospital by his mother the next day.**

- **At that time Nelson ward was an unlocked open ward. The locking of ward doors on open wards was governed by the Code of Practice (1993 Edition) :**

"18.24 The management, security and safety of patients should, wherever practical, be ensured by adequate staffing. Authorities are responsible for trying to ensure that staffing is adequate to prevent the need for the practice of locking patients in wards, individual rooms or any other area.

18.25 The nurse in charge of any shift is responsible for the care and protection of patients and staff, and the maintenance of a safe environment. This responsibility includes the care of patients who have been detained in hospital because they are considered a danger to other people. At his discretion, the nurse in charge may decide for all or part of the shift for which he is responsible to lock the door of the ward because of the behaviour of a patient or patients to keep the environment safe."

The Code goes on to describe the fairly complex procedure to be followed by the nurse in charge if he does make this decision.

- **The documents authorising Wayne Hutchinson's detention under section 2 of the Act at St. Thomas's Hospital indicated that it was necessary to detain him *"with a view to the protection of other persons"* as well as in the interests of his own health and safety.**

- **Wayne Hutchinson was not an isolated example of a patient absconding from the ward. We were given various estimates ranging from *"twice a week"* to *"more than daily"*. Although absconding from the ward appears to have been a common occurrence, we were unable to discover exactly how common as no records were kept either of the occasions when the ward was locked, as recommended by the Code of Practice, or of those who absconded. Efforts were, of course, made by nursing staff to prevent patients absconding. The nursing notes record many occasions when Wayne Hutchinson wanted to leave but**

was talked out of it. The second line of defence was 1 to 1 nursing for patients who were thought to constitute a high risk. Nurses were also posted to guard the door of the ward. We were told by Dr. Lawrence that at times three nurses were engaged in this task and that he had complained about it to management. This practice, which inevitably diminishes the overall therapeutic input of the nursing staff, occurs in some 13% of acute psychiatric wards in Inner London.(43) We were able to see for ourselves the disparity in size and strength between the rather small female nurses and Wayne Hutchinson himself and readily understand that confrontation would sought to be avoided. The last line of defence consisted of the hospital's security guards but they, we were told, could not help if they were not at their station. When it was certain that a patient had absconded, the police were informed.

COMMENT

- **We have not discovered any policy document from South Western Hospital concerning absconding patients or the locking of ward doors. It is not clear what the hospital's policy in this area was in 1994. The Internal Inquiry did not address this issue.**

- **The open nature of the ward also allowed unauthorised entry. The hospital faced serious difficulty in attempting to prevent the influx of contraband material, particularly drugs. On 17th September 1995, a year after the relevant events, Michael Andrews was blinded in one eye by a patient who had returned to Nelson ward unexpectedly from leave. One of the recommendations made by the Panel which examined this incident was:**

"The policy and practice in respect of access to the wards and the control of entry to the wards, especially at night, needs to be reviewed."

No doubt as a response to these various pressures, discussions on this issue were held with the MHAC. The conclusion is described in the report of a visit on 1st April 1996:

"After much discussion, it has been decided that the wards on the new South Western Unit will be locked, so that all patients, both formally detained and informal, will have to be "buzzed" in and out of the ward, rather than having free access."

- **"Buzzing" in this context means the use of an intercom system which allows the door to be opened from the ward office and only by the nurse in charge. Such a system was installed when the new wards were built and the practice has not been commented on again in any of the reports of subsequent MHAC visits, even though the practice appears not to be compatible with the Code of Practice. The legal issues raised by the admission of informal patients and, in particular, whether or not they should be allowed to come and go as they please, have been discussed recently by Dr. Azuonye(44), a Consultant Psychiatrist at South Western Hospital, who highlighted the need for psychiatric hospitals**

to have written policies about the administration of informal admissions. No such policy was in existence at South Western Hospital in 1994.

COMMENT

- **There was no practical method of keeping Wayne Hutchinson on the ward once he had decided to leave. The expedient of posting one or more nurses to guard the door of the ward is both wasteful of nursing manpower and ineffective, although we accept that this is a common practice in acute adult psychiatric wards which in Inner London may contain more than 40% of detained, and therefore reluctant, patients. The policy of sectorisation means that informal and detained patients from each sector will continue to share the same ward. In these circumstances, and with the current constraints on nursing provision, a continuing debate about the use of an intercom-controlled locking system is inevitable if nursing staff are to maintain proper control of the wards.**
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- **Had such a system been in place, Wayne Hutchinson would not have been able to leave the ward in the late afternoon of 10th November. Subject to the separate issue of bed availability, Dr. Lawrence would have been able to manage him on Nelson ward, whether or not his detention was sanctioned by section 2 or section 3 of the Act.**

284. Absconding patients also create problems for the police. Though we did not receive complaints directly from the police about this issue, we were told by the nursing staff that police officers had complained about the number of patients who absconded and the consequent time spent attempting to locate and return them to the hospital. It is understandable that an excessive amount of absconding might cause the police to be less than enthusiastic about returning psychiatric patients to hospital. It is easy to imagine the reaction of the police when they returned this patient to South Western Hospital in the afternoon of November 10th, only to be told that he had been granted leave earlier that day. WE RECOMMEND THAT:

- **The hospital, in cooperation with the local police, should formulate a written policy in relation to patients who are absent from the ward without leave.**
- **The hospital should monitor and audit the incidence of absconding from the ward.**
- **The hospital should formulate a policy concerning the management of informal patients, with particular reference to the locking of wards.**
- **The Department of Health, in conjunction with the relevant professional bodies, should consider an amendment to the Code of Practice to reflect the position of informal patients in the context of the operation of intercom systems which control access to wards.**

The granting of leave

- **Under section 17, Mental Health Act 1983, only the responsible medical officer may grant leave to a patient, who has been detained under section 2 of the Act. This may be subject to such conditions as are considered necessary in the interests of the patient or for the protection of other persons. This leave may be either indefinite, on specified occasions or for any specified period and it may be extended in the absence of the patient.**
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- **The Code of Practice recognises that leave can be an important part of a patient's treatment plan. It emphasises that the decision to grant leave cannot be delegated to another doctor. The patient should be able to demonstrate to his professional carers that he is likely to be able to cope outside the hospital. He should also be fully involved in the decision and consent to any necessary consultation with relatives. The Code adds that the granting of leave and the conditions attached to it should be recorded in the patient's notes and copies given to the patient; to any appropriate relatives/friends, and to any relevant professionals in the community. The 1993 edition of the Code recognises the common practice whereby the RMO, after multi-disciplinary discussions, authorises short-term local escorted leave at the discretion of the nursing staff, but adds:**

"Whilst flexibility to respond to day to day changes in a patient's condition is helpful in rehabilitation, there is no formal authority for the RMO to delegate his power under section 17. He must, therefore, accept responsibility for any leave arranged with his general approval".

It recommended that:

"Hospitals should consider the use of a simple record form on which the RMO can authorise leave and specify the conditions attached to it."

- **The MHAC has recently expressed concern about inadequate documentation for section 17 leave arrangements and has emphasised that the advice to give written copies of the conditions of leave to patients, relatives and concerned professionals was seldom implemented.[(45)]**
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- **In 1994 there was no written policy at South Western Hospital in relation to the granting of leave. Forms were first published following the Internal Inquiry. A policy document was published in October 1996. WE RECOMMEND THAT when leave is granted under section 17, Mental Health Act 1983 an appropriate form should be completed and a copy provided to the relevant carer. Statistics which were provided to the Inquiry demonstrated that in October 1994 the number of patients on leave from Nelson ward varied between four and ten, which illustrates the extent to which leave played a part in patient management. On average, this means, surprisingly, that a third of a patient's admission would be spent on leave. In this sense, Wayne Hutchinson was not an**

exceptional case.

- **There can be perfectly proper reasons for granting leave or for lowering the threshold for granting it. Dr. Lawrence told the Inquiry that he had found during his years in Brixton that it was *"very important to demonstrate to the patient that we were not an arm of the state and that we were there for their benefit"* and for that reason he would always take a fairly liberal view in relation to the granting of leave. He also told us that, because of the shortage of beds,**

"the pressure to push people through, complete the assessment whilst they were on leave, was an enormous and irresistible force. If you did not move people out, then you could not admit the next patient who was severely ill".

He was also influenced in this liberal approach by his view that the ward conditions (see paragraph 233) were such that he faced the choice, either to medicate a patient so that he would not want to leave or to allow a greater degree of freedom than he would otherwise wish, simply to facilitate cooperation.

COMMENT

- **When Dr. Lawrence granted Wayne Hutchinson leave on November 3rd the potential significance of a patient with symptoms of schizophrenia on bail for an alleged firearms offence had not been adequately recognized. As has already been observed, further information should have been sought from his solicitors or from the police. The mere fact that Wayne Hutchinson denied the offence when he was seen by Dr. Lawrence was an insufficient basis on which to conclude that there was minimal risk to members of the community. Dr. Fotiadou had concluded, only a few days beforehand, that this patient did present a risk to other persons. When Dr. Saxena allowed Wayne Hutchinson to leave the ward on November 10th he, too, failed to recognise that Wayne Hutchinson was a danger to members of the public.**

CHAPTER TEN

Resources

The shortage of beds

- **Wayne Hutchinson was admitted to Lloyd Still ward at St. Thomas' Hospital from Scutari, the out-patient clinic, as an emergency case. Ideally such transfers should take place during working hours on a week day, but since the transfer took place late on a**

Friday afternoon, he was seen by the duty registrar at South Western Hospital rather than by Dr. Lawrence's registrar, Dr. Dewan. We have already addressed the question (see paragraph 91)why he was not admitted to Eden ward. It appears that he was admitted to Dr. Lawrence's ward - Nelson ward - simply because he lived in his sector. The question of bed availability was apparently raised for the first time on Wednesday, 9th November, after Wayne Hutchinson had absconded from the ward. Dr. Myers, the duty psychiatric registrar, wrote in the case notes:

"Pt. left the ward this afternoon -- police informed. When he returns will need sedation and to continue 1 : 1 obs. (there are no available beds on Eden ward)."

- **The last time that the availability of a bed was specifically addressed was on Monday, 14th November, the day Wayne Hutchinson was supposed to have returned from leave. The nursing note observes: *"When a bed is found inform family, then Matthew should come to hospital."* His bed had, by that time, been filled. Data presented to the Internal Inquiry showed that on that day all nineteen beds on Nelson ward were occupied and six patients were on leave.**

- **This was not an isolated phenomenon. On the same day all the other acute admission wards were full and had patients on leave. Throughout November 1994 all nineteen beds in Nelson ward were occupied and had between four and ten patients on leave giving total bed occupancies ranging from 121% to 153%. All the witnesses who gave evidence to the Inquiry accepted that the beds in Nelson ward were under great pressure.**

- **When no beds were available, the usual practice was to fill leave beds and then, when these were filled, to look for a bed in another hospital, either in another NHS Trust or at a private hospital, as an Extra Contractual Referral (ECR). Both junior doctors and nurse managers would become involved in a difficult and time-consuming process. The senior nurse manager was responsible for authorising the cost of an ECR. However, finding a bed was only the beginning. Since a new admission could not be diverted in this way, a stabilised patient nearing the end of his treatment would have to be transferred. There would then be a chain reaction of enforced bed movements of patients within the hospital to provide an appropriate bed for the new arrival. We were told that transfers would take place throughout the day so as to avoid transfers taking place at night but, even so, transfers after 9 p.m., which often involved patients being woken up, occurred about once a week on each ward.**

- **Erville Millar, the Chief Executive of Lambeth Health Care NHS Trust, told the Inquiry that this caused *"organised chaos",* a view which was shared by the nursing staff.**
- **There was no doubt that there was at this time an acute-on-chronic shortage of beds. This meant that there was considerable pressure to discharge patients from the ward. Dr. Oakley told the Inquiry that patients were discharged when they were *"still hallucinated"* and Dr. Lawrence described**

"a constant pressure to nominate the least sick patient so that he or she could be discharged so that the even sicker patient who was at home or in Brixton Police Station could be admitted".

(See also paragraph 293)

The nursing staff agreed with this assessment.

Occasionally, it came as a great relief to nursing staff if a relative who was visiting the ward asked if the patient could stay the night at home.

- **Extra Contractual Referrals are expensive. The Inquiry found it difficult to judge how they were regulated and we were not surprised to find different views expressed at different levels in the chain of management. Erville Millar said that:**

"Within our organisation we had systematically made it very clear, particularly because of the bed pressures . . . that we would never allow any financial pressures to dictate whether an issue of clinical judgment or the safety of the person was compromised . . . We have never denied for financial or other reasons access to the independent sector".

Dr. David Roy, the Medical Director, Lambeth Health Care NHS Trust, told the Inquiry that:

"If somebody requires admission the bottom line is that admission will never be refused".

Dr. Lawrence, however, described a *"virtual embargo"* on ECRs. Dr. Roy responded by asserting that there was

"a very delicate balance when working with colleagues to say that it jeopardises the whole service to have overspill placements that are unpredictable that have to be paid for out of whatever money is around".

Titus Musee, Registered Mental Nurse and Team Leader at South Western Hospital, told the Inquiry that he

"was very frequently reminded of the expense of having to buy beds in the private sector",

and summed-up the position in this way:

"If you did not cut down, you knew they were not going to recruit staff".

- **In 1994/95 the pressure on beds was such that there was an overspend of £1 million on mental health beds in the private sector by the three mental health Trusts in Lambeth, Southwark and Lewisham, which resulted in a financial crisis. In a subsequent year the overspend rose to £1.9 million. When this was investigated, it was found that ECRs of acute patients, previously rare, had started to rise at the beginning of 1994 and had then increased steadily.(46) This matched the situation in Greater London as a whole where bed occupancy rose to 100% at the same time. The authors of the study did not say whether the increased bed occupancy was due to an increase in the number of patients or due to an increase in length of stay. They concluded that the most important factor to account for this increase was the change in mental health policy brought about in the wake of the Ben Silcock and Christopher Clunis cases and, in addition,**

"a climate of blame of individual practitioners has developed as the inquiries into individual cases have judged the competency of named individuals. The introduction of the supervision registers and concern about litigation from senior psychiatrists acted as the final triggers for the 1994 bed crisis".

This in turn led to increasing caution on the part of clinicians who changed their admission and discharge thresholds.

- **The authors of this study also calculated that in 1994 in Lambeth, Southwark and Lewisham as a whole there was a shortfall of 75 beds, this being the number of beds required to return recorded bed occupancy to 85% : this is an acceptable figure which would require very few ECRs. Unfortunately, no individual estimate for South Western Hospital was provided.**

- **From this study it appears that ECRs from West Lambeth acute wards rose to about ten a month by the end of 1994. In addition, about twelve patients a month went to medium secure units. The number of beds required for these patients depended on the duration of their admissions. In October 1994 there was an average of seven acute and fourteen long stay beds occupied by these patients. This figure is almost a third of the total number of the Trust's acute beds which in 1994 numbered 68. (Lloyd Still 24, Luther King 20, Nelson 19 and Eden 5). To put it another way, it would have needed another whole ward to accommodate them. We were told that the situation was the same in 1997 and 1998.**

COMMENT

- **To have the equivalent of a ward of patients scattered over a variety of hospital settings is highly inappropriate in terms of continuity of care; the arrangements for aftercare; the stress on both patients and relatives, and from the standpoint of financial accountability.**
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- **Although this study explains the crisis that occurred in 1994, it is silent on the question of longer term trends and did not deal with the wider picture. The authors make the point that the documentation of bed numbers over time was poor. Psychiatric patients from the catchment area now served by South Western Hospital previously attended Tooting Bec Hospital which was finally closed in 1995. The majority of its long stay patients were accommodated in supported housing. Although the number of acute beds was not reduced as a result of the closure, the number of medium-to-long stay beds *was* reduced. The flexibility provided by a large hospital was lost, according to Erville Miller. Sue Lewis, who in 1994 was the service manager for acute mental health and had been much involved in planning the closure of Tooting Bec Hospital, told the Inquiry that no provision had been made for the 10-15 new long stay patients she would have expected to have been generated each year.**

- **At Tooting Bec Hospital there had been five beds in the locked ward. In 1994, five beds were provided in Eden ward. At that time the Trust had no medium secure beds of its own. It paid for five beds in the Dennis Hill medium secure unit, which was managed by another Trust, and no less than thirty patients needing medium security were being paid for in private units. The situation has not eased.. In addition, the Lambeth, Southwark and Lewisham districts had many patients in Special Hospitals: 95 in 1996 and probably about the same number in 1998.**

- **Both Erville Millar and Dr. Roy accepted that there had been an inadequate number of beds provided at South Western Hospital in 1994. They were unable to tell the Inquiry how the provision of beds had been calculated. Erville Millar suggested it had been done *"on a basis of need, Jarman index and gut feeling".* Nor could they say whether the provision actually matched the needs of the catchment area as estimated either by the Jarman index or by more up to date indices of need. These show that catchment areas with the highest levels of social deprivation may require far more resources than the least deprived areas. According to one recent calculation, this amounted to three times as much, with West Lambeth needing almost 70% more resources than the national average. The disproportion is even greater in respect of secure beds. These beds are filled by admissions from outside the hospital e.g. from the courts and prisons. If such patients need rehabilitating in less secure conditions, then, rather than being a resource for the open wards, the secure beds will, instead, increase the pressures on the open wards.**

COMMENT

- **There is no doubt that there was extreme pressure on the beds at South Western Hospital, especially on Eden ward at the time Wayne Hutchinson was in hospital. There was also some degree of pressure, which was both direct and indirect, to avoid transferring patients to other hospitals as Extra Contractual Referrals. This had an adverse effect on the care of all the patients admitted to the Trust's**

beds. The mechanism for granting leave was resorted to far too frequently as a safety valve, and

often in inappropriate circumstances, in order to provide the only practical means of acquiring a bed for a patient who needed it.

- **Since 1994 the number of beds has been increased. In the new wards, which were opened in May 1996, there are now twelve beds in Eden ward instead of five. Nelson ward and Luther King ward between them have an extra five beds. Five beds in Lloyd Still ward have been allocated to acute admissions. Previously they functioned as liaison psychiatry beds. In addition, the Trust now has 15 ½ beds in the Cane Hill medium secure unit. After these beds were opened the number of ECRs originating in the acute wards fell dramatically. However, in May 1998 the level suddenly increased. It would appear that demand and supply are not yet in balance. WE RECOMMEND THAT the need for beds, both open and secure, in the catchment area of South Western Hospital should be re-estimated, using contemporary methodology.**

CHAPTER ELEVEN

The Care Programme Approach and risk assessment

- **Health Circular HC(90)23/LASSL(90)11 (The Care Programme Approach for People with a Mental Illness) required District Health Authorities to implement the Care Programme Approach, as envisaged in HC(88)43, for people with a mental illness who have been referred to the specialist psychiatric services. The obligations on social services authorities were less in that they were only asked to collaborate with health authorities in introducing this approach and, as resources allowed, to continue to expand social care services to patients who were being treated in the community. The Circular required district health authorities to draw up and implement, by April 1991, in consultation and by agreement with social services authorities, local care programme policies to apply to all in-patients being considered for discharge and to all new patients accepted by the specialist psychiatric services for which they had managerial responsibility. Where a district health authority purchased psychiatric services from a self-governing Trust, the contractual arrangements required these organisations to have adopted the Care Programme Approach. By 30th April 1991 Regional Health Authorities were required to confirm to the NHS Management Executive that all district health authorities in their areas had introduced the Care Programme Approach. No additional funds were provided, on the grounds that different procedures rather than extra services were to be introduced. Expectation did not match reality: there were significant delays nationwide in implementing this policy.**
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- **The Care Programme Approach (CPA) is essentially concerned with care in the community and the preparations that should be made for this before a patient leaves hospital. This Circular has nothing to say about risk assessment; in-patient treatment or how the CPA should be linked with the arrangements for compiling treatment plans in hospital. The Circular sought to introduce more systematic arrangements for deciding whether a patient referred to the specialist psychiatric services could realistically be treated in the community but there was an important limitation on its scope:**

"If a patient's minimum needs for treatment in the community - both in terms of continuing health care and any necessary health care - cannot be met, in-patient treatment should be offered or continued . . ."

This aspect of the policy assumes that beds are available. This was, and is, frequently an unjustified assumption. The Circular stated that all care programmes should include arrangements for assessing the health care needs of patients who could, potentially, be treated in the community; arrangements with social services authorities for assessing and regularly reviewing the social care that such patients needed and effective systems for ensuring that agreed health and, where necessary, social care services are provided to those patients who can be treated in the community. The Circular stressed the need for multi-disciplinary collaboration and that the agreement of all the professional staff and carers who are to participate in the care programme, should be obtained. Once the assessment is made and it is agreed that the patient's needs can be met in the community, arrangements had to be made to coordinate this care and the Circular suggested that the ideal is for this to be done by a key worker who would keep in close touch with the patient.

- **The Circular left it to individual health authorities to draw up local policies for implementing these arrangements. These local arrangements would include assessments, meetings to decide what the care plan should be and the appointment of the key worker. The arrangements would also ensure that the care plan approach is coordinated with the arrangements made for the more limited number of patients covered by section 117 of the Act. These consist of those patients who have been detained, mainly under section 3 or section 37 of the Act, for whom the district health authority and the local social services authority have a duty to provide aftercare services. In practice this usually meant a combined meeting to consider both categories of patient.**

- **It appears that the CPA was originally introduced to South Western Hospital in 1992. At the time Wayne Hutchinson was admitted to hospital, a policy entitled *"Discharge and after care in the community : Summer 1994"* was in operation. The policy covered both the CPA and supervision registers (Circular HSG(94)27 had been published in May 1994). The local policy was somewhat further developed than the Circular, in that the question of risk was addressed, it being implied in that policy that, if with adequate supervision and medication in the community a patient might still present a serious risk, he should not be discharged. This policy was agreed between the Lewisham and Guy's Mental Health Trust, the West Lambeth Community Care Trust, the Maudsley and Bethlem Trust and the Lambeth, Southwark and Lewisham Health Commission. It was considered to be a far more practical document than the Circular itself.**

- **However, although the local hospital policy was otherwise in accordance with the terms of the Circular, the policy provided that not all patients accepted by the specialist psychiatric services would be accepted for the full CPA. The patients who did qualify were identified as those who:**

had a history of repeated relapse of their illness due to a breakdown in their medical or social care in the community;

had a severe social disability, or major housing difficulties, as a consequence of their illness;

required multi agency involvement and coordination;

had a history of severe self harm / suicidal risk, severe self neglect, or of violence / dangerousness to others as a consequence of their illness.

- **These patients were described in the local policy as Level Two patients, while other non-qualifying patients were described as Level One patients. Level One patients were said not to require multi-disciplinary reviews since their needs were not as complex*:***

"Usually there will be a single professional contact with a patient i.e. seen in out-patients by a doctor or by a community nurse at home etc".

- **The pressure on beds and resources was such that in 1994 it was reasonable for the Trust to exclude patients from the full CPA arrangements according to the Trust's own criteria. However, a too rigid application of the criteria might mean that some patients would be denied the care and supervision they really needed under the full CPA. WE RECOMMEND THAT the existing local criteria for inclusion on the CPA Register should be maintained, but should be interpreted flexibly according to individual clinical need.**

- **In the context of setting up the relevant CPA meeting the local policy required that the patient's named nurse should discuss with the multi-disciplinary team whether the patient will need coordinated care when he is discharged from hospital. If it is resolved that he will not need such care, no CPA meeting will be held. If a patient is considered to be a Level One patient and a CPA meeting is not held, the named nurse must ensure that a CPA checklist and a discharge care plan are completed by the multi-disciplinary team before the patient's care is transferred into the community.**

- **If a patient is a Level Two patient, and thus qualifies for a CPA meeting, the policy suggests that it should be chaired by the consultant or his deputy, that the social worker and CPN should be present, that a minute taker should be appointed and that particular attention should be paid to any known risk factors. The aim of the meeting is to draw up a coherent care plan and to identify the key worker. It also suggests that the RMO should be responsible for completing the pre-discharge checklist and chair the pre-discharge and**

subsequent review meetings.

COMMENT

- **This local policy is, in general terms, adequate, but it does not identify who is responsible for drawing up the care plan, who should sign it, or who is ultimately responsible for its implementation. The policy does not address the question of the action to be taken if a patient has absconded; or is absent without leave; or is uncooperative.**

- **The failure to allocate responsibility for the many aspects of the operation of the CPA has been a feature of its implementation nationally and has characterised a number of homicide inquiries. The Ritchie Report (1994) recommended, *inter alia*, that care plans should be formulated under the direction of the consultant psychiatrist. We agree. WE RECOMMEND THAT existing local policy should be amended. Decisions concerning CPA levels of care and the construction of care plans should be the responsibility of the consultant psychiatrist, after consultation with the relevant members of the clinical team.**

- **The fact that a policy was created does not, of course, mean that it was implemented as intended. Thus the record of a MHAC visit in July 1992 refers to a delay in implementing the CPA, and in June 1993 its implementation was said to be variable. It was noted that the policy was being revised. However in March 1994 the Commissioners were assured that section 117 meetings were being held at least three weeks before the projected discharge date and that patients' early discharge could only take place when aftercare arrangements were in place. By June 1994 (the last visit before Wayne Hutchinson was admitted to South Western Hospital) a CPA coordinator had been appointed and a computerised system was being set up. However it was noted that there were still problems. Thus there was not enough time to make proper assessments of patients who had been returned from the private sector; the CPA procedures were increasing the length of stay in hospital, and discharge plans were not to be found in the case notes. In 1995 the Commissioners again had difficulty finding CPA documentation and this documentation was sometimes seriously inaccurate. Similar problems were also noted during visits in April and October 1996.**

- **The assessment of the current operation of the CPA within the Trust is outside our Terms of Reference. However some audits that we have seen, and which post-date the relevant events, are not encouraging, despite the generally high standard of the criteria which have been adopted and the earlier progress of implementation of the CPA, which was above the national average.**

The Care Programme Approach and Wayne Hutchinson

- **Michael Andrews, Wayne Hutchinson's named nurse, made arrangements for a CPA meeting to be held. In his undated care plan, probably written over the weekend after Dr. Saxena had erroneously allowed Wayne Hutchinson to leave the ward, he wrote under**

the heading Nursing Intervention "*Arrange CPA date*". On Tuesday 15th November, the day after Wayne Hutchinson was supposed to have returned from leave, another nurse sent out formal letters of invitation to a pre-discharge section 117 /CPA aftercare planning conference to be held on 15th December to six people in addition to Wayne Hutchinson himself:

1 GP

2. Social worker

- **Case manager**
- **Outreach team**
- **Mother**
- **Sister**

Dr. Hitchens received this letter, but neither the social services department nor Mr. Raghoo, the CPN, have a record of receiving it.

COMMENT

- **Michael Andrews acted in accordance with hospital policy in arranging this meeting.**

- **Wayne Hutchinson failed to return to hospital. On 26th November his detention under the Act expired and on 28th November, after discussion at a ward-round, he was discharged in his absence. Dr. Dewan then addressed the CPA pre-discharge checklist. This form is designed to be completed *"at a RMO led multi-disciplinary meeting on all patients who may be discharged from hospital WITHOUT a formal pre-discharge CPA register meeting"*. On the front of this form the only item that received attention was a Yes/No question about whether the patient was subject to section 3 or 37/41: the Yes was crossed out. A Discharge Care Plan should have been set out on the reverse of the Form, but was not. However, the discharge summary sent to Dr. Hitchens said:**

"Patient was admitted on Sec. 2, after an assessment at A&E. Went home and refused to come back in spite of strenuous efforts. No follow-up. Discharged against medical advice".

- **Dr. Lawrence told the Inquiry that it was not his job to complete the pre-discharge checklist and he could not remember discussing this particular one at the ward-round. He**

explained that the bulk of the questions were not answered because the answers were unknown, since Wayne Hutchinson's assessment had not been completed by the time he absconded.

CPA meeting on 15th December

- **Dr. Lawrence told the Inquiry that none of those persons who had been invited came to the meeting on 15th December. There is no record of what happened on that occasion, and though he said that it was the usual practice to draw up care plans and distribute them, he could not remember where such meetings and the care plans which resulted from them were recorded. He did not believe that in this case there would have been any point in sending a note about the patient to anyone other than the general practitioner. He was aware that there was a hospital policy about these matters but his recollection of them was poor. In fact he told us he was very sceptical about the whole Care Programme Approach.**

COMMENT

- **There seems to have been considerable uncertainty whether Wayne Hutchinson was a Level One or a Level Two patient although he was eventually categorised as a Level One patient. Despite this, those who were invited to the meeting were invited on the assumption that he was a Level Two patient. It is therefore surprising that none of those invited came. There was therefore no multi-disciplinary discussion of his case, no formal risk assessment nor any documentation which could at least have forewarned the social workers and the CPN should they have had to deal with Wayne Hutchinson in the community, in future. A relapse, in his condition, was a very strong possibility. However, we accept that but for his failure to return to hospital, a properly arranged CPA planning meeting would probably have taken place.**

The development of risk assessment

- **Only a small proportion of mentally ill people are violent, and an even smaller proportion are dangerously so. The problem has always been to identify the violent and dangerous minority and to take appropriate precautions, without at the same time unduly restricting the freedom of, or otherwise interfering with, the civil liberties of the harmless majority. In this area there are no clear boundaries, and attitudes and practice have tended to swing between over-concern about dangerousness at one extreme and an undue emphasis on civil liberties at the other.**

- **In order to appreciate the context in which the events of 1994 were managed, it is useful to chart how attitudes, policy and practice have changed in recent years.**

- **The decades following World War II were characterised by a gradual liberalisation which was eventually exemplified in the 1959 Mental Health Act. That Act provided for the compulsory admission of a patient *"in the interests of his own health or safety, or with a view to the protection of other persons"*, either for observation for 28 days, with or without medical treatment (section 25), or for treatment for up to one year (section 26).**

How serious the risk to other persons had to be was not defined, but the phrase implied not only that consideration of risk was part of the admission procedure, but also that one of the objects of admission to hospital was to reduce that risk. This was really no more than a reflection of a traditional part of psychiatric practice.

- **In the 1960s, new medications, the acceptance of the essential harmlessness of many long-institutionalised psychiatric patients, together with concerns about civil liberties led to the development of policies for deinstitutionalisation and care in the community. This approach was encouraged by research in the United States which showed that some populations of mentally ill patients allegedly requiring maximum security were in fact remarkably non-dangerous when released into the community, and that psychiatrists had over-predicted dangerousness to an alarming extent.(47) In this country, too, there grew up an ethos hostile to admission to hospital. It is noteworthy that in the early 1970s an academic forensic psychiatrist, in a book published on the subject of violence,(48) devoted only one page to violence occurring in schizophrenia. Contemporary general psychiatric textbooks did not develop the matter any further.**

- **However, the Butler Committee(49) pointed out that there was a need to cater for patients who might be a risk to themselves, to other patients, to staff, or to the public, and recommended the setting up of units which provided a medium degree of security. After a hesitant start, these units are now well-established throughout the country, although there is probably an inadequate number of beds provided within them.**

- **The Mental Health Act 1983 made no essential changes to the criteria for admission for assessment (which replaced the word "observation") (section 2), or for treatment (section 3). The Code of Practice(50) which provides guidance on how the Act should be implemented, provides:**

In considering "the protection of other persons", it is essential to assess both the nature and likelihood of risk and what level of risk others are entitled to be protected from, taking into account:

reliable evidence of risk to others;

any relevant details of a patient's medical history and past

behaviour;

serious persistent psychological harm to others; and

the willingness and ability of those with whom the patient lives to cope with the risk.

These criteria refer specifically to assessment before admission. The Code of Practice is silent on the assessment of risk, or its management, *after* the patient has been admitted.

- **Current concern about the risks posed by psychiatric patients began in the early 1980s. In July 1984, Isobel Schwarz, a social worker, was killed by one of her former clients, in Bexley Hospital. The Inquiry which was set up under the provisions of section 84, National Health Services Act 1977, reported in 1988.(51)**

- **In the same year Larkland Francis killed a child while he was a patient on a Department of Health funded trial of community care.(52) The report of the subsequent Internal Inquiry was never published, but its importance to the present Inquiry lies in the fact that sometime after that tragedy, Dr. Lawrence worked for the project and would have been well aware of what had happened.**

- **In 1990, the Department of Health issued Circular HC(90)23 (The Care Programme Approach for People With a Mental Illness). Although the Circular considered the general question of assessment, it was silent on the question of assessment of risk or its management.**

- **In April 1991, Carol Barratt stabbed and killed an 11 year old girl in the street two days after discharging herself from hospital. Her RMO was criticised in the subsequent Inquiry Report(53) for discharging her without assessment, despite apparently realising that she was dangerous. Later that year, a committee chaired by Dr. John Reed reviewed the services for mentally disordered offenders. The report of the Hospital Advisory Group was published in November 1991 and, although it was mainly devoted to the question of resources, demonstrated that the needs of this group of patients was by then receiving a great deal of official attention. Furthermore, in the same year, the Confidential Inquiry into Homicides and Suicides by mentally ill people was established. By the end of 1991 the Royal College of Psychiatrists had issued a report entitled *"Good medical practice in the aftercare of potentially violent or vulnerable patients discharged from in-patient psychiatric treatment"*. This report was published in response to the recommendations of the report into the death of Isobel Schwarz. In December 1992 Jonathan Zito was killed by Christopher Clunis. This caused a great public outcry. The Inquiry Report, in 1994, revealed not only the fragmentation of London's psychiatric services but also that the patient in question had a history of violence which had not been properly explored or**

considered. In the meantime, in September 1992, Michael Buchanan had killed an innocent passer-by, Frederick Graver. The report of the subsequent Inquiry was published in November

1994:[(54)] it coincided with Wayne Hutchinson's failure to return to hospital.

- **Such had been the build-up of concern about risk assessment and management, that in August 1993 Virginia Bottomley, then Health Secretary, announced a "Ten Point Plan" for developing community care.[(55)] This was issued before the reports on the Clunis and Buchanan cases had been published but it took account of the conclusions of other Inquiries and events up to that date. The Plan proposed new legislation for supervised discharge. This is now enshrined in the Mental Health (Patients in the Community) Act 1995. The Plan also led to the publication of Circular HSG(94)5, in February 1994: *"Introduction of supervision registers for mentally ill people, from 1st April 1994"*. This was the first time that general psychiatrists were being specifically asked to consider the question of risk. The Circular introduced arrangements for identifying and supervising patients *"known to be at significant risk, or potentially at significant risk, of committing serious violence or suicide, or of serious self-neglect as a result of severe and enduring mental illness"*.**

- **Paragraph 3 of HSG(94)5 makes it clear that consideration for inclusion in the supervision register should take place not only as part of the discussion of the care programme before a patient leaves hospital, or at care reviews following discharge, but also for *new patients at an initial assessment*. This meant that *all* patients were subject to the requirement that a risk assessment should be carried out.**

- **It is appropriate to repeat here the requirements of HSG(94)(5) for the purposes of determining whether a patient should be included in the supervision register:**

    - **the risk assessment should be performed by the consultant psychiatrist in conjunction with other members of the multi-disciplinary team. The consultant has the responsibility of deciding whether the patient should be included on the register;**
    -

(ii) the risk assessment should have regard to any evidence which may be available from any criminal justice agency with which the patient has been involved;

(iii) the evidence upon which the risk assessment is made must be recorded in writing and be available to the relevant professionals at the next review meeting. Signs of deterioration in a patient's mental condition must also be recorded;

(iv) in cases of doubt or difficulty, a forensic psychiatrist should be consulted;

(v) hospital managers should ensure that there are sufficient beds in locked wards or other secure units to cope with the needs of patients who cannot be nursed on open wards because of the risk that they represent to other patients, members of staff, and the general public.

- **Later that year, in May 1994, Circular HSG(94)27: *Guidance on the discharge of mentally disordered people and their continuing care in the community*, was published. Although the Circular emphasised the importance of risk assessment, it also advised that violence more often occurred when drug or alcohol misuse coexisted with major mental illness.**
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- **Given the facts revealed in this Inquiry, it is worth summarising the fundamental approach of that Circular.**

"Those taking individual decisions about discharge have a fundamental duty to consider both the safety of the patient and the protection of other people. No patient should be discharged from hospital unless and until

those taking the decision are satisfied that he or she can live safely in the community and that proper treatment, supervision, and support and care are available."

". . . those known to have a potential for dangerous or risk-taking behaviour need special consideration, both at the time of discharge and during follow-up in a community. No decision to discharge should be agreed unless those taking the clinical decisions are satisfied that the behaviour can be controlled without serious risk to the patient or to other people. In each case it must be demonstrable that decisions are being taken after full and proper consideration of any evidence about risk the patient presents."

"Before discharge, there must be a careful assessment by both the multi-disciplinary team responsible for a patient in hospital and those who will be taking responsibility for his or her care in the community. Those involved must agree the findings of a risk assessment, the content of a care plan and who will deliver it. In accordance with good practice in the delivery of the Care Programme Approach generally, there must be a contemporaneous note of the outcome of any risk assessment and of any management action deemed necessary and taken."

- **Similar considerations should apply, as a matter of good practice, whenever the granting of leave is being considered in the case of a detained patient. The care of Wayne Hutchinson was provided against that contemporary background and its delivery and quality must be judged accordingly.**

- **It is only since 1994 that more detailed and convincing, though as yet unvalidated, guidelines for the assessment of dangerousness have appeared, such as, for instance, those by McCarthy *et al* in 1995. The authors of this paper included Dr. David Roy and Dr. Zerrin Atakan, both of whom were working at South Western Hospital in October 1994. In 1995, Dr. Maurice Lipsedge provided a list of factors predictive of violence in a**

book on clinical risk management.[(56)] This was followed in 1996 by the Royal College of Psychiatrists' production of *"A useful guide to the assessment of risk"*, and in 1998 by *"Clinical practice guidelines for the prevention and management of violence in mental healthcare settings"*. In 1996, the NHS Executive published a manual entitled *"Risk Management in the NHS"*. Apart from a brief mention of arson, it is surprising that there is no discussion in that publication of the risks posed by psychiatric patients. The concept of risk management in the psychiatric context appears, even today, to be still "*an emerging agenda*", at least for general psychiatrists. Even though it has been more established in the field of forensic psychiatry, the profession as a whole has been slow to respond to this important concept.[(57)]

Risk assessment : local protocols and policies

- **The hospital policy document dated "Summer 1994" (see paragraph 314) differed from Circular HSG(94)5, in that it did not include patients who were at risk of suicide, and its minimum criteria for inclusion on the supervision register included all of the following:**

(1) ***a diagnosis of a major mental illness;***

(2) ***treatment resistance or a documented history of relapse following non-compliance;***

(3) ***a history of serious violence or serious dangerousness to others, due to psychotic symptoms;***

(4) ***a significant risk of future violence or dangerousness;***

(5) ***a history of being detained in hospital under the Mental Health Act.***

- **The local policy document sets out a list of factors associated with dangerousness. These are, in our view, more realistic than those contained in the Circular . The policy document required a discussion about inclusion on the register to be held on all new patients as a matter of routine at an initial assessment; before leaving hospital; and at CPA reviews in the community. The decision whether to include a patient on the register was to be made by the consultant psychiatrist in consultation with the multi-disciplinary team. If a patient was included on the register he was categorised as a Level Three patient and was subject to a higher level of supervision in the community than was a Level Two patient.**

- **The earlier hospital policy document, dated April 1994, sought to bring together the requirements of section 117, Mental Health Act; CPA; supervision registers and discharge, into a single document. The policy document dated Summer 1994 reflected the additional requirements of HSG(94)27. By mid-June 1994 a CPA coordinator had been appointed and a computer programme for the operation of section 117 was being set up. By June 1995 the supervision register contained 62 names.**

The risk assessment of Wayne Hutchinson

- **Although we are primarily concerned with risk assessment in the medical context, a form of risk assessment was carried out by the Clerkenwell Magistrates' Court on 28th July when bail was granted to Wayne Hutchinson. Although there was then no suggestion that he was, or appeared to be, suffering from a mental disorder, the potential risk to the public was a substantial issue for the Court.**

- **The GP, Dr. Hitchens, carried out an informal risk assessment on 27th October 1994 when he decided that Wayne Hutchinson needed admission to hospital. His letter of referral succinctly described four risk factors: hallucinations and delusions; that he was blaming his mother for his symptoms; an apparent increase in aggression, and that he was on bail for possessing a firearm. As he was clearly deteriorating, referral to hospital was the correct method of managing the risk that he clearly posed to members of the public.**

- **Dr. Fotiadou carried out a risk assessment for the purposes of the medical recommendation required by section 2, Mental Health Act 1983, when she also recorded that Wayne Hutchinson needed to be detained *"with a view to the protection of other persons",* as well as for his own health and safety. This decision was reached against a background of verbal and physical aggression in Scutari, when he attacked nursing staff. But Dr. Fotiadou was also aware of -- and took into account -- the allegation that a serious criminal offence had been committed.**

- **Although the preliminary nursing care plan drawn up on Lloyd Still ward correctly reflected Dr. Fotiadou's assessment it did not note the risk of absconding from the ward nor that he had been violent to nursing staff. In that sense, inappropriate assessments of immediate risk were made during the first twenty-four hours of his detention.**

- **When Wayne Hutchinson was first transferred to South Western Hospital, no assessment of whether he should be admitted to an open or, alternatively, a locked ward environment, was carried out. Such an assessment is important and should be made jointly between medical and nursing staff, and recorded in the medical and nursing notes. It is clear that he required a locked ward environment. Information was available which should have enabled such a decision to have been made: the fact that Chris Strahan's report was not available to the South Western Hospital staff should have made no difference. The report**

would have added nothing to the basic information which was already available to them.

- **After Wayne Hutchinson was transferred to South Western Hospital he tried to leave the ward, but for most of the time he was sedated. He was still drowsy when he was first seen by Dr. Lawrence at the ward-round on Monday, 31st October. This was the first opportunity for carrying out a formal risk assessment, albeit a provisional one. Information was available to Dr. Lawrence about Wayne Hutchinson's accusations that his mother was poisoning him and turning him into a woman; that he had been violent in the Casualty Department; that he was on bail for a firearm offence and that he was probably involved with drugs. There is no note of any discussion of these aspects of his case nor of any formal risk assessment, multi-disciplinary or otherwise, being carried out either then, or indeed at any other time during his short admission. Dr. Lawrence admitted not only that he had not carried out a risk assessment on Wayne Hutchinson, but that it was not his practice to do so in respect of *any* patient.**
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COMMENT

- **When Wayne Hutchinson was admitted to hospital there were clear indications that he represented a risk to others and, in particular, to his mother. He held the delusional belief that the food that she gave him was causing a vagina to develop on his body. Sexual delusions of this kind are extremely disturbing and, when the harm is attributed to a particular person, that person is at risk, especially when both persons are emotionally close, as they were here. He had stopped eating his mother's food which demonstrated that his delusions about her were beginning to alter his behaviour. However, until he was abusive to her in Scutari, he had not displayed any hostility or aggression towards her. Those who might have needed to restrain him if he tried to abscond from hospital were also at risk. This was obvious from his behaviour in Scutari and very apparent to the nursing staff at a later stage. He also posed a risk to others due to his association with drugs. He denied taking anything more harmful than cannabis, but such denials in the face of the information given by his sister to Chris Strahan should not have been accepted at face value. The most serious manifestation of risk concerned the allegation that he had been in possession of a firearm and ammunition. When questioned, both Wayne Hutchinson and his mother denied the firearm allegations but, once again, his denials should not have been taken at face value.**

- **Whether his denial of the firearm offence was thought to be true or false is beside the point. The possibility that a psychotic patient might have access to firearms is one that needed urgent investigation and should not have been ignored by medical staff. The dangerousness of a disturbed schizophrenic with access to firearms is self-evident. It does not require any complicated process of risk assessment to identify this. It was suggested that many patients at South Western Hospital were as disturbed as Wayne Hutchinson and that thus he was by no means unusual. This is an inadequate observation. His behaviour on the ward may have been unremarkable by those standards but his recent, albeit alleged, involvement in firearms offences put him into an entirely different category.**

- **By the time leave was granted, on 3rd November, no adequate risk assessment had been**

carried out. Nor had a full mental state and social assessment been carried out. To have based a decision to grant leave merely on the basis of such a short period of settled behaviour on the ward and on the success of two hours' leave with his sister the day before is insufficient, given what was already known about this patient. The Internal Inquiry was wrong to conclude that *"appropriate consideration of risk"* had been given. This patient was still deluded : the next day he attempted to kill three men outside *Mixes* night club with a pistol. Far from being granted leave, this patient should have been in a locked ward. There was no real basis at that time, or even later, for displacing Dr. Fotiadou's assessment that he posed a risk to other members of the public.

- **When Wayne Hutchinson was returned to the ward by police, in handcuffs on 8th November -- a day later than required -- no risk assessment was carried out even then. Merely to note that he was an absconding risk was wholly insufficient. No real attempt was made to investigate the circumstances of the "fight" in which he said he had been involved; nor was any attempt made to investigate the circumstances surrounding the firearm allegation. Even when the nursing care plan did identify this task, no action was taken. It is of great significance, too, that this task was not even identified until after Wayne Hutchinson had left the hospital for the last time. This was a matter of great importance and should have been overseen by Dr. Lawrence personally.**

- **On 10th November, it is inconceivable that leave would have been granted by Dr. Saxena had he been aware of the content of the medical notes and nursing care plan, and had he known that he was a detained patient. A bed was available that morning. The available documentation noted that he was an absconding risk (indeed he had absconded the day before); that he had been violent, and that the plan was for sedation and one-to-one nursing care upon his return to the ward that day. In the result, no assessment of risk took place because of a fundamental breakdown in communication. It follows that there was a serious failure to take into account his potentially dangerous behaviour on this occasion.**

- **In the circumstances it is thus all the more regrettable that the nursing staff did not detain Wayne Hutchinson on the ward when requested to do so by Dr. Lawrence when police brought him back to the ward later the same day. Even if no bed was, by then available, that was no good reason for letting him go.**

- **Equally mystifying is why no steps were then taken by Dr. Lawrence to rescind Dr. Saxena's erroneous decision even though Dr. Saxena had no power under the Act to grant leave to this patient. Instead, he allowed this dangerous patient to roam the neighbourhood in the expectation that he would return to the ward on Monday 14th. Steps should have been taken to bring him back by enlisting the help of the police forthwith. It is not surprising that Wayne Hutchinson did not return to the ward on Monday 14th.**

- **Although a CPA conference was arranged in advance for December 15th (on the assumption that Wayne Hutchinson would have returned to the ward by then), no risk**

assessment was ever carried out at that meeting. That was the last opportunity for carrying out a risk assessment. If an adequate risk assessment had been carried out then -- or even earlier -- after appropriate enquiries had been made, the inescapable conclusion would have been that this patient was potentially highly dangerous. In those circumstances, even though the section had expired on 26th November, much more pro-active steps could and should have then been taken to locate this patient. If he was -- as he probably would have been -- showing signs of mental illness, he could have been brought back to the ward. There should have been active cooperation with the police at Brixton. At the very least, they should have been alerted to the fact that he was on bail for a serious criminal offence. The mere fact that he was -- as is likely -- living with his mother for some of this latter period of time, meant that he was also in breach of his bail conditions. He was liable to be arrested for that breach alone.

- **Although the supervision register was in operation by mid-November, no consideration was ever given by the team to the inclusion of Wayne Hutchinson's name upon it. If the multi-disciplinary team -- armed with information about the possession of the firearm -- had considered this matter, he would have been a clear candidate for inclusion on the register.**

COMMENT

- **We disagree with the conclusion of the Internal Inquiry on this issue. The inclusion of Wayne Hutchinson's name on the register, or even discussion about its application, would have triggered close liaison between the hospital and the local police and probably would have resulted in Wayne Hutchinson being brought back to the hospital and being detained under section 3 MHA 1983. The tragedies which later took place would have been prevented.**

- **The failure of the hospital staff to make contact with any representative of the criminal justice system contrasts with the actions of Dr. Hitchens, who wrote not only to the police but also to Wayne Hutchinson's solicitor at the time he referred him to hospital.**

- **There was a failure by the multi-disciplinary team, and in particular by the consultant, to carry out any adequate risk assessment on this patient. This was a serious error judged against the background of the relevant Health Circulars and local hospital policies which were current at that time. Had the issue of risk assessment been properly addressed, this patient's potential dangerousness would probably have been revealed and he would not have been permitted to leave the hospital. Alternatively when he did leave, strenuous attempts would have been made to seek his return. As it was, there was a distinct lack of urgency in the attempt to achieve this (see paragraphs 153 and 157). Despite the publicity surrounding the publication of the Report on the death of Jonathan Zito in early 1994 and the publication of Health Circulars and local hospital policies, there was a significant gap between the principles of good and safe practice which these publications exemplified and the management of this patient. WE RECOMMEND THAT a system of clinical monitoring of the implementation of and compliance with local policies, protocols and procedures relating to leave, discharge, absconding and risk assessment should be established. WE FURTHER RECOMMEND that a rolling programme updating nursing**

staff on care planning, record keeping, the responsibilities of named nurses, the code of practice, NHSE guidance and local policies, protocols and procedures relating to leave, absconding, discharge and risk assessment should be established.

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CHAPTER TWELVE

The Role of the Police

Brixton Police

- **After Wayne Hutchinson failed to return to hospital on 7th November 1994 the local police at Brixton acted promptly and efficiently in bringing him back to the ward. They also acted correctly in bringing him back to the ward during the afternoon of the 10th. They had been told by hospital staff on the 9th that he had absconded during the day and were responding accordingly. They had not been told that Dr. Saxena had allowed him to leave the hospital on the morning of 10th November.**

- **The local police were also alerted on 14th November, immediately after Wayne Hutchinson failed to return to the ward. They went to his mother's address on Tuesday 15th, only to discover that he had just left the premises. That appears to be the last time that local police officers went to that address in an attempt to bring him back to the ward.**

- **The local police, however, did not know at that time that he was on bail for firearm offences nor that he was in breach of his bail conditions, having failed to report to Croydon police station. They had received no information from DC Loudon, the officer in charge of the firearm case (see paragraph 382). South Western Hospital had not informed them that he was on bail for a firearms offence, nor that he was potentially dangerous. The hospital should not only have made enquiries as a matter of priority, about the firearm allegations but deserves serious criticism for not advising the local police of these matters.**

- **It is inconceivable that the local police would not have made strenuous efforts to find Wayne Hutchinson had they been aware of these factors. At the very least, contact would have been made with DC Loudon and with Croydon police station. As a result, Brixton police would have discovered his brother's address in Croydon and his sister's address, and would probably have made further visits to Mrs. Hutchinson's home. The police -- whether from Brixton or from Clerkenwell -- would have viewed him, correctly, as a danger to the public. Of course, the police at Clerkenwell had believed that he was a**

danger to the public since July. But the police from both stations would have recognised that there had been a radical change in his circumstances since he had been granted bail on 28th July. In any event it is likely that Wayne Hutchinson would have been detained before he committed the Index offences in December 1994. He would have been nursed in conditions of security and would not have been able to kill and injure members of the public a few weeks later.

- **Even though Brixton police were apparently unaware of this important information, their efforts to locate him were unsatisfactory. We recognise that an extra burden is placed on the shoulders of the police when they are asked to look for patients who have absconded or failed to return from leave. Despite that, they paid only one visit to Mrs. Hutchinson's home before his lawful detention under section 2 expired. There were no visits thereafter.**
-

- **When police officers saw Wayne Hutchinson at his mother's address on 30th December (see paragraph 5) as part of their routine enquiries following the death of Anthony Kellman, they did not realise that he had a psychiatric background and had absconded from South Western Hospital, nor that he was in breach of his terms of bail having been accused of serious firearms offences. Those officers did not know that their colleagues had been asked, on 14th November, to bring him back to the hospital. Nor were they aware of the information that DC Loudon possessed. However, Wayne Hutchinson was not considered as a suspect for the murder of Anthony Kellman at that time. He was treated as a potential informant and as an associate of those persons who, police believed, might have been responsible.**

COMMENT

- **The inadequate performance of the Metropolitan Police as described above -- despite the failure of the hospital to provide crucial information about Wayne Hutchinson -- is easily explained. A Missing Person Form was not completed at Brixton Police Station in respect of the alert on 14th November. Such a form had been correctly completed on each of the previous occasions when the hospital had telephoned Brixton Police Station. This was now the third occasion on which the police had had to deal with this particular patient. If such a form had been completed, it would have served as a continuing reminder to police officers that Wayne Hutchinson needed to be found and detained.**

Furthermore, no mechanism existed in the Metropolitan Police Service at that time for assessing the risk to members of the public when a patient was reported missing from a psychiatric hospital. Subsequently, in 1998, a written policy was introduced to deal with this important issue. Now the element of risk is graded. If the risk is assessed as medium or high, a Detective Superintendent or Detective Chief Superintendent is assigned to oversee the location of the missing patient. If the current system had been in place in 1994, the local police would inevitably have sought relevant information from the hospital staff. Such important information as they possessed would, in turn, have been disseminated amongst local police officers and probably would have led to his apprehension before Christmas 1994. At the very least he would have been detained on Friday December 30th (see paragraph 5).

DC Loudon

- **DC (now DS) Loudon treated the firearm allegations very seriously. He presented his reasons for opposing bail in the strongest possible terms, to the Crown Prosecution Service, in Form MG7. The objections to bail at Clerkenwell Magistrates' Court on July 28th (see paragraphs 51 and 52) were well-founded: he appreciated that there was a significant risk that Wayne Hutchinson would acquire another firearm if he was granted bail. In fact, Wayne Hutchinson either already had access to, or subsequently acquired, at least two other firearms. He used them on November 4th in an attempted shooting outside *Mixes* night club; on December 26th; and on December 27th when he killed Anthony Kellman.**

- **The grant of bail was, with hindsight, a tragic mistake. We suspect that the Court was swayed by the fact that Wayne Hutchinson was a young man of good character at the time. On the other hand, if he had been remanded in custody at the end of July he would never have committed the index offences. The subsequent decline in his mental state**

would have been observed whilst in custody. Any subsequent conviction in relation to the firearm matter -- the likelihood of which was strong -- would have resulted, inevitably, in either a custodial sentence or a Hospital Order under the Mental Health Act 1983.

- **On November 1st 1994, DC Loudon received by fax from Croydon police station a copy of Dr. Hitchens' letter of 18th October (see paragraph 62). He telephoned Dr. Hitchens to confirm its authenticity. Dr. Hitchens emphasised that Wayne Hutchinson was, in his opinion, mentally ill, and that he had ceased to report to Croydon police station because of his condition.**
-

- **On November 13th, DC Loudon very properly provided this information to the Crown Prosecution Service at Clerkenwell, which was dealing with the firearm matter. At this stage DC Loudon did not know that Wayne Hutchinson had absconded from the ward or even that he had been admitted to hospital. There was no reason why he should have known: no-one had told him.**
-

- **Since DC Loudon (and the CPS) believed, as a result of Dr. Hitchen's intervention, that Wayne Hutchinson had a justifiable reason for failing to report to Croydon police station, no action was taken to arrest him for breach of his bail conditions. Even though DC Loudon and the CPS did not know he had been admitted to hospital this was regrettable. Had he been arrested he would have been remanded in custody or, alternatively, returned to hospital. In those circumstances it is unlikely that he would have been allowed to leave hospital again. By that route the hospital would have gained valuable information about the firearm offences. Nor did DC Loudon inform Brixton police station of the circumstances surrounding his breach of bail. There was no need for him to do so, since he did not know that the local police had been asked, on November 14th, to locate him and bring him back to hospital. He did not know that Brixton police had any role in this case**

at all.

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SUMMARY OF RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

		Paragraph No.
1	**The Terms of Reference of an inquiry such as this should require the Panel as a matter of principle to invite the primary and secondary victims and their relatives to contact the Inquiry Panel.**	Page ii

2	**The Trust should offer to provide appropriate therapy as a matter of course to all those who may have been directly or indirectly affected following events such as these.**	Page ii
3	**All primary and secondary victims and those centrally concerned with the relevant events should be given advance warning of publication of the Inquiry Report.**	Page iii
4	**Clear procedures governing transfers between St. Thomas's Hospital and South Western Hospital should be established**	**91**
5	**Hospital medical staff who have no first-hand or contemporary knowledge of a patient's circumstances should not take clinical decisions without first scrutinising the relevant case notes.**	**129**
6	**A medical and nursing handbook for full-time and temporary staff should be produced which identifies and explains existing policies, protocols and procedures and which summarises the legal framework of the Mental Health Act.**	**134**
7	**The number of beds in the locked ward should be maintained at an adequate and realistic level.**	**147**
8	**Full discharge summaries should be completed as soon as possible after a patient's discharge from hospital and the time taken to do this should be audited.**	**152**
9	**Whenever a patient has absconded from hospital his case should not be closed, even though the relevant period of detention under the Act has expired and no plan for aftercare has been formulated: further attempts should be made to locate and persuade the patient to return to hospital.**	**156**
10	**All patients admitted to the psychiatric wards at South Western Hospital should be tested for substance misuse.**	**186**
11	**Policies should be drawn up for, and staff trained in, the treatment of dual**	**191**

	diagnosis patients.	
12	**Communication between South Western Hospital, the local Drug Dependence Services, the Stockwell Project, the Lambeth Social Services Department, the Police, and the local Drug Action Team, should be greatly improved and the responsibilities of each, for dual diagnosis patients, clearly defined.**	**192**
13	**The Department of Health, in conjunction with the relevant professional bodies, should formulate guidelines for testing for substance misuse and for the management of dual diagnosis patients.**	**193**
14	**The Department of Health, in conjunction with the relevant professional bodies should formulate guidelines for the assessment of patients detained under section 2, Mental Health Act 1983.**	**196**
15	**Consultants should be responsible for ensuring that ward-rounds are properly minuted and the minutes circulated to all members of the clinical team.**	**208**
16	**There should be a single set of ward-round minutes which contain clearly identified plans and agreed actions together with the identification of the persons responsible for their implementation.**	**208**
17	**The Department of Health, the Mental Health Act Commission, and the relevant professional bodies should clarify and coordinate the policies relating to treatment plans for hospital in-patients and the CPA.**	**210**
18	**In the meantime, consultants should be responsible for drawing up and circulating treatment plans in accordance with the Code of Practice for all psychiatric in-patients so that all members of the clinical team are aware of the role they are to play in the patient's treatment.**	**210**

19	**If a nurse is allocated to permanent night duty, he or she should not be appointed as a named nurse.**	**224**
20	**Two registered mental nurses should be on duty at all times on an acute psychiatric admission ward.**	**226**
21	**Whenever social services have performed a statutory function under section 2 or section 3, Mental Health Act 1983, they should be advised of the outcome, even if no formal referral of the patient has been made.**	**260**
22	**Pre-admission social assessments carried out by social services should always be included in a patient's medical case notes.**	**274**
23	**The hospital, in cooperation with the local police, should formulate a written policy in relation to patients who are absent from the ward without leave.**	**285**
24	**The hospital should monitor and audit the incidence of absconding from the ward.**	**286**
25	**The hospital should formulate a policy concerning the management of informal patients, with particular reference to the locking of wards.**	**287**
26	**The Department of Health, in conjunction with the relevant professional bodies, should consider an amendment to the Code of Practice to reflect the position of informal patients in the context of the operation of intercom systems which control access to wards.**	**288**

27	**When leave is granted under section 17, Mental Health Act 1983 an appropriate form should be completed and a copy provided to the relevant carer.**	**292**
28	**The need for beds, both open and secure, in the catchment area of South Western Hospital should be re-estimated using contemporary method-ology.**	**310**
29	**The existing local criteria for inclusion on the CPA Register should be maintained, but should be interpreted flexibly according to individual clinical need.**	**317**
30	**Decisions concerning CPA levels of care and the construction of care plans should be the responsibility of the consultant psychiatrist, after consultation with the relevant members of the clinical team.**	**321**
31	**A system of clinical monitoring of the implementation of and compliance with local policies, protocols and procedures relating to leave, discharge, absconding and risk assessment should be established.**	**367**
32	**A rolling programme updating nursing staff on care planning, record keeping, the responsibilities of named nurses, the code of practice, NHSE guidance and local policies, protocols and procedures relating to leave, absconding, discharge and risk assessment should be established**	**367**

APPENDICES

APPENDIX 1

Chronology

Chronology

Date	**Event**
10 November 1974	Wayne Hutchinson born in Lambeth.
	Father died soon after his birth.
Aged 3 ½	Started at nursery school.
Aged 4	Started at Stockwell Junior School and Sunday School.

Aged 9	Transferred to St. John's Church of England School.
Aged 11	Transferred to Archbishop Michael Ramsey School. Special tuition for reading and writing.
Aged 13 or 15	Started smoking cannabis.
Aged 16	Left school with 6 low grade GCSE passes.
Aged 16	Notified to Court Section of Social Services.
	Worked for 5 months as apprentice carpenter.
Aged 17	Obtained conditional place at a college in Paddington.
	For one year worked 3 or 4 days a week casual labouring.
13 January 1993	Cautioned for possession of cannabis.
Autumn 1993	Started working for South Western Communications.
March 1994	Obtained a gun.
27 July 1994	Arrested near King's Cross Station and charged with possession of firearm and ammunition.
28 July 1994	Appeared at Clerkenwell Magistrates' Court. Released on conditional bail.
August 1994	Reporting to Croydon police station.
13 August	Cautioned for possession of cannabis and using insulting words.

1994	
8 September 1994	Committed for trial to Middlesex Guildhall Crown Court.
18 October 1994	Dr. Hitchens (GP) writes to police and defence solicitor informing them that Wayne Hutchinson was mentally ill.
27 October 1994	Referred by Dr. Hitchens to Accident & Emergency Department at St Thomas' Hospital. Admitted to Lloyd Still ward under section 2, Mental Health Act 1983, under the care of Dr. Oakley, Consultant Psychiatrist. Seen by Mr. Chris Strahan, Psychiatric Social Worker.
28 October 1994	Transferred to Nelson ward, South Western Hospital under the care of Dr. Lawrence, Consultant Psychiatrist.
3 November 1994	Granted leave by Dr. Lawrence.
4 November 1994	Fired gun outside *Mixes* (club/bar) while on leave.
Date	**Event**
10 November 1994	Given leave by Dr. R. K. Saxena.
14 November 1994	Failed to return to hospital from leave.
November - December 1994	Whereabouts unknown.
28 November 1994	Discharged from hospital in his absence.

30 November 1994	GP issued a medical certificate for 6 months.
15 December 1994	Section 117/CPA meeting.
26 December 1994	Attempted murder of Delroy Thomas: shotgun fired.
27 December 1994	Murder of Anthony Kellman: shotgun fired.
29 December 1994	Marlon Snape attacked with knife
30 December 1994	Interviewed by police.
31 December 1994	Paulo Pereira attacked with a knife.
1 January 1995	Murder of Marie Hatton: attacked with a knife. Arrested. Urine test positive for cannabis and cocaine.
3 January 1995	Remanded to HMP Feltham.
16 January 1995	Transferred to HMP Belmarsh.
2 February 1995	Discharge Summary written by Drs. Dewan and Lawrence.
13 February 1995	Transferred to Broadmoor Hospital under sections 48/49, Mental Health Act 1983.

15 February 1995	Firearms case transferred to Central Criminal Court.
June 1995	Interim report of Internal Inquiry.
5 January 1996	Convicted at Central Criminal Court.
1 February 1996	Sentenced to life imprisonment. Returned to Broadmoor under sections 47 and 49, Mental Health Act 1983.
12 November 1996	Court of Appeal quashed the sentences of life imprisonment. Hospital Order with restrictions on discharge without limit of time substituted.
18 March 1998	Mental Health Review Tribunal hearing. Not discharged.
22 October 1998	Mental Health Review Tribunal hearing. Not discharged.

APPENDIX 2

Procedure at the Inquiry

Procedure at the Inquiry

The formal sittings of the Inquiry were held in private at the Eurocentre, Lavington Street, London, SE1. Comfortable facilities were provided with the appropriate furnishings. Stenographic or tape-recorded facilities were provided by Barnett Lenton & Co. Limited. The transcripts of evidence were available to the Inquiry a few days after the relevant evidence had been given.

Prior to the first hearing in September 1997, much of the relevant documentation had been obtained by Brian Morden, the Inquiry Coordinator, from the main agencies, namely the Police; Crown Prosecution Service; Lambeth, Lewisham & Southwark Health Authority; Lambeth Healthcare NHS Trust, and Lambeth Social Services. Further documents were obtained from these agencies on subsequent occasions.

Against that background a selection was made of those witnesses who, in the opinion of the Panel members, should be invited to give evidence. Documentation, which had been generated for the purposes of the Internal Inquiry in early 1995, provided us with some initial guidance.

The Panel also attempted to identify the important issues that each potential witness would be expected to deal with. Individual witnesses were advised by a formal letter from the Inquiry Coordinator that they could be represented while they gave evidence, or attend with a friend. Some witnesses took advantage of that offer: others did not.

At the hearings the representative was permitted to ask questions of his or her own witness so as to clarify or add to any existing written statement, or by way of re-examination.

The general approach which was adopted in the Inquiry into the Care and Treatment of Christopher Edwards and Richard Linford was also adopted here, but with appropriate modifications. In the result it was never necessary for a representative of one witness to seek to cross-examine another witness, or to require a witness to be present during the evidence of another. Two witnesses were, however, recalled, when matters subsequently emerged which affected their earlier evidence.

Panel members visited the new South Western Hospital and also attended Broadmoor Hospital to interview Wayne Hutchinson.

The Inquiry Panel invited Wayne Hutchinson's family; those who were injured, and the relatives of those who were killed, to attend or to provide written observations to the Inquiry. .

APPENDIX 3

Schedule of Witnesses

Witnesses who attended to give evidence

Name	Description	Representative
Dawoo Agunbiande	Registered Mental Nurse	
Michael Andrews	Registered Mental Nurse	W. J. Reynolds
Dr. H. B. Dewan	Psychiatric Registrar	
Sara de Witt	Team Manager Mental Health, Lambeth Social Services	
Dr. Maria Fotiadou	Senior Psychiatric Registrar, St. Thomas' Hospital	
Lorraine Hewitt	Manager, The Stockwell Project	
Dr. J. Hitchens	General Practitioner	
Christine Hutchinson	Wayne Hutchinson's sister	
Judith Hutchinson	Wayne Hutchinson's mother	
Gloria Jagesar	Nursing Assistant	
Sue Lewis	Service Manager, Adult Mental Health Services, Lambeth Healthcare NHS Trust	
Dr. Robin Lawrence	Consultant Psychiatrist	J. Melman-Jones
J. Lemince	Registered Mental Nurse	B. Morgan

Erville Millar	Chief Executive, Lambeth Health Care NHS Trust	
Titus Musee	RMN Team Leader	
Omar Nandoo	Nursing Assistant (Agency)	
Dr. Henry Oakley	Consultant Psychiatrist	
Lucita Quiaiot	Enrolled Nurse	
Dr. David Roy	Medical Director, Lambeth Health Care NHS Trust	
Dr. R. F. Saxena	Locum Psychiatric Registrar	
Irene Stiller	Manager, Lambeth Social Services	
Chris Strahan	Approved Social Worker, Lambeth Social Services	

APPENDIX 4

Hearings of the Inquiry

Hearings of the Inquiry

The Inquiry sat formally on the following days:

1997 29 September 1997

30 September 1997

1 October 1997

25 November 1997

3 December 1997

1998 17 August 1998

14 October 1998

Members of the Panel visited the former South Western Hospital site on 14th October 1997 and Broadmoor Hospital on 16th July 1997, and 29th January 1999.

Members of the Panel met privately on other occasions.

APPENDIX 5

Bed Occupancy Levels

Occupancy levels of Acute admission wards and Intensive Care Unit at South Western Hospital on 10th November 1994

Ward	Beds Available	Beds Occupied	Clients on leave	Occupancy %

Nelson	19	19	6	132%
Luther King	20	20	4	120%
Eden	5	5	n/a	100%
Lloyd Still	24	24	3	113%

Nelson Ward - Bed State : November 1994

Date	**Available beds**	**Occupied beds**	**Clients on leave**	**Total clients on book**	**Total % occupancy**	**No. on MHA sections**	**Total % on sections**
01.11.94	19	19	8	27	142%	11	41%
02.11.94	19	19	8	27	142%	10	37%
03.11.94	19	19	10	29	153%	9	31%
04.11.94	19	19	10	29	153%	9	31%
05.11.94	19	19	10	29	153%	9	31%
06.11.94	19	19	10	29	153%	9	31%
07.11.94	19	19	9	28	147%	9	32%
08.11.94	19	19	6	25	132%	9	36%

09.11.94	19	19	6	25	132%	9	36%
10.11.94	19	19	6	25	132%	9	36%
11.11.94	19	19	6	25	132%	9	36%
12.11.94	19	19	6	25	132%	9	36%
13.11.94	19	19	6	25	132%	9	36%
14.11.94	19	19	6	25	132%	9	36%
15.11.94	19	19	6	25	132%	9	36%
16.11.94	19	19	7	26	137%	9	35%
17.11.94	19	19	5	24	126%	9	38%
18.11.94	19	19	6	25	132%	9	36%
19.11.94	19	19	6	25	132%	9	36%
20.11.94	19	19	6	25	132%	9	36%
21.11.94	19	19	6	25	132%	9	36%
22.11.94	19	19	5	24	126%	9	38%
23.11.94	19	19	5	24	126%	9	38%
24.11.94	19	19	7	26	137%	9	35%

25.11.94	19	19	7	26	137%	10	38%
26.11.94	19	19	7	26	137%	9	35%
27.11.94	19	19	7	26	137%	9	35%
28.11.94	19	19	4	23	121%	9	39%

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1. [0] During 1994 there were 476 convictions for homicide in England and Wales, of which 61 were by persons who were suffering from an abnormality of mind at the relevant time (defined by a conviction for manslaughter on the grounds of diminished responsibility).

2. [0] Modernising Mental Health Services: safe, sound and supportive. London. Department of Health (1998).

3. [0] On November 27th 1995, very shortly before the trial of Wayne Hutchinson was due to begin, Mr. Foster, the owner of the shop and a material witness to the killing of Marie Hatton, was shot and killed by two men as he left his premises. No-one has been arrested in connection with his death.

4. [0] See Code C (1991 Edition) issued under Police and Criminal Evidence Act 1984.

5. [0] The taking of an intimate sample is now governed by section 65, Police and Criminal

Evidence Act 1984, as amended by section 58, Criminal Justice and Public Order Act 1994; and by Code D (1995 Edition).

6. [0]This pistol had been used in an attempted murder some five weeks earlier in the Kennington area of south London. Two people had been arrested but Wayne Hutchinson was never a suspect for this crime.

7. [0] In early 1995 the proceedings were subsequently transferred to the Central Criminal Court so as to combine with the more serious Index offences. Following his conviction the counts relating to the firearm matter were ordered by the Court to lie on the file, on the usual terms.

8. [0] 2. - (1) A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as "an

application for admission for assessment") made in accordance with subsections (2) and (3) below.

(2) An application for admission for assessment may be made in respect of a patient on the grounds that --

(a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and

(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with.

(4) Subject to the provisions of section 29(4) below, a patient admitted to hospital in pursuance of an application for admission for assessment may be detained for a period not exceeding 28 days beginning with the day on which he is admitted, but shall not be detained after the expiration of that period unless before it has expired he has become liable to be detained by virtue of a subsequent application, order or direction under the following provisions of this Act.

9. [0] Wayne Hutchinson killed Anthony Kellman on the same day.

10. [0] See also Ward and Applin, 1998.

11. [0] Heginbotham, 1994.

12. [0] Ritchie, 1994.

13. [0] Satel *et al*, 1991; Poole and Brabbins, 1996.

14. [0] Gossop, 1987.

15. [0] Strang *et al*, 1993.

16. [0] Ramsay and Percy, 1996.

17. [0] Jones *et al*, 1995.

18. [0] Strang *et al*, 1990.

19. [0] Parker and Bottomley, 1996.

20. [0] Baumer, 1994.

21. [0] Swanson *et al*, 1990.

22. [0] Moss and Tarter, 1993.

23. [0] Honer *et al*, 1987.

24. [0] Miller *et al*, 1991.

25. [0] Cordess and Murray, 1991.

26. [0] Shaner *et al*, 1993.

27. [0] Menezes *et al*, 1996.

28. [0] Cuffel *et al*, 1994.

29. [0] Scott *et al*, 1998.

30. [0] Kofoed *et al*, 1986.

31. [0] Smith and Hucker, 1994.

32. [0] Carey, 1989.

33. [0] Borowy, 1998.

34. [0] Cranfield *et al*, 1992.

35. [0] Pearson *et al*, 1995.

36. [0] Donmall *et al*, 1995.

37. [0] Polkinghorne, 1996.

38. [0] President of the Council, 1998.

39. [0] Weaver *et al*, 1999.

40. [0] American Psychiatric Association. 1994.

41. [0] Section 3 provides:

(2) An application for admission for treatment may be made in respect of a patient on the grounds that --

(a) he is suffering from mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital ; and

(c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section.

42. [0] Ford *et al*, 1998.

43. [0] Ford *et al*, 1998.

44. [0] Azuonye, 1998.

45. [0] 1995-97 Biennial Report.

46. [0] Guite, *et al*, 1995.

47. [0] Steadman and Cocozza, 1974.

48. [0] Gunn, 1973.

49. [0] Home Office and DHSS, 1975.

50. [0] Department of Health and Welsh Office, 1990, 1993. See now the 1999 Edition.

51. [0] DHSS, 1988.

52. [0] Connolly, *et al*, 1996.

53. [0] Trent RHA, 1991.

54. [0] Heginbotham, *et al*, 1994.

55. [0] Department of Health, 1993.

56. [0] Lipsedge, 1995.

57. [0]Department of Health/University of Manchester 1996 and Roy, 1997.