# The Independent Inquiry into the Care and Treatment of Wayne Licorish

## Northamptonshire Health Authority and Northamptonshire Social Services

## 1999

Index


| | Page |
|---|---|
| Panel Membership | 3 |
| Acknowledgements | 4 |
| Terms of Reference | 5 |
| Introduction | 6 |
| The facts | 7 |
| Discussion | 32 |
| The Health Authority's Consideration of the St Andrews Proposal | 33 |
| Diagnosis | 36 |
| Risk Assessment and the Forensic Services | 43 |
| Psychology / Psychotherapy Services | 49 |
| Risk Assessment - Documentation | 51 |
| Clinical Directorate Responsibilities | 52 |
| Mr Licorish's Literacy | 54 |
| Social Services Issues | 55 |
| Structure and Organisation of Community Mental Health Teams | 57 |
| Mental Health Planning in Northamptonshire | 59 |
| Counselling for the Victim's Family | 61 |
| Recommendations | 63 |
| Appendix 1 List of Witnesses | 67 |
| Appendix 2 Written Evidence | 68 |
| Appendix 3 Background Reading | 70 |

PANEL MEMBERSHIP

Biographical details

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ACKNOWLEDGMENTS

We would like to thank everyone who gave evidence to us and who spoke so freely to us, particularly the members of the Burningham family for whom it must have been a painful task.

It is inevitable in an Inquiry such as this that other statutory agencies are involved and we would like to acknowledge the co-operation of both the police and Crown Prosecution Service in Northamptonshire which enabled the Inquiry team to complete their task.

We would also like to extend our gratitude to the staff of the Training Department of Northamptonshire Social Services for their courtesy and for looking after all our needs whilst we took evidence in Wellingborough.

TERMS OF REFERENCE

1. To examine the circumstances surrounding the treatment and care of Mr Wayne Licorish, in particular:

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

(ii) the appropriateness of the care plan, treatment and supervision provided in the context of:

(a) his assessed health and social care needs;

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

(c) his previous psychiatric history including drug and alcohol abuse;

(d) the number and nature of his previous court convictions.

2. The extent to which Mr Licorish's care corresponded to statutory obligations, in particular the Mental Health Act 1983; relevant guidance from the Department of Health including the Care Programme Approach HC(90)23/LASSL (90)11, Supervision Registers HSG(94)5 and the discharge guidance HSG(94)27; and local policies.

3. The extent to which his prescribed care plans were:

(i) Effectively drawn up, communicated and delivered; and

(ii) Complied with by Mr Licorish.

4. The adequacy of the arrangements for collaboration and communication between the agencies involved in the care of Mr Licorish as well as his family.

5. To prepare an independent report and make recommendations to Northamptonshire Health Authority and Social Services as co-sponsors of the Inquiry.

## INTRODUCTION

On the night of 16th January 1997, Caroline Burningham was killed by Wayne Licorish. The sympathy of all of us goes out to Caroline's family and friends. The precise circumstances of Caroline's death remain unclear. Although Mr. Licorish has been convicted of manslaughter, on the basis of diminished responsibility, he has not explicitly acknowledged his involvement and the reasons for his actions remain obscure.

In the years prior to this tragedy, Mr. Licorish had had contact with the mental health services in Northamptonshire and furthermore, in the year prior to January 1997, he had extensive contact with the Social Services. He also was well known to the police and to the Courts so consequently had amassed an extensive criminal record, albeit of relatively minor offences. Many of his offences were connected in some way with abuse of drugs; either being drug related offences, or offences committed under the influence of drugs.

One of the principal purposes of this Inquiry, commissioned as it is jointly by the Northamptonshire Health Authority and the Northamptonshire Social Services, is to establish whether there are any lessons to be learnt for the mental health services and/or for the Social Services; and whether there are any steps which can be taken to lessen the risks of a similar tragedy occurring in the future

## THE FACTS

### Mr. Licorish's Background

Mr. Licorish was born on 25.6.65, being one of six children, all of his siblings being sisters. Both his parents are of Afro Caribbean origin and are from Barbados, and Mr. Licorish was born in London, moving to Wellingborough when he was five. He started school at this time, but was identified as having learning difficulties after starting secondary school and was transferred to a school for children with learning difficulties. It appears that he never acquired any significant literacy skills.

The family background was unsettled and the family was subject to intervention by the local Social Services.

### Mr. Licorish's School Years

Mr. Licorish's contact with the psychiatric services began whilst he was at school. His behaviour there was causing disturbance and in May 1973, he was referred to the school psychological service by his head teacher, who suggested he was immature and of below average intelligence. He was then referred to Dr Philips, a Consultant Psychiatrist.

Mr. Licorish's first contact with the police appears to have been in November 1977, when he was cautioned for taking a moped. In March 1978 he assaulted another boy at school resulting in head injuries and a dislocated jaw. As a result, in June 1978, he was given a Supervision Order for 12 months, with an Intermediate Treatment Order of 30 days attached.

In November 1978 Mr. Licorish was, with his parents' agreement, taken into voluntary care. There was, however, a further attack on a girl at school, resulting in her requiring five stitches to her scalp. The police and Social Services were again involved and a Care Order was made by Wellingborough Juvenile Court on 2.2.79. It was suggested

that Mr. Licorish should be assessed for a residential school placement to cater for his emotional disturbance and borderline intelligence, and he then went as a boarder, under the care of the Local Authority, to St John's, Tiffield, a community home providing educational services.

Whilst boarding at Tiffield, there were reports of Mr. Licorish having been found masturbating and engaging in possible homosexual activities with other boys. He had also been aggressive and violent and had indecently exposed himself to a West Indian woman. In February 1980, therefore, he returned to live at home and attended Tiffield as a day pupil. Later that year he was cautioned by police after attacking another boy who also required sutures. Towards the end of 1980 he was involved in a fracas at the court buildings and struck a policeman. He subsequently refused to go back to Tiffield and behaved so badly that his parents barred him from home and he went to stay with Rastafarian friends.

1982 - 1993

On 16.4.82, Mr. Licorish was informally admitted to St Crispins Hospital, Northampton under the care of Dr David Jones, Consultant Psychiatrist, having apparently tried to jump through a window. Dr Jones has given evidence to the Inquiry. Mr Licorish's behaviour on admission was said to be bizarre and a diagnosis of schizophreniform psychosis was made. He denied using any drugs except occasional marijuana permitted by a Rastafarian sect which he had apparently recently joined. His behaviour on the ward was said to be *"difficult to differentiate between a psychosis and acting out"*. He responded to medication and on 18.5.82, he was discharged back to his parents' home with the support of a social worker. He was also assigned a Community Psychiatric Nurse ("CPN").

On 18.6.82, Mr. Licorish was re-admitted to St Crispins, again under the care of Dr Jones. The reason for the re-admission, which was informal, was disturbed behaviour after being thrown out of the house by his parents, and the diagnosis made was of

behavioural problems. Mr. Licorish showed no evidence of psychotic behaviour. He settled rapidly on the ward and was discharged on 21.6.82 with appropriate medication.

On 20.10.82, Mr. Licorish was again informally admitted to St Crispins under the care of Dr Jones. The diagnosis was again behavioural problems. It was noted, on this occasion, that Mr. Licorish had apparently stopped his medication, Depixol, a few weeks prior to admission, following which he had been excitable and, on the day of admission, he had threatened to jump in front of a car for some uncertain reason. During the admission no clear evidence of psychosis was noted, although Mr. Licorish was verbally aggressive and frequently wandered off the ward. He refused medication. It was not considered appropriate to detain him compulsorily and he was discharged without medication. He failed to attend a follow up appointment on 22.10.82.

On 13.12.82, Mr. Licorish was convicted of two offences of criminal damage, for which he was fined and ordered to pay compensation.

The next contact with the mental health services appears to have been on 27.03.83. Mr. Licorish had been arrested in connection with charges of indecent exposure and Dr Jones was asked by the Court to prepare a psychiatric report. Mr. Licorish was accordingly examined by Dr Jones who recorded that, although at the time of the examination there was no evidence of mental illness, Mr. Licorish had a severely disturbed personality with immaturity, difficulty in relating and poor grasp of social realities and values. Dr Jones noted a chronic drug problem and borderline intelligence. Mr. Licorish was, at this time, also complaining of erectile impotence. Dr Jones offered further treatment, perhaps as a condition of a probation order. On 18.4.83, Mr. Licorish was bound over for 12 months.

In June 1983, Mr. Licorish appeared before the Northampton Crown Court in connection with a number of offences, including possessing controlled drugs with intent to supply. Mr Davis, of the Social Services Department, produced a sympathetic report on 1.6.83, recommending a fine or probation, but on 13.07.83, Northampton Crown Court sentenced Mr. Licorish to 6 months youth custody. As a result, in

September 1983, Social Services agreed that Mr. Licorish's Probation Officer should take over the primary role in dealing with Mr. Licorish.

In early 1984, Mr. Licorish was again in trouble with the police, charged with attempted theft and two counts of indecent exposure. Dr Jones produced a further psychiatric report for the Court, in which he concluded that Mr. Licorish had a disordered personality, as well as a problem with impotence. He recommended investigation and treatment of Mr. Licorish's impotence and on 02.04.84 the Court made a 2 year Probation Order.

There followed regular meetings between Mr. Licorish, Dr Jones and the Probation Services. However, on 11.07.84, Mr. Licorish was convicted of a number of further offences, including assault occasioning actual bodily harm, indecent exposure, and theft. He was given a Community Service Order (120 hours) and ordered to pay compensation.

On 13.11.84, Mr. Licorish was fined £40 by the Northampton Magistrates Court for shoplifting.

On 11.12.84 Mr. Licorish took an overdose of medication and was admitted overnight to Kettering General Hospital. He was seen by a CPN who found him angry and uncommunicative. He was homeless and had recently thrown himself at a stationary car. He had also been involved in a fight in the probation office. He refused an offer of admission to the hospital.

On 21.1.85, Mr. Licorish was convicted of assault occasioning actual bodily harm, and shoplifting. On 11.02.85 he was also convicted of indecent exposure and criminal damage. As he was in breach of the Probation Order made on 2.4.84, he was again sentenced to youth custody for 6 months.

At around this time, Mr. Licorish had formed a relationship with a woman, who will be referred to in this Report as "LM". In September 1985, following Mr. Licorish's

release from youth custody, they obtained a council house together. However, the relationship was clearly an unstable one and in November 1986, LM had a child, but not by Mr Licorish. Their relationship thereupon ended with LM leaving to return to live with her parents.

On 24.02.86, Mr. Licorish was convicted of theft, criminal damage, and of taking a conveyance without authority. On this occasion he was given a Probation Order for 6 months.

On 20.06.86, he was convicted of various further offences, including assault occasioning actual bodily harm and indecent assault on a woman. Being in breach of the Probation Order made on 24.2.86, he was sentenced to youth custody for 6 months.

By December 1986, Mr. Licorish was again in trouble with the police, this time in connection with charges of theft and indecent assault. On 31.12.86 his Probation Officer, Mr Willis, prepared a probation report, recommending that the court obtain a psychiatric report. Accordingly, on 19.01.87 Mr Licorish was seen whilst on remand at Bedford prison by Dr R Pinto, a Consultant Forensic Psychiatrist. Mr. Licorish told Dr Pinto that he had experienced symptoms which Dr Pinto took to be delusions and auditory hallucinations which were worsened by marijuana and made better by depot injections. Dr Pinto thought Mr. Licorish probably suffered from chronic schizophrenia. He recommended that psychiatric treatment might be given as a condition of supervision by the probation service.

Mr. Licorish's solicitor throughout this period, and indeed thereafter, was a Mrs Jenny Lawrence. She gave evidence to the Inquiry. Throughout her time as Mr Licorish's solicitor, she showed commendable concern about Mr. Licorish's situation and it is clear that she is one of the few people whom Mr. Licorish trusts. She formed the strong view at this time that Mr. Licorish had serious mental health problems and was in need of medical help. She accordingly made determined efforts to secure further psychiatric advice about Mr. Licorish's needs. She approached a Dr Jukes of St Andrews Hospital, Northampton, a private hospital.

Dr Jukes felt that Mr. Licorish might benefit from a period as an in-patient in St Andrews. It may be that the programme he recommended would be regarded by some as a little controversial - Dr Blewett, for example, who gave evidence to the Inquiry, described it in the following terms:

> *"... a behavioural programme including rewards and punishment to modify his anti-social behaviour. I do not regard that as part of medicine."*

On 9.3.87 Dr Jukes contacted the Kettering Area Health Authority (as it then was) about the possibility of funding for Mr. Licorish's placement at St Andrews. The request was passed to Dr Rodgers, the Health Authority's District Medical Officer, a position equivalent to that now known as Director of Public Health. He gave evidence to the Inquiry.

Dr Rodgers' response to Dr Jukes' proposal was to seek advice from Dr Jones, plainly a sensible step in view of Dr Jones' extensive previous involvement with Mr. Licorish. Unfortunately, it seems that Dr Jones was unwell at that time and accordingly unable to examine Mr. Licorish, but there is evidence, in a letter which Dr Jukes wrote to Mrs Lawrence on 11.3.87, that Dr Jones spoke directly to Dr Jukes indicating that he was in *"broad agreement"* with Dr Jukes' recommendations. The letter was copied to Dr Jones.

Dr Jones himself, however, wrote to Dr Rodgers on 18.3.87, stating that he had not seen Mr. Licorish since 1984; but that he was *"somewhat doubtful"* that Mr. Licorish would benefit to a great degree from the proposed treatment at St Andrews, due to Mr Licorish's poor motivation. Dr Jones suggested some form of community treatment order.

Notwithstanding that Dr Jones had not been able to see Mr Licorish, Dr Rodgers did not obtain a further opinion, but instead, on 20.3.87, told Dr Jukes that Dr Jones had

advised that he did not believe the behaviour modification programme at St Andrews would be appropriate for Mr. Licorish and that the Health Authority would not, accordingly, be providing funding for Mr. Licorish to be treated at St Andrews. This summary of Dr Jones' advice may not have been entirely accurate - Dr Jones had told Dr Rodgers merely that he was *"somewhat doubtful"*; and had apparently told Dr Jukes that he was in broad agreement with the proposals. It is in any event surprising, from a purely medical standpoint, that Dr Rodgers placed so much weight on Dr Jones' assessment of Mr. Licorish's needs in view of the fact that Dr Jones himself had not seen Mr. Licorish since 1984.

In any event, in the absence of monies being made available to fund a placement at St Andrews, Mr. Licorish was on 10.4.87 sentenced by the Northampton Crown Court to 12 months in prison.

Mr. Licorish was released in November 1987 and he was then referred by his GP to Dr Jones for treatment. However, Dr Jones wrote back to the GP on 15.12.87 that he considered that Mr. Licorish was *"not really helpable by psychiatric treatment"*. It was disappointing to see such a response from Dr Jones at this time; firstly because Dr Jones had not seen Mr. Licorish since 1984 and so could hardly be in a position properly to assess whether or not Mr. Licorish could be helped; and secondly, because Dr Jones was aware that another psychiatrist, Dr Jukes, had, in early 1987, formed a different view. How Dr Jones could confidently assert that Mr. Licorish could not be helped, when he had not seen him for over 3 years, is difficult to understand.

Mr. Licorish was in trouble again in 1988, being charged with assault on LM and several counts of indecent exposure. Again his solicitor, Mrs Lawrence, made determined efforts on his behalf to obtain what she perceived to be essential medical treatment. The issue of funding for a placement at St Andrews again arose and on 10.2.88, articles appeared in local newspapers indicating that the Health Authority was awaiting the direction of the Court before deciding upon whether to allocate funds to Mr. Licorish. Mrs Licorish, who also gave evidence to the Inquiry, spoke to the press

about her unhappiness at the Health Authority's refusal to provide funding in the face of recommendations from psychiatrists.

On 03.01.88, Mr. Licorish was again seen by Dr Pinto. Dr Pinto described him as *"a man of immature and inadequate personality who chronically abuses cannabis which almost certainly leads to periods of acute psychosis"*. In contrast to his earlier diagnosis of schizophrenia, Dr Pinto did not find evidence of mental illness at the time of assessment and made no specific recommendation to the court.

On 08.01.88 Mr Willis produced a Probation report in which he noted that Mr. Licorish admitted use of alcohol and cannabis. Mr Willis suggested that Mr Licorish might be suitable for a probation order with a condition of residence and he was offered a place at a hostel in Essex.

A short psychiatric report was obtained from a Dr Mateu, a Consultant Psychiatrist, for the North Northamptonshire Magistrates Court dated 1.3.88. This recorded that, after a *"relatively short examination"*, in which Mr. Licorish had proved highly uncooperative, Dr Mateu found no evidence of a mental disorder within the meaning of the Mental Health Act. However he concluded that Mr Licorish suffered *"from psychopathic personality disorder with aggressive delinquent tendencies, also being a multiple drug abuser"* and he expressed the view that Mr. Licorish was *"totally unsuitable"* for any form of psychiatric treatment.

The Inquiry was a little surprised that such a firm opinion could be expressed by Dr Mateu after a short and obviously unsatisfactory examination of Mr. Licorish. It was a view which contrasted with that of Dr Jukes; with a later opinion obtained from a Dr Earp, a Consultant Forensic Psychiatrist; and with the views of the Probation Services which recommended in a later report that psychiatric treatment in a controlled environment was necessary.

Mrs Lawrence accordingly obtained a further medical report from Dr Jukes who reported on 17.05.88. Dr Jukes found no evidence of mental illness but suggested that

Mr Licorish should be offered a behavioural programme. He recommended admission to St Andrews under Section 37 of the Mental Health Act. He expressed the view that Mr. Licorish *"will re-offend if not provided with psychiatric care"*.

On 20.5.88, Mr. Licorish's case came before His Honour Judge Crane in the Northampton Crown Court. The judge strongly urged that funds be found to allow Mr. Licorish to be treated at St Andrews in accordance with Dr Jukes' recommendations. Mrs Lawrence made determined efforts to secure this funding, writing repeatedly both to the Social Services and to the Health Authority. She also obtained a second opinion on the appropriate treatment for Mr. Licorish from Dr Earp, Consultant Forensic Psychiatrist, and Director of the East Midlands Centre for Forensic Psychiatry. Dr Earp's report, dated 9.6.88, stated that he considered that Mr. Licorish's drug abuse and indecent exposure were a reaction to social isolation, inadequacy and anxiety. He diagnosed secondary psychopathic disorder and recommended admission to St. Andrew's Hospital under Section 38 of the Mental Health Act. He stated that Mr. Licorish had *"a reasonably good chance of ... responding to the treatment offered by Dr Jukes at St Andrews"*. Dr Earp accepted that it was not possible to say with certainty whether Mr. Licorish would respond to the proposed treatment at St Andrews, and so he suggested an Interim Hospital Order under Section 38 of the Mental Health Act in order to provide reassurance to the Health Authority about the appropriateness of funding this treatment.

Notwithstanding the two reports which had by now been obtained by Mrs Lawrence recommending treatment at St Andrews, the Health Authority's response to Mrs Lawrence's requests for funds for Mr Licorish was less than helpful. Dr Rodgers was initially more concerned with Mrs Lawrence's failure to have adopted the right procedures before making an application for funding - specifically, he said that she should have referred Mr. Licorish's case to Dr Jones, rather than relying on outside Consultants' views. This strikes the Inquiry as having been an unhelpful line to take, particularly when viewed in the light of Dr Jones' response to the GP's request for assistance in December 1987. Eventually, on 14.7.88, Dr Rodgers asked Dr Jones to advise. What then happened is unclear and inadequately documented by the Health

Authority. It seems that the views of a Dr Henrietta Bullard, Consultant Forensic Psychiatrist in Oxford, were sought in some way. Dr Jones seems to recall sitting down with her, with Mr Licorish's notes, after she had come to Kettering to give a lecture; but it does not seem that she ever had an opportunity to take the notes away to consider them; and it is clear that no notes were made, or at least kept, of her views; nor was any written confirmation of her views ever obtained.

Dr Bullard herself was contacted by the Inquiry and indicated that she had only a vague recollection that from the information given to her, she had agreed with Dr Jones. However, she also said that if she read his notes, and given formal advice she would have recorded that advice in the notes. It seems clear that such advice as she may have given was given informally, and after, at best, a brief opportunity to look through Mr Licorish's voluminous notes. This strikes the Inquiry as a wholly inadequate foundation for rejecting, on medical grounds, a bona fide request for funding from Mrs Lawrence.

In any event, the result of this informal contact with Dr Bullard was that on 20.7.88, Dr Rodgers wrote to the Court stating that Mr. Licorish's diagnosis was *"not in doubt"* and that there was only a question mark over the possibility of successful treatment. He stated that the Health Authority had no obligation to pay for private treatment for Mr. Licorish and concluded that, in the circumstances, he could not justify the expenditure.

In the absence of any offer of funding, Mr. Licorish was, on 27.7.88, sentenced to imprisonment for 3 months.

After his release, Mr. Licorish remained in trouble with the Courts. On 10.04.89, he was convicted of a variety of offences, including possession of drugs, theft and assault occasioning actual bodily harm. He was imprisoned again for 6 months. On 08.05.90, he was convicted of further offences of dishonesty. On 17.07.90, he was convicted of assault with intent to resist arrest, and shoplifting, and given a suspended sentence. On 31.05.91, at the Northampton Crown Court, he was convicted of shoplifting and imprisoned for 12 months. Later in 1991, he was convicted of vehicle related offences

and sentenced to a further 3 months in prison. In August 1992, a further Probation Order was made after a conviction for theft.

However, notwithstanding this repeated offending, there does not appear to have been any contact with the Health Authority's mental health services over this period. Mr Licorish also appears to have formed a relationship with a woman who will be referred to in this Report as "KH". The relationship between Mr Licorish and KH lasted for over 2 years, and they had a daughter, who will be referred to as "K".

1993 - 1997

On 20.09.93 an urgent request for a psychiatric assessment was received from Mr. Licorish's GP after KH had told the GP that Mr. Licorish had been saying that he was going to kill people and that he was getting violent. Mr. Licorish was, on 22.09.93, seen by a Dr Bhattacharyya, a Locum Consultant Psychiatrist, and a CPN, Malcolm Thomson, at home. Dr Bhattacharyya considered that Mr. Licorish was not normal; and that he had a mild degree of psychosis, possibly drug induced. However, Mr. Licorish refused all medication.

A few days later, Mr. Licorish was seen by Dr Jones in the local police station having attacked KH and ransacked his mother's house. He was described as *"disinhibited, over-talkative, preoccupied and hyper-aroused"*. His mother complained that he was disinhibited, pacing up and down, wearing no clothes and asking if anything was wrong with his penis.

Dr Jones concluded that he was clearly in a psychotic state, and that a relationship with drug abuse was a strong possibility. On 23.9.93, he was accordingly admitted to Kettering General Hospital under the care of a Consultant Psychiatrist, Dr Mitchell, under Section 2 of the Mental Health Act 1983. On admission he was described as aroused, evasive and paranoid. He was extremely violent and required restraint. He was initially taken to the Intensive Care Unit ("PICU"), which the Inquiry was told was used, in effect, as a secure unit. A urine drug screen was positive for cannabis. The

diagnosis made was of drug induced psychosis with a psychopathic personality. Mr. Licorish settled after a few days and on 30.9.93 he was transferred from the PICU to Addington Ward. The notes record that this was *"in view of the pressure on beds in the PICU"*.

Mr Licorish absconded from Addington Ward on 1.10.93. He was returned by his mother the following day. By 5.10.93 it was recorded that he was slightly suspicious and angry but had no psychotic symptoms. He had been refusing medication for three days. He was persuaded to take a small dose of medication, and he was discharged on 11.10.93, with appropriate medication, to be followed up in the community by a CPN.

At around this time, KH obtained a court injunction preventing Mr. Licorish from visiting her or K. This injunction was served on Mr Licorish during his time as an in-patient.

After his discharge on 11.10.93, Mr Licorish attended an out-patient appointment on 8.11.93. His concerns at this time were centred around getting to see KH and K. However, he failed to keep the next appointment for 6.12.93. It was recorded later that he then threw away his medication and smoked about £20 worth of cannabis a week. He became increasingly agitated and disinhibited. His mother could not cope with his behaviour and on 26.1.94, his GP sent Mr. Licorish to Kettering General Hospital's Out-Patients Department. As a result of some misunderstanding, however, Mr. Licorish went back to Addington Ward, where, after assessment, he was informally admitted under the care of another Consultant Psychiatrist, Dr Blewett. Dr Blewett had joined the Rockingham Forest NHS Trust in November 1993, and he thereafter played a very significant role in Mr. Licorish's subsequent treatment. He gave evidence at length to the Inquiry.

After his admission, Mr. Licorish remained restless and over-active with some pressure of speech although he did not have any hallucinations or delusions. No firm diagnosis was made. A urine drug screen was negative. He was re-started on Trifluoperazine and urged to remain on this medication when he was discharged on 5.2.94. The

intention at that time, as recorded in the notes, was that he would be followed up by the Wellingborough Mental Health Continuing Care Team at the Redcliffe Centre. The Continuing Care Register was described by Dr Blewett as *"a ... local predecessor of what would now be regarded as the full version of Care Programme Approach."* Mr Richard Appleton, a CPN, who also gave evidence to the Inquiry, said that: *"In practical terms it was broadly equivalent to having a key worker and regular reviews within a multi-disciplinary team. It involved regular reviews of the patients on the list."*

On 04.03.94, Mr. Licorish was seen as an outpatient by Dr Blewett and by Mr Appleton. There was some conflict in the evidence about Mr Appleton's previous knowledge of Mr Licorish. Dr Blewett said that Mr Appleton *"knew him well, informally as it were, in terms of street knowledge"* and referred to Mr Appleton as saying words to the effect *"I have known this chap a long time."* Dr Blewett accordingly said that he had relied upon Mr Appleton's views as to the appropriate approach to Mr Licorish. Mr Appleton himself, however, said that he had never previously met Mr Licorish, although he was aware of his local reputation. There is certainly no indication in any of the records which have been produced to the Inquiry that Mr Appleton had had any earlier contact with Mr Licorish.

In any event, on 4.3.94, Mr. Licorish was noted to be well but using illegal drugs. Medication was recommended and a further appointment was made. This appointment had subsequently to be changed for some reason to 15.4.94, but Mr. Licorish did not attend on this date and Dr Blewett informed Mr. Licorish's GP accordingly.

The notification of the change of appointment to 15.4.94 was given to Mr. Licorish by letter, notwithstanding that Mr Licorish was unable to read. Dr Blewett stated that he was, in fact, unaware of Mr. Licorish's literacy problems until 1996, when Mr. Licorish came to see him with someone from the Adult Literacy Service, although he was aware that Mr. Licorish had learning difficulties (Mr. Licorish has, in fact, been assessed as having an IQ of 70 which is, as Dr Blewett pointed out, just within the normal range.) There was evidence that Mr Licorish, on occasion, asked his family to read letters to

him, and he may, accordingly, have received and understood this letter and either forgotten or decided not to attend the appointment. Obviously, however, sending appointment letters to a patient who has difficulty reading is not an appropriate procedure, at least in the absence of other means of communication being used as well.

Having been placed on the Continuing Care Register, Mr. Licorish was discussed, on 27.5.94 and 10.6.94, in multi-disciplinary meetings. According to a later memorandum from Dr Blewett, the discussion on 27.5.94 was about whether or not to appoint a keyworker for Mr Licorish. No one was, in fact, appointed, and Mr. Appleton's recollection was that the problem was that no one was particularly anxious to take on this role vis a vis Mr Licorish. Eventually, Mr Appleton recalled, Dr Blewett himself had to volunteer to take on this role, and it may be that this explains why a further appointment was set up for Mr Licorish to see Dr Blewett on 12.7.94. However, Mr. Licorish failed to attend this appointment - again, unfortunately, it was an appointment notified to Mr Licorish by letter.

Dr Blewett then decided, after discussing the matter with Mr Licorish's GPs, Dr Sharp and Dr De, not to offer Mr Licorish any further appointments, but to see him on an ad hoc basis as and when problems arose. After consultation with the rest of the Community Mental Health Team ("CMHT") - although there was some conflict in the evidence about the extent of that consultation - Mr Licorish was removed from the Continuing Care Register.

The Inquiry had some difficulty in following the reasoning behind this decision, bearing in mind that no one had had any contact with Mr. Licorish over the period of time from 4.4.94 to 12.7.94. Dr Blewett's explanation was that, in the intervening period, he had had an opportunity both to discuss Mr. Licorish's case with Mr Appleton, and to review all of Mr. Licorish's notes. He said, in this connection: *"It became apparent to me that the primary problem was one of personality disorder and that he was misusing substances."* He also stated that: *"I felt that realistically the only option we had with him was to be available if and when a difficulty arose."*

However, Mr Licorish's notes would surely have been fully reviewed by Dr Blewett whilst Mr Licorish was an in-patient under his care. Furthermore, Mr Appleton's knowledge of Mr Licorish seems to have been largely anecdotal, apart from his attendance at the meeting on 4.3.94. It is, therefore, far from clear to the Inquiry what had changed since 4.3.94 which led to Mr Licorish's removal from the Continuing Care Register. The reality of the situation may lie in the pressures on the mental health services, of which the Inquiry heard a great deal; and the pressures on Dr Blewett in particular. Pressed as Dr Blewett undoubtedly was at the material times - a newly appointed Consultant in a new setting - it may be that he formed the view that acting as Mr. Licorish's keyworker, in addition to all his other obligations/responsibilities, was not the highest of priorities, particularly in the light of Mr Licorish's apparent reluctance to keep appointments. Given that Mr. Licorish had shown that he could and would access the services as and when he felt it necessary, if this was Dr Blewett's thinking at the time, it could not be considered unreasonable.

On 15.11.94, Mr. Licorish was seen by Dr Blewett following an incident where Mr. Licorish had masturbated in a taxi that he was sharing with a young woman. Mr. Licorish told Dr Blewett that he had been smoking sixteen joints of cannabis a day. Dr Blewett noted no evidence of mental illness but recommended that Mr Licorish should take Trifluoperazine at times.

In early December 1994, Mr Licorish apparently turned up at the Out-Patients department at the Kettering General Hospital requesting admission. He was not thought to be psychotic and he was not admitted, but an appointment was arranged for 13.12.94. Mr. Licorish failed to keep this appointment.

On 11.08.95 Mr. Licorish attended the mental health unit at the suggestion of his GP, Dr Sharp. He saw Mr Appleton who advised him to return to his GP for medication. An appointment was made for him to return later for re-appraisal. He did not attend.

In December 1995, Mr Licorish contacted a Mr Andy Barker of the CAN Drug and Alcohol Services, seeking help in managing his drugs problem. Mr Barker, who gave

evidence to the Inquiry, saw Mr Licorish on a regular basis until May 1996. His impression was that Mr Licorish was a regular user of cannabis, but that he was not using other drugs.

In January 1996, Mrs. Licorish contacted Christine Collymore of Social Services seeking assistance. Mrs Licorish was planning to go to Barbados for a break, and felt that Mr. Licorish would be unable to cope on his own. Ms Collymore, who is also of Afro-Caribbean background, was allocated as Mr Licorish's social worker. She contacted Dr Blewett for background information and set up an appointment for 15.2.96. Mr Licorish told Ms Collymore of his contact with CAN Drug and Alcohol Services, and she contacted Mr Barker for further information. She also arranged for a Community Support Worker, Mr Peter Southern, to be available to assist Mr Licorish. Mr Southern also gave evidence to the Inquiry. He appears to have got on well with Mr Licorish; he described him as sometimes excitable, but never violent or threatening.

At about this time, there were also Court proceedings between KH and Mr Licorish over K, with Mr Licorish attempting, unsuccessfully, to establish a right to contact. Ms Collymore obtained background information from the Peterborough Social Services about these proceedings as well.

In view of Mrs Licorish's trip to Barbados, arrangements were made by Ms Collymore for Mr. Licorish to be admitted to the Meadhurst Residential Centre, a residential and day resource centre set up and funded by Social Services. This centre was initially created to provide a kind of rehabilitation for up to six months for people returning to the community from hospital, but it seems to have developed into a centre handling a lot of short admissions for people in crisis. The centre also provides day services four days a week; and a 24 hour telephone support service for referred people. Mr Licorish was assessed at Meadhurst on 14.2.96, and accepted for admission.

On 15.2.96 Mr. Licorish attended an out-patient appointment with Dr Blewett. No psychotic symptoms were noted and Mr. Licorish said that he was using illegal drugs less frequently; that he had been receiving counselling from Mr Barker; and that he was

also attending basic English and mathematics classes. Mr. Licorish asked for social support and it was suggested that he may want to attend the sex offenders group run by the probation service.

Mr. Licorish went to stay at Meadhurst on 20.2.96, the intention being that he would remain there until 19.3.96. As a condition of admission there, he agreed to abide by Meadhurst's "No Drugs" policy. Unfortunately, Mr. Licorish did not keep to this agreement. Meadhurst was initially tolerant of Mr Licorish's breaches of the rules; and it appears he settled in well, at least at first. He was seen by Dr Blewett at Meadhurst on 14.3.96, and was noted to be doing well, although it was also noted that he was using cannabis. He did not, however, show signs of mental illness. He was noted to be eating and sleeping normally; he was not suffering from delusions or hallucinations; and there was no apparent thought disorder, or indeed other health problems. Dr Blewett diagnosed personality disorder with anti-social traits, low IQ and poor educational achievement.

Whilst Mr Licorish was at Meadhurst, Ms Collymore made efforts to find appropriate supported accommodation for Mr Licorish, and at a meeting on 7.3.96 presented him with various options. Arrangements were made to extend Mr Licorish's time at Meadhurst to 10.4.96, and it was decided to ask Dr Blewett to refer Mr Licorish to a psychologist for further help and assessment.

Mr Licorish continued to disregard Meadhurst's "No Drugs" rule, and on 4.4.96, he was, accordingly, required to leave. Between April 1996 and July 1996, Ms Collymore saw Mr. Licorish on a number of occasions, and made suggestions in respect of his accommodation, continuing support, and finding work. Ultimately, however, Mr. Licorish was not interested in the suggestions being made - indeed, at a meeting with Ms Collymore on 19.6.96 he stated that he did not want any more practical assistance. It is difficult to see what more Social Services could have done to try and help Mr Licorish.

As planned, however, Mr. Licorish was given an appointment with Mr Fritz, a Clinical Psychologist employed by the Trust. The appointment could not, however, be made before 20th August 1996 - the time lapse of 3/4 months was not considered by Mr Fritz to be unusually long.

On 31.07.96, Mr. Licorish was taken to Wellingborough Police Station in connection with offences of indecent exposure and burglary. The police surgeon, Dr Gordon (who gave evidence to the Inquiry), had concerns about his mental state, largely as a result of Mr. Licorish refusing police food as he thought it was poisonous. He accordingly arranged for a formal Mental Health Act assessment to be carried out. The psychiatrist who attended was Dr Sean Scanlon, Consultant Psychiatrist, East Northants Community Mental Health Team, who was the duty doctor at the time; and the Approved Social Worker ("ASW") was Gail Thompson (now Mrs Jarvis), a member of the Emergency Duty Team ("EDT"). Both gave evidence to the Inquiry.

Neither Dr Scanlon nor Mrs Jarvis had had any previous contact with Mr Licorish; and Mrs Jarvis, as a member of the EDT, had no means of accessing any of the relevant files on Mr Licorish. In any event, Mr. Licorish proved unco-operative and uncommunicative, and no evidence of mental illness was noted. He was not, therefore, considered detainable under the Mental Health Act.

On 20.08.96, Mr. Licorish failed to attend the appointment with the psychologist, Mr Fritz, notwithstanding reminders by Ms Collymore. Indeed, Mr Licorish told her on 16.8.96 that he had decided not to see Mr Fritz. A further appointment was made with Mr Fritz but, unsurprisingly, Mr. Licorish did not attend this either. Mr Fritz was never accordingly directly involved in Mr. Licorish's care.

On 22.8.96, Mrs Licorish asked Ms Collymore to carry out an ASW assessment of Mr Licorish. Ms Collymore attended at Mrs Licorish's home, with a colleague, Evelyn Rees. Mrs Licorish was anxious that Mr. Licorish should be taken to hospital for assessment. After speaking to Mr Licorish the social workers visited Mr. Licorish's

GP, Dr Patel for further information. Ms Rees then telephoned Dr Mitchell, Consultant Psychiatrist who gave further details of Mr Licorish's history. Dr Mitchell (who had had some involvement himself with Mr Licorish in September 1993) then apparently spoke at length with Mr Licorish's GP, read through the notes, and advised Ms Rees that he did not feel, on the information presented by Ms Rees that a mental health assessment was necessary at that time. A Care Plan was then formulated by Ms Rees with Ms Collymore.

On 23.08.96, Ms Collymore and Ms Rees again attended at Mrs Licorish's home to tell her and Mr Licorish of the results of their consultations. Mr. Licorish responded angrily, being both physically and verbally abusive. He threw water into the face of Ms Rees, abused her, and moved towards her in a threatening way. It was a very frightening incident for Ms Rees. The police and an ambulance were called and Mr. Licorish was taken by ambulance to the A&E Department at Kettering General Hospital. He was hallucinating and restless, but refused help and was sent home.

He re-attended at the A&E Department at Kettering the following day, when he was assessed by a Senior House Officer who noted no mental illness.

On 27.8.96, he was seen again by Dr Gordon at the police station, but only, according to Dr Gordon, in connection with stomach problems. No mental health assessment was carried out. Mrs Lawrence, Mr. Licorish's solicitor, however, had a note to the effect that Dr Gordon had expressed the view on this occasion that Mr. Licorish was *"not sectionable"* and that he was *"fit to be detained and interviewed."*

On 28.8.96, Mr. Licorish went to Bedford where he was arrested for shoplifting in Boots, the chemists. Mrs Lawrence's contemporaneous note records that Mr. Licorish's interview was terminated by the police as Mr. Licorish became very irrational. She noted that Mr. Licorish was seen by a Dr Norris who concluded that Mr. Licorish was fit to be detained but that if he was interviewed he ought to have an "appropriate adult" present.

On 30.8.96, Mr. Licorish approached and behaved in a threatening manner towards Ms Rees and a colleague, Ms Bell, in Sainsburys in Wellingborough. He spat at them and the incident understandably caused Ms Rees, in particular, very great distress. Happily, as she told the Inquiry, she received very good support from her colleagues at Social Services. Her line manager was immediately available to offer support and she was also given a mobile telephone for a period of time, and received support from the staff group.

On 02.09.96, Mr. Licorish was seen in A&E at Kettering General Hospital by Dr Odelola, Registrar in Psychiatry. Mr Licorish said that he could not cope and had no money and no food. On examination, however, no evidence of psychosis or depression was noted.

On 23.9.96, Ms Collymore, Mr. Licorish's social worker, was told by her superiors that, in the light of Mr. Licorish's conduct, particularly on 30.8.96, she was not to see him alone.

Mr. Licorish then failed to attend his further appointment with Mr Fritz on 07.10.96. There was further discussion of his case at a CMHT meeting on 8.10.96.

On 16.10.96, Mr. Licorish was charged with threatening behaviour after he had waved an axe at a neighbour. A Ms Paula Denton from the Court Diversion service arranged to assess him following this incident on 17.10.96. She later notified Ms Collymore that Mr Licorish was on remand, and that he had been assessed under the Mental Health Act but not admitted to hospital.

On two separate occasions on 22.10.96 Mr. Licorish stole items from shops in Wellingborough, and, when challenged, produced a knife.

On 23.10.96, Mrs Lawrence had a note which recorded that Mr. Licorish had been arrested again. She was also told that Mr. Licorish had been seen by a Dr Sue Haynes

who had concluded that there was no mental disorder, only a personality disorder and drug abuse.

The Probation Services were closely involved in Mr Licorish's affairs at this time, having been asked to prepare a report in connection with Mr Licorish's recent offending, in particular, the events of 22.10.96 which involved charges of theft, possessing an offensive weapon in public place, and using threatening, abusive words or behaviour. The report was delegated to a relatively new member of staff, Mrs Kay Roberts, and unfortunately it seems that she probably did not accumulate sufficient information about Mr Licorish's background before she submitted her report. She did telephone Ms Collymore to have a chat about his background, but, in the words of her superior, Mr McNally, who gave evidence to the Inquiry, *"she had not been around long enough to ask the right kinds of questions to find out a bit more about Wayne."*

In any event, her recommendation, in a report dated 15.11.96, was for a Probation Order, and when the various matters were dealt with by the Wellingborough Magistrates Court on 18.11.96, Mr. Licorish was indeed given a Probation Order for a period of 12 months. Mr McNally told the Inquiry, quite frankly that even without the benefits of hindsight, he would probably not have recommended such an order, because things had got to the point where the probabilities were that Mr Licorish would simply not co-operate with the Probation Services.

Events quickly demonstrated the truth of this. On 20.11.96, Mr. Licorish attended at the Probation Services offices and a violent incident developed with Mr. Licorish spitting at Probation Officers. As a result of this, Mr Licorish was placed on the "Violent to Staff" register at Wellingborough, the reporting requirement of the Probation Order was suspended and immediate steps were taken by the Probation Services to have the Probation Order rescinded. At the initial hearing, the Court adjourned the matter until the end of January. Unhappily, the tragic events of 16th January 1997 then supervened.

On 26.11.96, Mr. Licorish was struck off his GP's list. The circumstances were described to the Inquiry by Dr Patel. Mr. Licorish had come to see a doctor in connection with an eye problem. Before he was examined he was, apparently, offensive to the staff. Whilst Dr Patel examined him, he felt Mr. Licorish's behaviour was abnormal, possibly because of drugs or alcohol. In any event, Mr. Licorish had a bloodshot eye; and he wanted Dr Patel to provide a certificate to support a complaint of mistreatment by the police. As Dr Patel was preparing a note of Mr. Licorish's injury, however, Mr. Licorish again became aggressive and foul-mouthed, and Dr Patel accordingly made the decision to bar Mr. Licorish from the practice.

Mr. Licorish had also declined further help from Social Services. On 28.11.96, Ms Collymore spoke to Dr Blewett on the telephone about Mr Licorish's situation. Dr Blewett advised that he did not consider that there were any appropriate services in the mental health field which could help him because his problem was that of a personality disorder. On 31.12.96, Mrs Licorish felt that in the light of a deterioration in Mr Licorish's behaviour, she had to bar him from her home. A decision was taken by Social Services to close Mr Licorish's file, although they maintained contact with and support for his mother.

<u>January 1997 - date</u>

Mr Licorish was arrested on the night of Friday 17.1.97 and charged with the murder of Caroline Burningham. Her body had been discovered on the morning of 17.1.97 in her car outside her house. The post mortem concluded that she had died from obstruction of her air passages and she was noted to have bruising and lacerations to her head, face and upper neck. There was some evidence of sexual abuse. She was eight weeks pregnant.

Mr Licorish apparently had some connections with Caroline Burningham. Her current boyfriend had been married to Mr Licorish's sister. Mr. Licorish had apparently been angry when the marriage ended and about two weeks prior to the killing, he had been observed to stare in at Caroline and her boyfriend while they were in a pizza restaurant.

In addition, Caroline was renting a room in a house which belonged to the mother of Mr Licorish's past girlfriend, KH. It is relevant to note that KH described considerable violence at the hands of Mr Licorish, including having her jaw dislocated whilst she was pregnant with his child.

Medical evidence and other information suggested that Caroline had died during the evening of 16.1.97. Various witnesses had observed Mr Licorish during 16.1.97 before and after the killing, and attested to unusual and concerning behaviour. During the afternoon of 16.1.97 he had attended at the Redwell Medical Centre in Wellingborough and asked to register as he did not currently have a GP. Whilst the receptionist tried to sort out the problem Mr Licorish went into the toilets and remained there for approximately thirty minutes. He was heard talking to himself. Dr Chung, one of the GPs, went inside and asked if he was OK following which Mr Licorish came out. He was given the relevant telephone number in the local Health Authority to obtain a GP and appeared to pretend to talk to someone. The receptionist commented that *"he was of a different state of mind or certainly behaviour after he came out of the toilet from when he went in"* - the obvious inference being that he had taken drugs. He was told that he would not be accepted as a patient at the practice and he then returned to the foyer, wandering about.

At approximately 9.00 p.m. Mr Licorish was observed in a shop. He was known to the shop assistant because of previous disturbances, following which he had been banned. This behaviour included masturbating in view of the security cameras and muttering comments such as *"I am going to rape them, I am going to kill them, I am going to cut up their bodies"*.

Mr Licorish's home was observed on the night of 17.1.97. At 3.00 a.m. the police made a forced entry, and Mr Licorish was found lying wrapped in a quilt on the bathroom floor with the lights on.

On 18.1.97, following his arrest for murder, Mr. Licorish was assessed at Wellingborough police station by Dr Blewett, his GP and an ASW. Dr Blewett noted

his history of personality disorder and drug abuse and suggested any symptoms were fictitious or malingered. He was considered fit to be interviewed.

He was interviewed on several occasions over the next three days. He generally gave no answers at the advice of his solicitors who were, of course, well aware of his psychiatric problems. A Mr Noel Duiganan, from Social Services, attended to act as an appropriate adult. During these interviews Mr Licorish was often noted to mumble and to sit with his head on his hands, but Mr Duiganan did not consider that he showed any evidence of mental illness - had he thought there was such evidence, he would have requested a further assessment.

Mr Licorish was remanded in custody and on 4.02.97 he was seen by Dr H Beckett, Consultant Forensic Psychiatrist, Milton Keynes Regional Secure Unit, at the request of the prison. At this time Dr Beckett found relatively little abnormality in his mental state although he noted that Mr. Licorish tended to stare "fixedly".

No particular problem was, in fact, noted until 22.4.97 when Mr. Licorish was noted to appear elated in mood. He was hyperactive and his speech was rapid. On 11.06.97, he was noted to be walking around the wing with no trousers or underpants and attempting to expose himself to a female prison officer. Then, on 15.06.97, when given dinner through the hatch, he grabbed the hand of the nurse and wiped semen on her hand.

He was seen again by Dr Beckett on 20.6.97. Dr Beckett noted that he had been also observed to talk to himself, including into mirrors. He also apparently described auditory hallucinations in the second and third person, with a denigrating content. It was felt that Mr Licorish was exhibiting overt psychotic symptoms. In conjunction with his vagueness, detachment, lack of realism and incongruent affect, a schizophrenic illness was thought likely and he was referred to Broadmoor Special Hospital ("Broadmoor").

On 16.07.97, Mr. Licorish was seen by Dr J Vince, Honorary Senior Registrar at Broadmoor. Dr Vince found Mr Licorish to be extremely mentally disordered and unable to give a coherent history. There was evidence of grandiosity and other signs of mania. Dr Vince recommended transfer to Broadmoor.

At Mr. Licorish's trial for murder, the defence pleaded diminished responsibility. It appears that this was not seriously contested by the prosecution. Dr Blewett was ready, willing and able to give evidence for the prosecution, which would have been to the effect that Mr. Licorish had not been mentally ill, at least when Dr Blewett had had contact with him - but the prosecution elected not to call him to give evidence. The plea of diminished responsibility succeeded, and Mr. Licorish was sent to Broadmoor Special Hospital where he remains.

Like Dr Blewett, the Inquiry was a little puzzled by the prosecution's apparent reluctance to challenge the plea of diminished responsibility, particularly in the light of what appears to have been a significant deterioration in Mr. Licorish's mental health after his arrest, but that is not a matter within the remit of this Inquiry.

Mr Licorish was seen by the Inquiry team in Broadmoor, but no relevant or useful information was forthcoming.

## DISCUSSION

It is almost inevitable that any careful examination of the care and treatment provided to a patient by mental health services, Social Services and probation services over an extended period of time, will throw up occasions where, with the benefit of hindsight, it may be said that things could and should have been done differently. This case is no exception. However, it seems to the Inquiry that whilst there are areas where criticism is merited, and other areas where there is obvious scope for improvements in the services for the future, it is unlikely that shortcomings in the services provided can be blamed for the tragic outcome.

*The Health Authority's Consideration of the St Andrews Proposal (1987/88)*

This is an issue which has received a certain amount of media attention; and it is, of course, one of concern to both the Burningham family and the Licorish family. It is a matter largely of historical concern; but it is an issue which the Inquiry considers merits careful consideration.

We regret that we consider that the decisions made by Dr Rodgers, on behalf of the Health Authority, in both 1987 and 1988, to refuse to make funds available for Mr Licorish to go to St Andrews did not follow the sort of consideration which ought to have been given to that proposal. Dr Rodgers, when explaining his decision to the Court in 1988, sought to present his decision as one (a) where there was a bona fide, and, by implication, a properly informed, difference of view between doctors as to what was appropriate treatment for Mr Licorish; and (b) where, accordingly, it was not possible to justify the (considerable) expenditure required. We think this was somewhat misleading.

In the first place, Dr Rodgers' assertion that Mr. Licorish's diagnosis was *"not in doubt"* was surprising. The diagnosis of personality disorder contrasted, for example, with the views of Dr Pinto who had, as recently as 1987, made a diagnosis of schizophrenia. We think this indicates that Dr Rodgers had not had the benefit of any, or any comprehensive review, of Mr. Licorish's records. However, Dr Jones told the inquiry that he recalled Dr Pinto as a very busy visiting psychiatrist, who had only limited time at his disposal to make assessments. Dr Jones also told the inquiry that he had "a vague memory" that he had thought Dr Pinto's diagnosis was based, in part, upon information obtained about Mr Licorish's previous admission to St Crispin's under Dr Jones' care and that this may perhaps have played a part in the thinking of Dr Jones and Dr Rodgers at this time.

Further, Dr Rodgers' assertion that there was real doubt over the possible success of the treatment proposed by Dr Jukes and Dr Earp was apparently based upon the views of Dr Jones and/or Dr Bullard. Dr Jones had not seen Mr. Licorish since 1984 and had,

in any event, in 1987 expressed merely doubts about the efficacy of treatment proposed at St Andrews - or indeed, according to Dr Jukes' letter, was actually then in broad agreement with it. Dr Bullard never saw Mr. Licorish and, at best, talked through his case with Dr Jones one evening after having given a lecture. If the notes were available to her on that evening, she cannot have had a chance to digest them. No attempt appears to have been made to obtain her considered written opinion.

It may well be that there was room for genuine uncertainty, in medical terms, about the appropriateness of the treatment offered by St Andrews for Mr. Licorish. There might well have been a real doubt as to whether or not there was any realistic prospect of Mr. Licorish benefiting from the treatment offered by St Andrews. At the very least, there might have been sufficient uncertainty about the value of the proposed treatment for Dr Rodgers reasonably to have concluded that it was simply not worth expending money, on which there were, no doubt, many other pressing calls, in the hope that it might do Mr. Licorish some good.

It may well be, therefore, that if Dr Bullard had been asked to examine Mr Licorish and provide a formal and properly informed opinion about the merits of the proposal that Mr Licorish should go to St Andrews, she would have been against the proposal; or at least cast sufficient doubt upon that proposal to justify a decision by Dr Rodgers not to commit scarce funds to that proposal. That is not, however, what occurred - she was not asked to provide a formal and fully informed opinion; the matter was merely discussed with her by Dr Jones one evening in the aftermath of a lecture she had given.

We regret that we have concluded, therefore, that Dr Rodgers' response to the Court and to Mrs Lawrence's requests for funds was a response which was inadequately considered; and we fear that the reality was that Dr Rodgers had closed his mind to the possibility of making funds available at all. Bona fide requests for the Health Authority's assistance by Mrs Lawrence, on Mr. Licorish's behalf - requests supported by the recommendations of two Consultant Psychiatrists, and the urging of His Honour Judge Crane - were turned aside without the consideration that they merited.

Furthermore, the implication, in Dr Rodgers' letter to the Court, that there had been proper consideration of the merits of the proposal, and that the decision had been a medical one, based on informed advice about Mr. Licorish's condition was misleading, and we think, potentially dangerously misleading. A doctor reviewing the notes later might well conclude, having reviewed Dr Rodgers' letters, that there really was no doubt about Mr. Licorish's diagnosis; and it is not inconceivable that that impression might actually affect the view that was then taken by that doctor as to the appropriate treatment for Mr. Licorish. Certainly Dr Blewett, when giving evidence to the Inquiry, suggested that the fact that there had apparently been agreement between three psychiatrists in 1988 (Dr Jones, Dr Bullard and Dr Mateu) about Mr Licorish's untreatability had been a relevant factor when he reached a conclusion to the same effect.

Although, as we have said, this issue is now very old history, and although it is not of any direct relevance to any recommendations which this Inquiry proposes to make, the Inquiry wishes to express its grave concerns about the way in which Mrs Lawrence's requests for funding were handled by the Health Authority and the inadequate investigations carried out by Dr Rodgers into the proposals made by Dr Jukes and Dr Earp. It may very well have been the case that if an adequate investigation had been conducted, Dr Rodgers would have come to the same conclusion. We cannot, in any event, know whether Mr Licorish would have responded positively to treatment at St Andrews. But it is a source of regret that the Health Authority's response at that time even leaves open the possibility that a proper response to Mrs Lawrence's requests might have made a difference.

*Diagnosis*

Mr Licorish's history shows that he has had significant personality difficulties, with acute and transient psychotic disorders, which would appear to have been strongly associated with his regular drug use. The diagnosis of personality disorder, and the associated conclusion that Mr Licorish was effectively "untreatable", was reached by Dr Jones back in the 1980's; and it is a view which Dr Blewett came to share.

When Dr Blewett took over the care of Mr Licorish in 1993, it seems to us that he started with a fresh approach. He told the Inquiry that he had been raised in a tradition of being sceptical about the diagnosis of personality disorder, which he felt may have been used in the past as a reason for not treating people. He accordingly started with an open mind about Mr Licorish's diagnosis, initially recording a diagnosis of "undiagnosed" when communicating with Mr Licorish's GP. He also placed Mr Licorish on the Continuing Care Register, with a view to following him up in the community after his discharge.

However, this intention was not followed through, and after Mr Licorish had failed to attend two appointments with Dr Blewett, he was removed from the Continuing Care Register on 12.7.94. The Inquiry was not entirely happy with the reasoning behind the decision to remove Mr Licorish from the Continuing Care Register, bearing in mind that Mr Licorish had not been seen since March 1994, when Dr Blewett was content to have him on that Register. As we have suggested above, the decision may not perhaps have been made entirely for clinical reasons. However, it is unlikely that that decision, of itself, made any difference to the situation here. The likelihood of Mr Licorish attending appointments, or offering any useful new insights into his condition at such appointments, seems very small. The decision to proceed with a policy of responding to crises and to Mr Licorish's requests for assistance was certainly understandable, when one takes into account the pressures on the mental health services, and the resources available to Dr Blewett.

After July 1994 Dr Blewett had only sporadic contact with Mr Licorish. There was an attendance in November 1994; and an out-patient attendance on 15.2.96, followed by the meeting at Meadhurst on 14.3.96, when Dr Blewett diagnosed personality disorder with anti-social traits. When he discussed Mr Licorish with Ms Collymore at the end of November 1996, Dr Blewett advised that, because Mr Licorish had a personality disorder, he did not consider that there were any or any appropriate services in the mental health field which could assist Mr Licorish. In the period from March 1994 to November 1996, therefore, Dr Blewett had moved from the view that Mr Licorish should be followed up in the community, by being kept on the Continuing Care Register, to the firm view that Mr Licorish had a personality disorder and was, for practical purposes, untreatable.

Dr Blewett, in his evidence to the Inquiry, was firm in his view that the psychosis which he observed in Mr Licorish was probably drug induced; and he emphasised that he did not consider Mr Licorish to have schizophrenia at any time when he was under his care. He agreed that the association between the psychotic episodes and cannabis use was *"speculative - we were assuming that there was an aetiological role to cannabis"* but he pointed to the evidence of Mr Licorish's regular drug use, and to the fact that when Mr Licorish did have episodes of psychosis, they usually settled rapidly after his admission to hospital (and, accordingly, after he ceased to have ready access to drugs.)

Whilst his approach does not seem to us wholly unreasonable, bearing in mind the limited resources at his disposal, and in particular, the pressure on beds which may very well have made an extended admission as an in-patient impractical, the connection between Mr Licorish's psychotic episodes and his drug use was never conclusively proven. Dr Blewett's view seemed to us to take little account of the fact that Mr Licorish was, so it seems, a regular drug user - which raised, perhaps, the question of why he did not have more regular psychotic episodes, if drug use was the trigger. When this was put to Dr Blewett, he frankly said that he did not know the answer but pointed out that the effects of drugs on individuals were variable and not properly understood.

We are concerned that the episodes of psychosis which were observed in Mr Licorish were regarded as being drug induced without a full assessment, possibly as an in-patient, with regular drug screening to establish that he did not have psychotic symptoms without ingestion of drugs. We are concerned because if his psychotic episodes were not, or were not entirely, a result of his drug use, then this would surely have affected the diagnosis and the view that he had an "untreatable" personality disorder. It is, therefore, surprising that, over the time Mr Licorish was receiving treatment from the mental health services, no attempt was made to test conclusively the belief that his psychosis was drug induced, and drug induced alone.

The diagnosis of personality disorder, once made, can very often have the result that other psychiatrists would also regard Mr Licorish as untreatable - an approach reflected here in the views expressed by Dr Blewett himself. It is, therefore, unsatisfactory if that diagnosis is reached when other possibilities cannot fully be excluded. In this instance, there was an assumption that Mr Licorish's psychotic episodes were all drug induced. It was an assumption which, as Dr Blewett accepted, was never fully tested. Ideally, if resources, and more particularly beds, were not an issue, we consider that in-patient assessment of Mr Licorish for a sustained period, probably on a compulsory order, would have been appropriate. We consider that Wayne Licorish should have been assessed in hospital on an assessment order Section 2 of the 1983 Mental Health Act with a view to having a better understanding of his illness and greater clarity about the diagnosis. He would then have been closely supervised and monitored, with laboratory investigation being carried out on a regular basis in order to establish if he did experience psychotic symptoms in the absence of drug use. If necessary, this could have led to a further detention in hospital for treatment using Section 3 of the Mental Health Act.

Personality disorders are often aetiologically multi-factorial and it is sometimes possible to address some of the factors that are contributory to the disordered personality. A detailed multi-disciplinary assessment, particularly psychological testing, in an in-patient

setting, would, in our view, have provided a better understanding of the nature of Mr Licorish's disorder, and its treatability. We feel that it is only following such an assessment that a clinical team could have safely concluded that Mr Licorish suffered with a disordered personality which was not amenable to treatment.

We accept that it would, in practice, have been difficult for Dr Blewett, or anyone else, to have carried out such an assessment of Mr Licorish. Since it would have been a necessary part of any such assessment to ensure that Mr Licorish did not have access to drugs, it would probably have required use of the limited secure facilities which were available, either in the PICU or at Marlborough House, the Regional Secure Unit in Milton Keynes. We heard from almost everyone to whom we spoke that the in-patient resources were very limited and the pressure on the beds was always severe. The only other alternative was, perhaps, to re-visit the idea of sending Mr Licorish to St Andrews. As we have recorded above, Dr Blewett was not happy with the type of treatment offered at St Andrews, although he did agree that this idea might have been given consideration in 1994. He did say, however, that he felt that this was a proposal which had already been fully considered and rejected back in 1987/88. Interestingly, his perception was that rejection had been essentially a medical judgement by Dr Jones - and this reinforces our concerns about the misleading way in which Dr Rodgers sought to justify what was, it seems to us, in reality a financial decision.

It may very well be, therefore, that the resources were simply never there to allow a proper assessment of Mr Licorish along the lines outlined above. However, the clinicians ought not, in our view, simply to have accepted such a situation. In situations where a clinician forms the view that a particular course of action is appropriate for a patient, then, even though he may know that the resources probably do not exist to allow that course to be taken, we feel that he should nevertheless raise the issue with the managers for discussion with the Health Authority. The Inquiry was told by Dr Jones that at the time he had been clinical director (Medical Director) of adult mental health services, he had made vigorous efforts to secure further resources, particularly for inpatient beds, but had been largely unsuccessful. We formed the view that, as with other areas of mental health resources, there was probably a culture of "containment"

and managing with what was available, with the result that shortcomings in the services were not focused on in the way in which they ought to have been.

We cannot, of course, reach any definitive view as to whether the diagnosis of personality disorder with drug-induced psychosis was correct. One cannot ignore the fact that other psychiatrists, such as Dr Pinto, had concluded that there were signs of schizophrenia; and the fact that a Court has found that Mr Licorish was guilty only of manslaughter by reason of diminished responsibility. No definite proof was ever obtained of the causal connection between Mr Licorish's episodes of psychosis and his drug taking. The picture we have of Mr Licorish was sometimes a confusing one. There was anecdotal evidence of involvement in serious offending; and there were documented incidents of violence, leading to convictions by the Courts, albeit, perhaps, not very serious incidents; and there were also episodes of threatening and abusive behaviour. Everyone who gave evidence to the Inquiry was, however, taken by surprise by Mr Licorish's killing of Caroline Burningham. It may well be that Dr Blewett's diagnosis of Mr Licorish, at the time he was in his care, was the right one. Our concern is that Dr Blewett was not, we think, in a position to reach a definite diagnosis of personality disorder, without a firmer basis for his conclusion that Mr Licorish's psychotic episodes were all drug induced, and without excluding other possibilities.

On a wider issue, we heard in evidence to the Inquiry of other patients receiving treatment from the mental health services who were regarded as potentially capable of acts of extreme violence, but who could not be detained (could not be "taken off the streets"), either under the criminal law or under the Mental Health Act; and who probably cannot be given any effective help or treatment. Some of these would probably have been perceived as representing a far greater potential threat to the community than Mr Licorish, at least as he presented in the period 1993-96.

During this Inquiry the issue of drug misuse and associated mental health problems has been uppermost on the minds of the Team. In the course of their work there have been occasions when discussions about young men who not only abuse drugs but also exhibit

signs of a more severe illness such as schizophrenia have taken place. This not least of all with some young men and their families, who, when there are symptoms of either auditory and visual hallucinations, tend to blame misuse of drugs and alcohol. The problem sometimes arises because the commencing of symptoms and drug taking may well coincide. It has also been suggested that some young men take drugs to negate their difficult to understand symptoms. It is also considered by some families to be less of a "stigma" to have a drug related illness rather than a severe enduring mental illness like schizophrenia. A point in question was a young man experiencing such symptoms whilst in prison, who admitted to taking drugs but following a near fatal incident was found to have an absolutely clean drug screening analysis. When pressed his family all spoke of times when was he quite distressed,"talking to someone in the room and being frightened of other things only he could see" but had made the assumption it was a side effect of the illicit drugs he was taking. Whilst we are not saying this was so in the case of Wayne Licorish, we feel the point requires making and should not be overlooked.

The problem of how to deal with patients with severe personality disorder is an issue much in the news these days, but without a change in the law, we have to live with the fact that there are dangerous people, potentially capable of acts of horrific violence, who are free to walk the streets, because there are only limited legal mechanisms available to the police or to psychiatrists to take them off the streets. Unless and until it is decided that people who are perceived by psychiatrists to have a personality disorder with the potential to commit violent crime should be taken off the streets, notwithstanding that the benefits of treatment are debatable, the risk of random acts of violence by dangerous individuals will inevitably continue to exist.

The current review of the Mental Health Act is, of course, considering, amongst other things, the issue of the treatment of those with severe personality disorder. The fundamental question to be addressed is whether provisions for such people should remain within the health care system; or be moved to the criminal justice system; or whether an entirely new facility which takes into consideration their particular needs should be developed. The law, as it stands, means that people with a severe personality disorder may be released at the end of a prison sentence or discharged from hospital, even though they still present a significant risk. There is a small group of

people with severe personality disorder who come to the attention of mental health or social services practitioners, or to the police, as presenting a genuine risk but who have not been involved in any criminal offence. Some of these people may benefit from a range of interventions intended to reduce risk, but not all are suitable for treatment as patients in hospital settings. The Government, in its paper "Modernising Mental Health Services, Safe, Sound and Supportive", has put forward the proposal that there should be a new form of reviewable detention for those people with severe personality disorder who are considered to pose a grave risk to the public. This is a proposal which obviously raises important civil liberties questions, and this Inquiry was divided about the merits of such a proposal - a split which probably reflects a split in public opinion on this issue generally. As the law stands, however, there will continue to be the danger of another tragedy.

*Risk Assessment and the Forensic Services*

We do not consider that Dr Blewett could, with the resources at his disposal, reasonably have predicted that Mr Licorish was likely to commit the crime which he did. Although Dr Blewett did in evidence describe Mr Licorish as, in some ways, a "textbook case", we consider that that is a view reached only with the benefits of hindsight. Mr Licorish's criminal record included a large number of offences of violence, including numerous convictions for assault occasioning actual bodily harm and threatening behaviour. Many of these convictions were when Mr Licorish was younger, and whilst there were incidents of violence later, including a sequence of violent incidents towards the end of 1996, nothing in this history would have suggested that Mr Licorish was capable of the extreme violence of which he has now been convicted.

Nevertheless, with Mr Licorish's repeated offending and repeated involvement with the Courts, it seems to us that his assessment, and indeed his treatment, would undoubtedly have been better dealt with by a forensic mental health team, with their greater experience of this area. At the very least, we consider that Dr Blewett would have been greatly assisted in assessing and treating Mr Licorish by forensic mental health expertise. One aspect of the services provided by the Rockingham Forest NHS Trust which has, therefore, caused the Inquiry considerable concern is the lack of sufficient resources in the forensic mental health services. In the words of Dr Scanlon, the Clinical Director, Adult Mental Health: *"The whole issue of forensic services in Northamptonshire needs review. We don't have any realistically."*

The background to this problem is that, as we were told, the mental health services in the Kettering area have been developed by opportunity rather than by design. Prior to the inception of NHS Trusts, all the services used to be managed out of St Crispins Hospital in Northampton, and, because of the geographical location of the hospital being in the south of the County, community-based services developed in the north. As a result of the changes following the setting up of NHS Trusts, St Crispins is now in another NHS Trust.

Such forensic mental health services as are now available to the Rockingham Forest NHS Trust are provided by the Regional Secure Unit run by the Milton Keynes Community NHS Trust at Marlborough House in Milton Keynes, a purpose built centre for patients exhibiting disturbed behaviour requiring a secure environment. For the last two years or so Dr Shubsachs has been the medical director there; and it seems from all accounts that he has effected a significant improvement in the service being provided to the Health Authority. Even so, the present situation is far from satisfactory.

Under the present contractual arrangements with Marlborough House, as we understand them, the Health Authority contracts only for an in-patient service. The beds contracted are for the use of both the Rockingham Forest NHS Trust and the Northampton Healthcare NHS Trust, which covers the remainder of the county for which Northamptonshire Health Authority has responsibility. It seems that, for one reason or another, the Rockingham Forest NHS Trust has used a smaller proportion of the beds contracted for at Marlborough House than its population would merit, often only using two or fewer of the contracted beds.

There is no contractual provision for out-patient follow-up by Marlborough House - the Inquiry has been shown a copy of the contract with Marlborough House which covers the provision of beds alone. The contract does not have any formal provision for a consultation service or for forensic opinions to be provided by staff at Marlborough House, although it seems that, in practice, such a service is provided.

The service presently provided by Marlborough House seems to be an improvement on what it might have been in 1993. Dr Blewett stated that when he had attempted, in the past, to get opinions from the forensic service at Marlborough House, the response had not been helpful - he referred to problems with a series of locums and vacant Consultant posts in Marlborough House, which meant, he said, that in effect there was no forensic service. Whilst things have improved, Dr Blewett still said that if he wanted to get an opinion today it would take a matter of weeks to get an opinion for an in-patient; and probably two months or so to get an opinion on an out-patient. He did also

say, however, that following Dr Shubsachs' arrival at Marlborough House, he did now feel that he could ring somebody up there and have a chat which is obviously a step in the right direction.

The delay in getting opinions from Marlborough House has probably resulted in a lack of referrals being made by Rockingham Forest NHS Trust doctors. Dr Blewett said that he tended not to refer people from community for an opinion from forensic psychiatry, saying *"You have to be pretty bad to get a forensic psychiatry opinion locally"* and again making the point that until recently there really was no meaningful forensic psychiatry service to access for opinions.

In any event, the lack of any contractual obligation on Marlborough House to provide out-patient follow-up means, in effect, that after discharge from Marlborough House, a patient returns into the care of the Trust's Consultants. This is unsatisfactory. We consider that patients who, like Mr Licorish, have extensive criminal records are best treated by psychiatrists with a forensic training, who are better placed to assess and manage the risk. The Inquiry's view is, therefore, that the Health Authority should be aiming at establishing a parallel service, where difficult patients - repeat offenders who are difficult to manage in the community - are looked after as out-patients. We do not consider it satisfactory that all the Trust has access to, contractually speaking, by way of forensic mental health services, is an in-patient service.

Linked to this issue is the problem of a shortage of secure beds. Presently in Rockingham Forest NHS Trust there is a 25 bedded acute admission ward based at Kettering Hospital and the Lowick Unit which has a Rehabilitation ward and a 7 bedded PICU based at St Mary's Hospital, Kettering. In addition there are three funded beds in the acute mental health service of Milton Keynes Community NHS Trust. Work is currently being undertaken to reprovide the acute ward on to the St Mary's site so that the acute ward and the PICU are together in an appropriate setting.

There is no provision at all actually within the Trust for patients requiring more secure services, and Marlborough House represents the only medium secure beds contractually

available to the Trust. However, sending patients to Marlborough House is rarely seen as an option for Rockingham Forest clinical teams because the Health Authority's contractual capacity there is regularly exceeded. Dr Blewett stated that, as a matter of practicality, he did not regard getting a patient admitted to a medium secure unit (i.e. to Marlborough House) as a realistic option. Dr Scanlon also said that in recent years when he has tried to get somebody into a medium secure unit, he has been unable to do so.

For practical purposes, therefore, the PICU at St Mary's Hospital in Kettering has been used by the Trust's Consultants as a secure unit - an option which arises because, fortunately, the nurse manager presently at the PICU has a forensic background and has worked in a secure unit. She has therefore brought a level of expertise that none of the other nursing staff possesses; and this has meant the Trust has been able to manage people that it would not otherwise have been able to manage appropriately. This arrangement is, however, unsatisfactory and inappropriate. It depends upon the expertise of an individual who happens to be employed in the PICU at present and this is clearly not a situation which can continue in the long term. The workload of both Addington and the Lowick Intensive Care wards is nearly always 100% and despite the (limited) use of Marlborough House, there are patients, on both wards, who require a more secure environment and who are not, therefore, in the right setting for their needs. This inevitably puts an added burden on the staff because of the increased use of "one to one" observation for individual patients and the increased number of patients requiring to be observed for their own safety. We understand that there have been occasions when the number of beds has had to be reduced because of the severe needs of the patients in Lowick PICU that the RMO felt it was unsafe to take the full complement.

We are of the view that this is very unsatisfactory, and the contractual arrangements require an urgent review. The present arrangement is at least an attempt at creating an integrated service, but a parallel forensic service would enable difficult to treat individuals such as Mr Licorish to be handled by people with the relevant experience and expertise. We consider, therefore, that the contractual arrangements with the

regional forensic mental health services should be extended to include the assessment, treatment and rehabilitation in a secure setting for mentally disordered offenders, as well as community follow up for patients of both sexes, who have, or are suspected of having, a mental illness or personality disorder, and who may represent a danger to others or who have offended. The contract should also include provision for detailed risk assessment; and assessment and advice on treatability issues, particularly for patients with personality disorders; treatment of patients until they can be appropriately returned to local services; and liaison with local services along with treatment and transfer issues.

If the extent of the contractual arrangement with the regional forensic mental health services is extended as we suggest, one benefit should be that the duties of the so called "difficult to place patient group" would be reduced, with a saving of the time of senior clinicians who are involved. If, however, the group was to continue to review such cases, it would also seem sensible for a representative from Marlborough House to continue the current practice of being involved in those discussions - the Health Authority may wish to consider including this as part of the contractual arrangements as well.

As mentioned above, it does not appear that the Rockingham Forest NHS Trust in fact uses the beds contracted at Marlborough House by the Health Authority to the degree one would expect having regard to its population - Northampton Healthcare has had, it seems, the use of more of the contracted beds. Of course, there may be good reasons why this is the case, but we do suspect that Consultants at the Rockingham Forest Trust may have got into a position where they have got used to functioning without a forensic service; do not expect there to be a bed available at Marlborough House; and do not accordingly regard that as an option as often as they might. We have referred above to the possibility that there is something of a culture of "containment" and managing with what was available. We suggest, therefore, that there should be a process of monitoring of the use which Rockingham Forest makes of the contracted beds at Marlborough House, with a view to ensuring that a fair proportion of those beds is used by the Trust.

The absence of adequate contractual arrangements for the provision of forensic services to the Rockingham Forest Trust was discussed with the Health Authority's Locality Commissioners, Mr Martin Butcher, who has responsibility for Rockingham Forest and Mr David Morgans who has responsibility for Northampton Healthcare, but also takes the lead in mental health issues. They described to the Inquiry the current system for identifying areas where extra funding is needed. Meetings are held at regular intervals throughout the year with the management teams of the Trusts, which include clinicians, in order to discuss priorities for spending. Furthermore, it is said that clinicians are able to make direct contact with the Commissioners at any time to discuss these issues.

Interestingly, it appears that the nature of the forensic services offered by the Trust has not featured in these discussions - examples of recent issues raised by the Trusts included a request for resources in child and adolescent psychiatry; and extra funding for acute mental health services.

We can only speculate as to the reasons why such a request has not been raised before. Dr Blewett said that the need for more/better forensic mental health services had long been recognised; and Dr Scanlon, as we have recorded, does not consider that the Trust really has a forensic service at all. It may be that the explanation is that the Trust's Consultants, not having had any meaningful forensic services, and having managed to carry on, notwithstanding, have focused on trying to obtain incremental improvements in the existing services, which are used on a day to day basis. We would guess that, in a service where resources are so stretched, it may have seemed more realistic to do this, rather than open up a new area.

Nevertheless it is the firm view of this Inquiry that extra resources do need urgently to be provided to allow major improvements in the forensic services offered by the Rockingham Forest Trust to be effected.

*Psychology/Psychotherapy Services*

The view of this Inquiry is that psychologists and psychotherapists may have a great deal to offer in the treatment of patients who have been diagnosed as having certain types of personality disorder; and that Dr Blewett might have been assisted with help from therapists in these areas. We consider that there are shortcomings in the services provided by the Trust in this area which need to be addressed.

Although Mr Fritz had no actual contact with Mr. Licorish at all, and although his role in this matter was peripheral, the Inquiry was struck by what seemed to be uncertainties about the limitations upon Mr Fritz's role within the mental health services. Clinical Psychology is run as a department on its own with its own management and administration within the Trust; but psychologists are placed within the Community Mental Health Teams and Mr Fritz saw his role as to provide expertise in the field of psychology to any of the cases that may be referred to the CMHTs.

However, there seems to be uncertainty about the extent of Mr Fritz's contract. In the course of Mr Fritz's evidence to the Inquiry, he stated that his contract was to work with outpatients. He specially confirmed that dealing with inpatients was not part of his contract although he also stated that arrangements could be made for him to see an inpatient, notwithstanding this was not part of his contract. Subsequently, Mr Fritz wrote to the Inquiry stating that there was "agreement" that an inpatient could be referred on an individual basis to the psychologist covering the home address. We have seen Mr Fritz's contract and this agreement does not appear to be documented. This strikes us as strange. In any event Mr Fritz informed the Inquiry that there was rarely a specific need for psychological input for in-patients. He agreed that there is no psychologist specifically allocated to the in-patient team. Unsurprisingly, therefore, Dr Blewett felt that there was not sufficient psychological input for in-patients. He also said he had never seen a psychologist on Addington Ward in the 5 years he had worked for the Trust although Mr Fritz takes issue with this. This uncertainty about the contractual position of the Trust's clinical psychologist needs to be resolved. If Mr Fritz's contract does not extend to in-patient care, we consider that it ought to. If there

is some supplemental agreement as suggested by Mr Fritz, it ought to be reflected in his written contract. As stated above, we do think that psychologists have something to offer for patients with certain types of personality disorder, and we would suggest that the situation is clarified as a matter of urgency.

Furthermore, the Inquiry was also concerned that Mr Fritz may perceive his involvement with the CMHTs as essentially passive, in the sense of being available if asked, but not taking an active role. When asked, for example, about Mr. Licorish, who had certainly been discussed at CMHT meetings, Mr Fritz stated that:

> *"I was not really aware of Mr Licorish until he was discussed specifically with me and referred to me. ... If he was [discussed] I would not have paid any attention to it, because it is not part of my case load. It was not at the time."*

It was the firm view of the Inquiry that it should be suggested to Mr Fritz that he should consider playing a more active role in CMHT discussions, rather than waiting for referrals and taking interest only in discussions relating to referred patients. We do not think that in this case Mr Fritz could or should have done anything relating to Mr. Licorish over and above that which he attempted to do. The Inquiry is quite sure, however, that Mr Fritz has a great deal to offer to the Trust's mental health services generally and to the care and management of patients with personality disorder in particular, and feel that he should be encouraged to participate in discussions even over patients who have not yet been referred to him.

So far as psychotherapeutic services are concerned, Dr Scanlon told the Inquiry that the Rockingham Forest NHS Trust had recently managed to appoint, for the first time, a part-time psychotherapist. We consider this to be a sensible step forward. It has transpired, however, that that therapist is already overwhelmed. Dr Scanlon's view was that a psychotherapist could well have a role to play in treating people with personality disorder and we agree. We endorse Dr Scanlon's suggestion that the number of psychotherapy sessions should be increased as soon as possible.

*Risk Assessment - Documentation*

There are two further points arising out of the evidence given in this case which merit consideration in the context of risk assessment.

The first point is that Dr Blewett told the Inquiry that he had come into possession of anecdotal or hearsay information about Mr Licorish's activities. Dr Blewett referred to "grapevine evidence" about Mr Licorish's drug dealing; as well as a hearsay suggestion about possible involvement in a rape. Mr Appleton also spoke of hearsay knowledge of Mr Licorish's close association with a local character believed to be involved in violence. This information, which might have cast a different light on the assessment of the risk which Mr Licorish posed, was not however, recorded in any way in any notes. As a result, any third party coming to Mr Licorish's medical records would be unaware of the suggestion that this was a man who was capable of rather greater violence than his criminal record might suggest. Whilst we appreciate that there are difficulties in recording information which has been volunteered in a confidential setting from other patients, we feel that there ought to have been some record of these matters, in some form. Dr Blewett agreed that something should have been written in the notes to the effect that he had been informed by an unnamed person that certain events may have occurred.

The second point in this connection is that whilst there was a series of episodes of violence of one sort or another towards the end of 1996 - specifically the incidents involving the social workers; the incident with the axe and a neighbour; the incident with the Stanley knife; and the incident with the Probation officers - no one appears to have had the whole picture. Taken together, the incidents might, perhaps, have been perceived as suggesting that Mr Licorish was heading towards a crisis; but no one seems to have been in a position to step back and look at the wider picture. The multi-disciplinary approach is intended to facilitate the exchange of relevant information, so as to enable an overall picture to be obtained. It may be that closer links with the police would assist in keeping abreast of incidents such as these - but we have seen no indication either that Dr Blewett was ever informed of the incidents involving the social workers or the Probation officers.

*Clinical Director's Responsibilities*

The Trust operates a Clinical Directorate Management Structure. In the Mental Health Services there are two directorates, adult and elderly, each with a Clinical Director and a Nurse Manager. We heard evidence that over the last few years, savings had had to be made in the Trust and, accordingly, many manager posts had gone. The Clinical Director for the Adult Services is now Dr Scanlon whose clinical responsibilities include the seven bedded Intensive Care Unit at the Lowick Centre. As Clinical Director, he is responsible for representing the views of the Consultants without any management responsibility for them and he is accountable to the Medical Director of the Trust.

He told us he had been Clinical Director in effect since 1995 but in reality the impact was negligible until April 1996 when he moved from being a busy Sector Consultant to his current position. There has, however, been no formal agreement for this responsibility.

We suggest therefore that the Trust formalises the arrangements for the clinical director post and gives true recognition for the amount of time this post requires. The post is an important one and fitting its responsibilities in with a full clinical practice must present problems. It may indeed be that one of the reasons why the inadequacy of the forensic services available to the Trust has not been raised with the Health Authority is that it must be very difficult indeed for Dr Scanlon to find time to sit back and think about wider issues such as this.

We should add that, as perhaps one would expect, the evidence we heard from various clinicians led us to conclude that the workload of the CMHTs in general, and those of each clinician in particular, is excessive. We heard evidence of a Consultant's post having been vacant in Kettering for over 2 years now without attracting a suitable candidate. Whilst we understand that steps are now being taken to re-define the post in the hope of attracting interest, this situation seems to have been allowed to continue for far too long. It is well known that there is a shortage of Consultant Psychiatrists and therefore all avenues need to be explored to make this post attractive, perhaps by

linking with an academic post or making it a special interest post. Advice needs to be sought from the regional Advisor and/or the Post Graduate Dean.

*Mr. Licorish's Literacy*

Notwithstanding that Mr Licorish had limited literacy skills, he was, on occasion, sent appointment letters without any steps being taken to ensure that he understood what those letters said. A system which involves or allows giving patients with learning difficulties and literacy problems information, whether about appointments or otherwise, by letter needs urgent consideration.

The failure to ascertain that Mr. Licorish could not read or write was clearly an oversight by Dr Blewett - he accepted as much when giving evidence to the Inquiry. There should, in the future, be some systematic check upon or assessment of patients, particularly those who, like Mr. Licorish, were obviously of less than average intelligence, with additional or alternative means being employed to pass on information about appointments and the like.

It is not possible to be certain whether the practice of sending appointment letters to Mr. Licorish, notwithstanding that he could not read, did in fact result in some or all of his failures to attend at appointments. It may be that one or two of the missed appointments were due to Mr. Licorish not having been able to read the relevant appointment letter. However, Mr. Licorish was in a position of being able to ask his mother, or his sisters, to read letters for him, and he clearly did ask them to do this on occasion. Furthermore, the firm impression that the Inquiry got about Mr. Licorish was that he was the kind of person who might very well have chosen to ignore appointments. On balance, it seems to the Inquiry that it is unlikely that an inability to read for himself his appointment letters did play a major part in his repeated failures to attend appointments.

Nevertheless, there is no doubt that some systematic assessment and recording of patients' reading skills, and indeed their command of English, ought to be part of the initial assessment, so that a situation where patients are being given important information in a form which they cannot understand does not arise. Liaison with relatives and/or with the Social Services and the CMHTs can be used to ensure effective communications with patients who do have reading difficulties.

*Social Services Issues*

We heard throughout the evidence that links between the Trust and Social Services are very good; and this is to be applauded. Furthermore, it was clearly sensible for Mr Licorish to have been allocated a social worker who was also of Afro Caribbean origin. Ms Collymore did all that could have been expected of her. There are, however, a few points which did emerge during the Inquiry which need to be addressed.

The first is the negligible quantity of information available to the Emergency Duty Team when they are called out. When Mrs Jarvis attended on the assessment carried out by Dr Scanlon on 31.7.96, she knew nothing of Mr Licorish. She did not have access to his notes and we heard from Mr Douglas, Operations Manager, Social Services, that the Emergency Duty Teams, even when involved in carrying out a Mental Health Act assessment, cannot access the file of the individual concerned. He accepted that this was a major weakness inherent in providing a 24 hour service, in the absence of a fully integrated information system that covers Health and Social Services. There are dangers both to the ASW, who may be going to see a potentially dangerous individual; and to the individual being assessed, whose liberty may be determined, in part, by someone with no background information at all.

We are, however, pleased to note that, according to Mr Douglas, the provision of a fully integrated information system is now a priority.

However, this unsatisfactory situation is compounded by the fact that most GPs in this area do not, it seems, give priority to taking part in assessments of their patients for possible admission to hospital under the Mental Health Act. The point was made in evidence given to the Inquiry that there are probably a limited number of GPs who have a specialist knowledge of mental health and a real interest in the subject. The ASWs appear to have given up their attempts to persuade GPs to become involved and so it seems likely that the majority of patients being assessed in this area, are assessed by two doctors who have no previous knowledge of the patient. The Code of Practice recommends that *"other than in exceptional circumstances, the second medical*

*recommendation should be provided by a doctor with previous acquaintance of the patient".* In most cases that doctor will be the GP.

This is unsatisfactory. The GPs must be informed of their responsibilities in this matter and arrangements made for those lacking in the knowledge and skills of the Act to be given appropriate training. It would be helpful if the Social Services Department could monitor this situation and report outcomes to the Mental Health Act Commission.

We also heard from Mrs Jarvis that she had qualified as an ASW ten years earlier, but had not since had any formal refresher training (although she had attended some courses). We have accordingly given consideration to the overall picture of refresher training for all ASWs.

We were told that the Department organises three half day courses each year for ASWs, but attendance is not compulsory, although there is an expectation that they will attend.

Annual reviews of each ASW highlights the individual's training requirements but there is no guarantee that these requirements will be met in the courses which are provided. It was also pointed out to us that in the nature of their duties, it is extremely difficult to get out of hours ASWs to attend courses. Yet it is almost more important for these to get adequate updating, since their main work centres on child care, not mental health.

The Inquiry felt that the approach to ASW training needs to be formalised to bring it in line with accepted practice. The Social Services Inspectorate recommends that four days annually should be set aside for mandatory ASW attendance at structured refresher training. This would not only update ASWs on current best practice, but should give them time to reflect on the quality of their interventions. The present arrangement of monthly discussion groups should continue as before.

*Structure and Organisation of Community Mental Health Teams*

The Joint Purchasing Strategy for the Development of Mental Health Services states *"The purchasing authorities consider that Community Mental Health Teams, serving a defined locality, will form the basic building blocks of a comprehensive mental health service."* The Strategy - revised in 1994 - outlines the constituents of a quality CMHT service.

It was, therefore, disappointing to find that four years on, the structure and organisation of the teams as at present constituted, did not correspond to the description in the strategy document and fell considerably short of its aspirations.

We were told of current differing models of organisation, with some professions working more closely together as a team than others. Relationships between the Trust and Social Services, at all levels, are not always as good as one would wish, and this can have an effect on the working of the team. It was suggested to us that as long as teams function well, that they are not all organised by the same blueprint, is not of significance.

The model described in the Strategy document (and subsequently underpinned in the Department of Health publication, Building Bridges, November 1995) has been tested out in other parts of the country and seen to be operating effectively. We feel that the strengthening and updating of the structure and organisation of the CMHTs is overdue and this task should be pursued with vigour.

Towards this objective, an urgent and closer examination of management structures should be undertaken. To be effective, each team must have a designated manager with overall responsibility for the team's operation (c.f. Strategy 4.5.2 i). In our opinion, this manager/administrator post must be joint financed and jointly owned. That person would have responsibility for the organisation of the team, but would not have professional responsibility for service delivery. As in the present arrangement, professional line accountability will remain within the relevant agencies.

We understand that CMHTs will establish links with the newly developed Primary Care Groups with a view to offering advice and support. We welcome this, and where this has not already been done, we would advise that such links should be formalised in line with recent guidelines from the Department of Health.

Our advice and recommendations in this respect correspond closely to that offered recently to the Trust by HAS 2000 - a consortium of the Royal College of Psychiatrists, the Royal College of Nursing, the Office for Public Management and the British Geriatric Society. Its aim is to improve the delivery of health and social care services in partnership with statutory and non statutory organisations through reviewing a service by comparison with others and the use of explicit standards of good clinical and management practice.

We would add a further recommendation. Bearing in mind the financial constraints, we believe that in order to give the rejuvenation of CMHTs a "kick-start", a suitably experienced person should be appointed (on a time-limited contract) to undertake the re-organisation of the teams and provide them with the necessary policies and procedures which would enable them to carry out their tasks as outlined in the strategy.

*Mental Health Strategic Planning in Northamptonshire*

On a wider note, as mentioned in the previous chapter, the Inquiry was provided with the document entitled *"Joint Purchasing Strategy for the Development of Mental Health Services for Adults in Northamptonshire"* revised November 1994. This document quite naturally features the current thinking of that time. In the past few years there has been much emphasis on more joint working with Social Services, a range of options as an alternative to admission, e.g. assertive outreach models of care, 24 hour nursed beds and crisis intervention. Whilst it was pointed out that the Trust has successfully bid for the funding of an Eating Disorder Service, we were also told that was not necessarily the priority need but based on preference. There does not appear to be a strategic approach to setting priority areas for service developments - although no doubt this is partly due to the energy required to address the financial difficulties of the Rockingham Forest Trust over the last three years and in the Health Authority, as well as the need to focus on the reprovision of St Crispins Hospital in the south of the county.

Given the national agenda for mental health and the local needs there is a need for the Health Authority to invest in time to revisit the Strategy on a county wide basis and to include within that exercise all of the agencies (Social Services, probation, voluntary and independent providers) involved in the safe delivery of modern mental health services.

We suggest therefore that the Health Authority and its constituent organisations should consider updating the Strategy in light of new thinking in mental health services and should dedicate senior management resources to this task.

We were also given a draft Service Specification which is currently being piloted in the south of the county. This document clearly sets out the expectations of the contract and by which the service can be measured. It would be helpful to share this document with the Rockingham Forest staff and to discuss its implementation following completion of the pilot study in the south of the county.

We suggest, therefore, that the Health Authority should discuss the Service Specification currently being piloted in the south of the county and consider its implementation across the county.

*Counselling for the Victim's Family*

There have been about 40/50 inquiries following a homicide by someone in receipt of mental health services. In most instances, the perpetrator knows the victim but even this fact does not usually trigger any offer of support to the families at the time of the tragedy. Both families are left with dealing with press intrusion, and Court proceedings as well as their individual grief.

In the case of Caroline Burningham, the family dynamics were such that they no longer lived in the Northampton/Wellingborough area. Her mother and father had separated some years before and now her mother lived in the West Country whilst her father remained in Surrey where the family had previously lived. He told us he tried to keep in touch with Caroline but that it was difficult to do so. Caroline had in fact visited him shortly before her death, possibly to tell him she was pregnant.

No one either in the Trust or the Health Authority made contact with either of the families. As in most other inquiries the immediate support for Caroline's family came from the police who were charged with the investigation of the crime.

In July 1998 Mr Burningham made contact with the Health Authority because he had heard at the trial or read in the local press that there would be an inquiry. Caroline's mother felt she could not come to the Inquiry but wrote to us and said *"We seem to have been forgotten and have no help apart from that we have found ourselves".*

We heard from Caroline's sister, Jane, that she and Caroline had been inseparable and that she was having difficulty coming to terms with her death. She moved house several times but eventually moved back to Northampton.

The police involved in this case appear to have been very supportive, keeping the family members informed on the progress of the court case but had kept from Mr Burningham the extent of Caroline's injuries and he had to hear in open court that she had been

sexually abused. He was quite naturally distressed by the way this information was given.

Whilst recognising that the health services may not have all the details of families concerned in these matters, we consider that more effort should be made to contact and to keep families informed of the Inquiry process. There should also be the offer of appropriate counselling and support services if required by families. The Home Office in 1995 published a folder "Information for Families of Homicide Victims" which includes *"The Work of the Coroner, Going to Court, Coping when someone has been killed"* and leaflets about the criminal justice system as well as information about organisations which can help. This documentation does not appear to be widely distributed but could begin the process of engagement. This folder could be given at the time of dealing with the death certificate.

This is not just an issue for Northamptonshire but is a national issue. We suggest therefore that the Health Authority and Social Services should discuss with the Regional Office and the Social Services Inspectorate, an appropriate strategy for providing families affected by homicide by a mentally ill person, with support and putting them in touch with relevant organisations. The Health Authority, Social Services and the Trust should also discuss the future arrangements for such inquiries with the Regional Office, the Social Services Inspectorate and the Home Office. The discussion should take into account the negative media impact such inquiries have on the general public in relation to the delivery of safe mental health services.

We also suggest that the Health Authority, Social Services and the Trust should develop a method of identifying families who require support and counselling whilst recognising their grief and respecting that they may not wish to engage with the same clinical team, following a homicide by a person known to the mental health services. Consideration should be given to the implementation of a training programme for staff to promote the sensitive treatment of victims and the families of perpetrators.

RECOMMENDATIONS

1. The Health Authority and Rockingham Forest NHS Trust should undertake an urgent review of the forensic mental health services now provided, with a view to extending the existing contractual arrangements with the regional forensic mental health services to include:

(i) the assessment, treatment and rehabilitation in a secure setting for mentally disordered offenders;

(ii) community follow up for patients, who have, or are suspected of having, a mental illness or personality disorder, and who may represent a danger to others or who have offended;

(iii) detailed risk assessment of patients and advice on risk management of patients;

(iv) assessment and advice on treatability issues, particularly for patients with personality disorders;

(v) treatment of patients until they can be appropriately returned to local services; and

(vi) liaison with local services along with treatment and transfer issues, including participation in the "difficult to place" group discussions.

2. The Rockingham Forest NHS Trust should review the contract of Clinical Psychologists and ensure that that contract includes responsibilities for in-patients.

3. The Rockingham Forest NHS Trust should consider increasing the number of psychotherapy sessions as soon as possible.

4. The Rockingham Forest NHS Trust should formalise the arrangements for the post of Clinical Director, adult mental health services, giving true recognition for the amount of time this post requires.

5. The Rockingham Forest NHS Trust should implement a procedure whereby there is a systematic check upon, and assessment of, the literacy and English language skills of all patients, with a view to setting up alternative means of communicating adequately with those patients who do not have adequate literacy or English language skills.

6. The Health Authority and Social Services Department in conjunction with the Rockingham Forest NHS Trust should consider expediting the provision of a fully integrated information system covering Health and Social Services, in order, in particular, to ensure that the members of the Emergency Duty Teams are properly informed about individuals they are called upon to attend.

7. The Social Services Department should ensure that four days annually are set aside to enable Approved Social Workers to attend mandatory structured refresher training, in accordance with the recommendations of the Social Services Inspectorate.

8. The Health Authority, Social Services Department and the Rockingham Forest NHS Trust should undertake an urgent examination of the management structures of the CMHTs, with a view to ensuring that each team has a designated manager, jointly financed and jointly owned, with overall responsibility for the team's operation and organisation of the team.

9. The Health Authority and Social Services Department should consider the joint appointment of a suitably experienced person (on a time-limited contract) to undertake the re-organisation of the CMHT teams and provide

them with the necessary policies and procedures which would enable them to carry out their tasks as outlined in the 1994 Strategy document.

10. The Health Authority and its constituent organisations should consider updating the 1994 *"Joint Purchasing Strategy for the Development of Mental Health Services for Adults in Northamptonshire"* in the light of new thinking in mental health services and should dedicate senior management resources to this task.

11. The Health Authority should discuss the Service Specification currently being piloted in the south of the county with the Rockingham Forest staff and consider its implementation across the county.

12. The Health Authority and Social Services Department should discuss with the Regional Office and with the Social Services Inspectorate an appropriate strategy for providing families affected by homicide by a mentally ill person with support and putting them in touch with relevant organisations.

13. The Health Authority, Social Services Department and the Rockingham Forest NHS Trust should discuss the future arrangements for such inquiries with the Regional Office, the Social Services Inspectorate and the Home Office. The discussion should take into account the negative media impact such inquiries have on the general public in relation to the delivery of safe mental health services.

14. The Health Authority, Social Services Department and the Rockingham Forest NHS Trust should develop a method of identifying families who require support and counselling, following a homicide by a person known to the mental health services. Consideration should be given to the implementation of a training programme for staff to promote the sensitive treatment of victims and the families of them and of the perpetrator.

15. The Health Authority, the Social Services Department and the Rockingham Forest Trust should ensure General Practitioners are aware of their responsibilities as described in the Mental Health Act 1983 and where necessary provide the appropriate training for those GPs who are not conversant with their duties as defined in the Code of Practice.

16. The Northamptonshire Social Services Department should put in place a procedure to monitor GPs' non -availability to attend assessments of their patients under the Mental Health Act. The outcome of this monitoring should then be reported to the Mental Health Act Commission.