Report of the independent inquiry into the care and treatment of John Barrett

November 2006

Published by NHS London

The Independent Inquiry
into the
Care and Treatment of John Barrett

October 2006

Commissioned by

South West London Strategic Health Authority

Acknowledgement

The event which gave rise to this Inquiry was the death of Denis Finnegan whose life was cut tragically short on 2nd September 2004 when he was attacked without warning as he cycled through Richmond Park. Denis Finnegan was loved and respected by his brothers and sisters and his wider family. His death was shocking and painful for them and for his many friends. We are conscious from our meetings with Denis Finnegan's family that his loss is still deeply felt.

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Introduction

1. This Inquiry into the care and treatment of John Barrett was commissioned by the South West London Strategic Health Authority, with the support and co-operation of Wandsworth Council and the Metropolitan Police, in accordance with the Department of Health circular HSG(94)27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community*. It was established following John Barrett's conviction on 25th February 2005 for the manslaughter of Denis Finnegan. The tragic circumstances of Denis Finnegan's death are described in Chapter 1.8 of this report.

2. The Inquiry's terms of reference were:

Stage 1

1 *To review the treatment, care and housing services provided to John Barrett by the NHS and local authority from his first contact with mental health services to the time of his most recent offence. If relevant, his previous history should also be reviewed.*

2 *To review the Trust's internal investigation and assess the adequacy of its findings and recommendations.*

3 *To agree with the Strategic Health Authority any areas (beyond those listed below) for further consideration.*

Stage 2

4 *To assess the adequacy of the risk assessment and actions consequent upon those assessments, including:*

- *internal and external communication to relevant individuals and agencies; and*
- *communications with the Home Office.*

5 *To examine the nursing and medical leadership and management issues associated with John Barrett's care and treatment.*

6 *To examine the extent to which the concerns raised by relatives and close friends of John Barrett were taken into account in the management of his care and treatment.*

7 *To review the extent to which local services adhered to:*

- *statutory obligations and relevant national guidance;*
- *local operational policies; and*
- *to identify any deficiencies.*

8 *To review:*

- *the extent to which the procedures of the Mental Health Review Tribunal ensured that there was an adequate inquiry into the case before John Barrett's conditional discharge was made in October 2003;*
- *the clinical decisions made in relation to the conditions imposed by the mental health review tribunal especially when breached; and*
- *decision-making within the Trust in relation to recall.*

9 *To consider whether the matters raised by the inquiry have implications and lessons beyond South West London and St George's NHS Trust and, if so, what those are.*

10 *To make recommendations so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.*

11 *To provide a written report that includes recommendations to the Strategic Health Authority.*

3. The Strategic Health Authority enjoined the Inquiry to:

Conduct its work in private and be expected to take as its starting point the Trust's internal investigation supplemented as necessary by access to source documents and interviews, as determined by the panel. The panel is encouraged to seek to engage actively with relatives of the victim and the perpetrator, as well as with others e.g. staff who are identified as being able to contribute to the Inquiry. The panel will follow established good practice in the conduct of interviews, for example, offering the opportunity for

interviewees to be accompanied and given the opportunity to comment on the factual accuracy of notes.

4. The Inquiry panel comprised:

Robert Robinson solicitor (Chairman) – appointed April 2005
Jane Fenwick associate with the Healthcare Commission and non-executive director of a Strategic Health Authority – appointed August 2005
Simon Wood consultant forensic psychiatrist – appointed August 2005

Mary Walker of Verita, an organisation that conducts inquiries, investigations and reviews in the public sector, acted as the Inquiry manager.

5. In August and September 2005 we read the documents that had been provided by South West London and St Georges Mental Health Trust. We first met on 13th October 2005.

6. In the course of the Inquiry we have reviewed John Barrett's medical and social services records and other documents received from the South West London and St George's Mental Health NHS Trust. We have obtained documents from John Barrett's general practitioner, Broadmoor Hospital, the Metropolitan Police, the Crown Prosecution Service, the Home Office and John Barrett's solicitor. We have also corresponded with the mental health review tribunal and received documents and correspondence from Denis Finnegan's family and others.

7. Between October 2005 and May 2006 we interviewed 35 witnesses and in addition we held meetings with John Barrett and his responsible medical officer (RMO) at Broadmoor Hospital.[1] We also visited the Shaftesbury Clinic and met patients and staff there.

8. We have met on two occasions with members of Denis Finnegan's family.

[1] Responsible Medical Officer (RMO) is defined in the Mental Health Act 1983, in relation to a detained patient, as "*the registered medical practitioner in charge of the treatment of the patient*".

9. We are grateful to all those whom we interviewed and we also acknowledge the assistance we have received from South West London and St George's Mental Health NHS Trust.

10. This report was delivered to the Strategic Health Authority on 30th October 2006.

Summary

Introduction

1. John Barrett was convicted of three serious assaults in January 2002. He committed the offences under the influence of abnormal mental processes. A restricted hospital order was imposed under the Mental Health Act 1983 on the grounds that his detention was considered necessary *"for the protection of the public from serious harm"*.

2. In October 2003 John Barrett was conditionally discharged from detention under the Mental Health Act by a mental health review tribunal. He was readmitted to hospital informally on two occasions in 2004. On 2nd September 2004, the day after the second readmission, he was at large in Richmond Park where he stabbed to death a stranger, Denis Finnegan.

3. Homicides committed by psychiatric patients are rare events and unprovoked fatal attacks on strangers are still rarer.[2] The reconviction rate for violent offences committed by discharged restricted patients remains low and has not increased in recent years.[3] This, however, can provide no comfort to Denis Finnegan's family and friends. Every homicide committed by a psychiatric patient not only causes grief to those directly affected but gives rise to justifiable public concern. Where the perpetrator is a restricted patient under the Mental Health Act the public interest is necessarily greater because the legal regime gives particular emphasis to the protection of the public.

4. It might be suggested that this tragedy would not have occurred if it had not been for a single decision, to allow John Barrett out on leave from the medium secure psychiatric unit to which he had been re-admitted on the day before he killed Denis Finnegan. This decision was an essential link in the chain of causation leading to Denis Finnegan's death, but we consider it was only one of several instances where clinical

[2] See Safety First, Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. (Department of Health 2001)

[3] We were told by the Home Office Mental Health Unit in a letter dated 10 January 2006: *"The management of restricted patients generally works well. The most recent figures available show that 2 per cent of restricted patients were re-convicted for a sexual or violent offence within two years of discharge. This compares with an expected reconviction rate of 11 per cent"*.

interventions did not give sufficient weight to the risks John Barrett could pose to the public.

5. This report shows that many aspects of John Barrett's management as a patient of forensic mental health services were not attended to with sufficient thoroughness. Too much confidence was placed in clinical judgements unsupported by evidence and rigorous analysis. Ways of working did not facilitate effective discussion and challenge of clinical views. There was a tendency to emphasise unduly the desirability of engaging John Barrett rather than intervening against his wishes to reduce risk. There was insufficient regard for legal and good practice requirements. Trust management systems for monitoring and regulating the work of the Forensic Service were weak and poorly implemented. This amounted to a cumulative failure effectively to manage the risk John Barrett posed to others.

6. The remedy for what went wrong in this case lies not in new laws or policy changes. Nor is there any reason to believe that an insufficiency of resources contributed in any way to the shortcomings we have found. The challenge, both organisational and individual, is to ensure that the care of potentially dangerous psychiatric patients is based on sound clinical practice and the systematic application of established principles of risk and organisational management. We do not make detailed recommendations about these matters because they are well understood by practitioners and managers. However, as discussed below we are concerned about the capacity of the South West London and St George's Mental Health Trust to remedy the deficiencies we have found.

7. In this report we comment critically on the performance of some of those who were responsible for John Barrett's care and treatment. The individuals concerned were given the opportunity to respond to our criticisms. The question arises whether we have applied too high a standard when considering, with the benefit of hindsight, their acts and omissions. It might be suggested that we should have applied the standard used by the civil courts in adjudicating professional negligence claims, and specifically

the Bolam/Bolitho test for clinical negligence.[4] It could be argued that our failure to apply that standard amounts to arbitrariness that is unfair to the individuals we have criticised.

8. We consider that this suggestion could arise from a possible misunderstanding of the nature of an Inquiry such as this which is, we believe, to demonstrate through evidence and argument the validity of our conclusions. We are self-evidently not a court. Neither our procedures nor the evidence enable us to make findings equivalent to those of a court adjudicating a disputed clinical negligence action. We bring to the task a range of experience and expertise which informs how we weigh up the evidence. This report reflects our consideration of the evidence, including extensive discussion between ourselves during the course of the Inquiry. We do not presume to lay down standards but rather to express our own considered views on a single case.

9. We recognise that the views we express in this report, and the conclusions we reach, have to be based on a thorough and fair consideration of the available evidence. In Part 1 we set out fully the factual background. This is largely derived from the written records. Other written and oral evidence is referred to extensively in Part 2 where we consider the issues which arise for comment and discussion. We have tried at every point in Part 2 to demonstrate the evidential basis on which our views are founded.

Factual History

10. John Barrett was born in 1963. He had a troubled childhood and left school without qualifications. By the age of 28 he had more than 25 criminal convictions and custodial sentences had been imposed on eight separate occasions.

11. He reportedly first experienced symptoms of mental illness in his early 30s. By the time of his first contact with specialist mental health services in 1997, when he was 33, he had developed paranoid beliefs which had no factual basis. He believed that he

[4] The standard test for clinical negligence is whether medical treatment in question is in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of medical treatment in question (*Bolam v Friern Hospital Management Committee* [1957] 2 All E.R. The test was qualified, as it applies in some cases, by the subsequent decision of *Bolitho (administratrix of the estate of Bolitho (deceased)) v City and Hackney Health Authority* [1997] 4 All E.R. 771.

was the subject of police surveillance, which was connected in his mind with sexual offences that he believed he had committed but for which he had never been prosecuted. His paranoid thinking led him on several occasions to confront strangers in the belief that they were part of the police surveillance operation.

12. Between 1997 and 2001 John Barrett had five admissions to psychiatric hospital, all but the first being by way of detention under the Mental Health Act 1983. During periods of in-patient care his psychotic symptoms were treated with anti-psychotic medication, but his behaviour was unpredictable and at times violent. Invariably, when he was discharged from detention under the Mental Health Act he would stop taking medication, with a consequent deterioration in his mental state, and confrontational and other aggressive behaviour would recur. Various interventions were tried by specialist mental health services, including the use of powers under the Mental Health Act for supervised after-care, but they were unsuccessful in securing his engagement with services or compliance with treatment as an out-patient.

13. On 8th January 2002 John Barrett seriously injured three people with a knife in the waiting area of a general hospital clinic. His behaviour was influenced by his belief that the principal victim of the assaults was linked to the supposed police surveillance operation. After a period on remand, in April 2002 he was transferred under the Mental Health Act to the Shaftesbury Clinic, a medium secure forensic psychiatric unit. At that time he was experiencing symptoms of a psychotic mental illness. These were not limited to the beliefs, which persisted, about police surveillance. On 20th September 2002, following his conviction for the three assaults, he was made subject to a restricted hospital order under sections 37/41 of the Mental Health Act.

14. At the Shaftesbury Clinic John Barrett was treated with anti-psychotic medication and it was considered that by October 2002 his psychotic symptoms had remitted. They returned briefly in May 2003 when he covertly stopped taking the prescribed oral anti-psychotic medication.

15. In October 2003 John Barrett was conditionally discharged from detention by a mental health review tribunal and he left the Shaftesbury Clinic. The conditions imposed on his discharge included residence at his home address, monthly medical

reviews and fortnightly meetings with a social worker and a community psychiatric nurse(CPN), compliance with prescribed medication and co-operation with urine screening for drugs. As a conditionally discharged patient he remained liable to be recalled to hospital by the Home Secretary for further treatment in the event that problems, notably any relating to risk, arose.

16. John Barrett lived alone when he was first discharged but in January 2004 his long-term partner moved in with him. He had started a college course when he left hospital but he gave it up after a few weeks. In January 2004 he began a collaboration with a professional musician, playing and recording music, with the intention of releasing their work commercially. They continued working together, at varying intensity, throughout the period of conditional discharge.

17. In April 2004 John Barrett complained of auditory hallucinations, which he described as whispering voices. They stopped after a few days, but in May 2004 they returned as intrusive voices, speaking directly to him, saying *"you are going to die"*, *"we are going to kill you"*. He found these distressing. At his request he was re-admitted to hospital, to an open ward, where the voices soon reduced to whispers. He was discharged home after five days.

18. During the summer of 2004 John Barrett continued to experience whispering voices intermittently. According to his partner and family members, his demeanour changed in ways that led them to believe he was becoming mentally unwell. By the end of July they were expressing their concerns to members of the care team. In August there were reports of specific incidents where John Barrett's behaviour had suggested that he was again becoming paranoid. A psychiatrist who examined him found him to be irritable and defensive.

19. On 31st August the decision was made, in light of his deterioration, to admit John Barrett to hospital. He was told about this when he saw the team's social worker on 1st September. John Barrett reluctantly agreed to informal admission, in preference to formal recall by the Home Secretary, although he did not consider admission to be necessary. The only symptoms he reported were the whispering voices which had been intermittently present for the previous three and a half months. He was admitted at

about midday to the Shaftesbury Clinic. He expressed his unhappiness at being admitted to a secure unit, saying he believed that as an informal patient he should have been placed on an open ward.

20. The original plan was that John Barrett would remain on the ward and be seen later that afternoon by the consultant psychiatrist in charge of his treatment. However, she telephoned the ward to say that she was no longer able to see him that day but would do so the following morning. She decided to allow him an hour's leave in the hospital grounds. She stipulated that if he did not return from the authorised leave, she was to be informed and consideration would be given to requesting the Home Secretary to issue a warrant formally recalling John Barrett to hospital.

21. Just after 3pm on 1st September John Barrett left the Shaftesbury Clinic, having been allowed out to take his hour's leave. He did not return after an hour, and at about 4.30pm nursing staff instigated the absent without leave procedure. A message was left for the consultant psychiatrist but she was not informed that he had not returned. In the meantime, according to his own account, John Barrett had started hearing loud auditory hallucinations commanding him to kill. He bought a pack of kitchen knives and went to Richmond Park where he intended to spend the night. But it was cold in the park and he arranged instead to stay with his musician friend. He told his partner where he was and she telephoned the ward to let them know that he was staying with a friend and that he had said he would be returning to the Shaftesbury Clinic in the morning.

22. John Barrett says that when he awoke on the morning of 2nd September the commanding voices were still there. He went by taxi to Richmond Park, with the pack of knives. He had decided that he was going to kill someone and at about 10am, within half an hour of entering the park, he attacked Denis Finnegan with a knife. Staff at the Shaftesbury Clinic were made aware shortly after 9am that John Barrett was in possession of a knife and had taken a taxi, although it was not known where he was going. The police were contacted but John Barrett's whereabouts were not discovered until after the fatal attack on Denis Finnegan.

23. In March 2005 John Barrett received an automatic life sentence for the manslaughter of Denis Finnegan. He had already been transferred to Broadmoor Hospital under the Mental Health Act and remains there as a detained patient.

The Inquiry's Findings

Care and Treatment 1997 – 2001

24. We consider that the care and treatment John Barrett received before 2002, as a patient of general adult psychiatric services, was effective only during the relatively short periods when he was detained under the Mental Health Act. Throughout these years his engagement with treatment was limited. He disliked anti-psychotic medication and was not willing to take it. He did not accept he had a mental illness for which he required treatment. He tended to minimise his symptoms and learned not to disclose his abnormal mental experiences to clinicians. John Barrett did not recognise the risk he posed to others, despite the serious concerns of mental health professionals and his partner about his actual and potential violence.

25. We make no criticisms of the care before 2002. It was typical of the interventions to be expected of general adult psychiatric services. That so little was achieved is attributable to John Barrett's lack of insight and limited engagement rather than because of any failure by mental health services.

Care and Treatment 2002 – October 2003

26. The quality of care and treatment John Barrett received as an in-patient at the Shaftesbury Clinic, fell short in a number of important areas, of what we would have expected. We consider that the team agreed prematurely in January 2003 to support his forthcoming application to the mental health review tribunal for conditional discharge. Thereafter insufficient attention was paid to factors that indicated that he was not clinically ready for discharge. Even when he covertly stopped taking the prescribed anti-psychotic medication in May 2003, this did not impede his progress towards discharge.

27. The specific matters on which we comment include: John Barrett's failure to take responsibility for the January 2002 offences and his lack of remorse; his circumscribed and incomplete understanding of his mental illness; his limited acceptance of the benefits of medication; his disengagement from occupational therapy (OT) and his lack of realistic plans for how he would spend his time when he left hospital. Our view is that these were all matters of relevance to his proposed discharge and that the team did not pay enough attention to them.

28. We also conclude that during this period there is little evidence that the team had a comprehensive understanding of John Barrett's psychiatric history, which we consider was relevant both to the diagnosis and treatment of his condition and to the management of risk.

29. We comment adversely on the quality of the clinical records, both their organisation and content. We also consider the quality of decision-making within the multidisciplinary team, which we conclude failed to give sufficient weight to non-medical views.

30. Our overall conclusions in relation to this period of care are that John Barrett's clinical management placed too much importance on his wishes and preferences, with correspondingly less emphasis on the principles of sound risk management. We consider that more should have been done to prepare him for discharge and to establish the clinical management framework within which conditional discharge would operate. While this conclusion does not depend for its validity on demonstrating that problems arose following discharge, that they did tends to support our analysis.

Care and Treatment October 2003 – 30th August 2004

31. We criticise the team for not fully implementing the care plans during this period when John Barrett was subject to conditional discharge. The particular areas of concern are that he was not offered regular out-patient appointments with a psychiatrist, that we have not found evidence of random urine testing for drugs, and that effective steps were not taken to engage him in structured activity. We also conclude that the team did not communicate effectively with John Barrett's partner

and they were slow to make contact with the musician with whom John Barrett was working throughout the period of conditional discharge.

32. We are critical of the team's response in 2004 to the return of symptoms, in the form of auditory hallucinations. Our view is that following the admission in May there should have been closer monitoring of his mental state and that more consideration should have been given to adjusting his medication with the aim of relieving the symptoms he was experiencing. We consider the persistence of auditory hallucinations was unhelpful to him and detracted from the effectiveness of his clinical management.

33. We conclude that John Barrett's mental illness was not adequately treated towards the end of the period of conditional discharge and that he was relapsing. We consider that clinical interventions should have been more forceful and that there were sufficient grounds for readmitting him to hospital before 31st August when the decision was taken.

34. We draw attention to failures to report to the Home Office as required, and specifically to inform the Home Office when John Barrett was admitted to hospital in May and when it was decided on 31st August to admit him the next day.

35. It is easy with hindsight to identify clinical interventions that would have reduced the risk of John Barrett committing further acts of violence. Doing so would be to focus on particular decisions and judgements made in circumstances quite different from those in which we now review his care and treatment. In important respects the care delivered by the team fell short of what the care plan and the mental health review tribunal required. In the case of a restricted patient like John Barrett the primary purpose of tribunal conditions and requirements in care plans is to reduce and manage the risk of serious violence. Where the care delivered falls short of such conditions and requirements the inference is that the risk is not being properly managed.

The 1st September admission

36. We criticise the way this admission was planned and executed. In particular, we consider that informal admission was not appropriate because it was clear that John Barrett did not wish to be admitted. We accept that those involved acted in what they believed to be John Barrett's interests, but their actions had the opposite effect to that intended and left John Barrett feeling he had been tricked into agreeing to the admission. This appears to have been a factor in his decision to abscond.

37. We conclude that the decision of the consultant psychiatrist to grant John Barrett unescorted leave, without having assessed him, was seriously flawed. It appears to have arisen from a concern to maintain the therapeutic relationship with John Barrett. Inadequate consideration was given to the potential risks arising from his deteriorating mental health. Indeed, there was insufficient clinical information available on which to make a decision to grant leave to a patient who was known to present a serious risk of violence when unwell.

Events following John Barrett's absconding

38. The response when John Barrett failed to return from leave fell short of what we would expect to find in a medium secure forensic unit. We point to poor communication between nurses and the failure of a nurse properly to implement the absent without leave procedure, but our overall conclusion is that what occurred is illustrative of systemic failures in the Forensic Service.

Mental Health Review Tribunal

39. We consider the proceedings of the mental health review tribunal which ordered John Barrett's discharge in October 2002. A number of considerations lead us to question whether the hearing afforded a sufficiently rigorous inquiry into John Barrett's case. These include: the brevity of the hearing, that John Barrett's RMO did not attend the hearing, that members of the care team had not seen the Home Secretary's objections to discharge in advance of the hearing, and that the tribunal's reasons did not deal fully with those objections. Our terms of reference invited us to

consider whether the case had implications beyond the Trust. We make recommendations in relation to tribunal proceedings affecting restricted patients and in particular to enhance the role of the Home Secretary in such proceedings.

Home Office

40. There were failures to report to the Home Office as required, and the reports which were submitted did not always provide a full and accurate picture. We make recommendations designed to improve both compliance with reporting requirements and the quality of reports.

Multi-agency Public Protection Arrangements (MAPPA)

41. We are critical of the failure of South West London and St George's Mental Health NHS Trust to have implemented its own MAPPA policy while John Barrett was a patient of the Trust's Forensic Service. We consider that the way this was handled was representative of more general failures and problems of organisation.

Conclusion

42. Our terms of reference required us to review in detail the care and treatment of a single patient. In the course of this Inquiry weaknesses in management and governance have been drawn to our attention, but without a consensus about what needs to change. As far as the Forensic Service is concerned, John Barrett's case is illustrative. We conclude that during the period he was a patient of the Forensic Service deficiencies in systems, processes and governance arrangements put patients and the public at risk.

43. We remain concerned about the lack of management processes and clinical governance arrangements to monitor implementation and compliance. More fundamentally, while there have been limited improvements in recent months, our firm impression is that the culture of the Forensic Service has not changed.

44. We doubt whether there is the managerial capacity within the Forensic Service or the wider Trust to achieve within an acceptable timescale the objectives that have been set. We conclude that this has serious implications for the safe delivery of patient care by the Forensic Service. We recommend that a service improvement team, taking a national perspective, work with the Trust and the Forensic Service to turn around the performance of the Service, to identify failings and put in place systems and processes that are robust and effective with regular monitoring to ensure safe and effective patient care.

45. We question whether the Shaftesbury Clinic should continue to operate as a medium secure unit until this work has been undertaken. This is for others to decide.

PART ONE

Factual Information

Chapter 1.1 - South West London and St George's NHS Trust: Structure, organisation and management of the Forensic Service

Introduction

1. Between March 1997 and September 2004 John Barrett was a patient of South West London and St George's Mental Health NHS Trust. For five years his care was provided by general adult services and latterly he was a patient of the Trust's Forensic Service. The purpose of this chapter is to provide background information about the Trust and more particularly about the Forensic Service. We do this under the following headings:

- South West London and St George's Mental Health NHS Trust
- Clinical governance arrangements
- The Forensic Service
- Management and Organisation of the Forensic Service 2002 – 2004
- Organisational changes affecting the Forensic Service since September 2004

South West London and St George's Mental Health NHS Trust

2. The following is taken from the Trust's Annual Report 2004 - 2005:

> *The Trust's core purpose is to provide integrated health and social care for local people with mental health problems in Kingston, Merton, Richmond, Sutton and Wandsworth and more specialist mental health services for people throughout the United Kingdom.*
>
> *Established in 1994, the Trust delivers services to those with learning disabilities, children and adolescents, adults of working age and older people. In addition, the Trust provides specialist services regionally and nationally, including addiction, eating disorder, personality disorder, forensic and deaf services. The Trust is currently the only provider in the UK delivering highly specialised in-patient mental health services for deaf children.*

The Trust has 3,000 staff, 18,000 service users, 875 beds and a budget of £170 million. It operates across more than 50 sites and is covered by four Primary Care Trusts and five local authorities.

3. For the training of medical, nursing and other health professionals the Trust works in partnership with St George's Hospital Medical School and the Faculty of Health and Social Care Sciences at Kingston University.

Clinical Governance Arrangements

4. Clinical governance is defined by the Department of Health as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. All NHS organisations are required to have effective governance arrangements to provide the quality control necessary for the organisation.This includes all aspects of delivery of service, from financial monitoring, through policy development and implementation, to staff training and supervision.

5. The Trust's clinical governance arrangements have not changed since 2004. Kim Goddard has been assistant director (governance) since September 2003. Under her are a clinical governance manager, a complaints manager and a risk manager. The Trust has an annual clinical governance plan for all its services and this is monitored by the clinical governance committee which co-ordinates the flow of information on quality and risk. It reports quarterly to the Trust board. Each individual service has a service clinical improvement group that reports to the clinical governance committee.

6. Non-executive directors of the Trust are all involved in some aspect of clinical governance arrangements. Ms Goddard commented that:

Judith Chegwidden is the non-executive director lead for governance issues. She jointly chaired firstly the clinical governance committee and then the governance committee, and now she is the chair of the audit committee, which has taken on a lot of those governance committee roles. The other non-executive directors are each involved in different sub-aspects of governance…

for example… the Mental Health Act and complaints and… race and equality issues.

7. The chief executive has responsibility to provide value for money and to make sure that there is a good quality of clinical care. Under the old directorate structure, which we describe below in relation to the Forensic Service, the clinical director had the same responsibilities within the directorate. Since re-organisation clinical governance is written into every job description and becomes the responsibility of everyone. Ms Goddard commented that:

We now have a general management structure, the line management accountability is now with the service director for that borough. However of course all of the staff, I would argue everyone down to the most part-time person, has exactly the same duties. I suppose one of the key things that for me has changed is clinical governance not being something that people do as an add-on to their day-to-day work, but is something that is reflected in all of their objectives.

The Trust now has the Department of Health integrated governance handbook which was published in early 2006.

The Forensic Service

8. In 1987 a service for forensic patients was founded by two consultant psychiatrists Patrick Galway and Nigel Eastman, at St George's Hospital Medical School. It was primarily an assessment service, without its own beds. An in-patient service was later established on the Springfield Hospital site with the development of the Shaftesbury Clinic, a purpose-built medium secure forensic unit. In 1992 the Forensic Service was absorbed by the current Trust's predecessor which at that time was responsible for all services on the Springfield site.

9. During the period that John Barrett was a patient (2002 – 2004) the Forensic Service had 71 beds, including intensive care, rehabilitation and a low secure ward. It had responsibilities for approximately 50 out-patients in the local community, most of

whom had previously been discharged by the in-patient service. The Forensic Service also provided a range of other services, including prison in-reach.

10. In 2004 six consultant forensic psychiatrists were employed by the Forensic Service, four of whom were half-time clinical appointments. Of the four, three also held academic appointments at St George's Hospital Medical School which took up the remainder of their time, and the fourth was Dr Deij Oyebode who spent the other half of his time as the Trust's medical director. One consultant post was vacant in 2004. Dr Oyebode told us that in recent years they had difficulty in recruiting to vacant consultant medical posts, even though they continued to have a good throughput of specialist registrars (SpRs) who would know the service well. Professor Nigel Eastman, consultant forensic psychiatrist, confirmed this. In addition to the consultant psychiatrists there were within the Forensic Service at any time seven full-time SpRs and six full-time senior house officers (SHOs). A full-time consultant forensic psychiatrist within the Forensic Service normally had a caseload of not more than 15 in-patients and a variable number of out-patients.[5]

11. The in-patient service was organised clinically into teams led by consultant forensic psychiatrists. The teams were not aligned to the wards so at any time a team would have patients on two or more wards. Ward-based nursing staff therefore worked with different consultant psychiatrists, each with his or her own multi-disciplinary team, in respect of different in-patients. Each consultant-led team included an SpR, usually an SHO, a social worker, an occupational therapist (OT) and a psychologist. When patients were reviewed individually at the consultant's weekly ward round a nurse attended from the patient's ward.

Management and Organisation of the Forensic Service 2002 – 2004

12. The Forensic Service was one of nine directorates within the Trust, each with a service manager and a clinical director. Each directorate was managed on a locality basis and the Forensic Service came under the Borough of Merton for managerial purposes.

[5] Dr Gillian Mezey, John Barrett's consultant forensic psychiatrist, had a half-time academic appointment. Her clinical caseload in 2004 was eight in-patients and five out-patients.

13. The management structure within the Forensic Service was divided between medical and non-medical staff. The clinical director had overall management responsibility for all consultants, their medical teams, quality of service and meeting financial duties. Dr Annie Bartlett, who was one of the consultants with a half-time academic appointment, was appointed clinical director in 2003. She combined the role of clinical director with her part-time clinical responsibilities. As clinical director her line manager was the chief executive, Dr Nigel Fisher and she was professionally supervised by the medical director.

14. The nursing team and other non-medical staff within the Forensic Service were managed by Caroline Leveaux, who in 2003 was seconded from deaf services in the Trust to the post of service manager. She also had responsibility for managing the directorate's finances. She was professionally supervised by the Trust's borough director for Merton, Mark Clenaghan and her line manager was the clinical director. The role and responsibilities of her job were wide, managing a budget of £8 million a year with 200 full-time equivalent non-medical staff. She worked with five London Primary Care Trusts (PCTs) as well as groups of PCTs in Surrey and Sussex. She also had responsibility for placements, complaints, critical incidents and staffing issues.

15. Below the service manager, nurse management was localised within the ward structure. Alpha Sankoh, the ward manager of Halswell Ward where John Barrett was admitted on 1st September 2004, described his role: *"each ward has a ward manager managing the physical environment, staff, patients, and also managing pre-admission assessments"*. There was also within the Forensic Service a lead nurse, who worked with the service manager and the clinical director. The lead nurse post was introduced in 2003, with responsibility for the performance of nurses and to provide advice to the service manager on the management of nurses. Michael Hever, who was the lead nurse at this time, described his role as: *"the lead on professional development and also looking at training and development"*. There was neither a nurse consultant nor a modern matron within the Forensic Service and no senior nurse with responsibility for nursing at an operational level.

16. The Forensic Directorate had its own social work team, supervised by the team manager. The social work team manager post was vacant for some of the time that

John Barrett was a patient of the Forensic Service and supervision was then provided from outside the team to individual social workers.

Organisational changes affecting the Forensic Service since September 2004

17. Dr Fisher became the Trust's chief executive in 2002 having been medical director, and before that a consultant psychiatrist with the same organisation or its direct predecessors for a total of 14 years.

18. There have been significant organisational changes within the Trust since September 2004 and there have also been internal changes within the Forensic Service.

19. Dealing with the Trust as a whole, in a memo dated 1st November 2004 Dr Fisher made a number of criticisms of the arrangements that were then in place. In summary these were that services and associated management were too centralised and unresponsive to local need, and that management was medically dominated with insufficient operational management strength at borough level. He pointed to variable operational management strength and a large gap between service managers and the Trust's chief operating officer. He also noted that there were tensions between managerial and professional lines of accountability.

20. The main change since reorganisation is that all staff including doctors are now within a single management structure based on boroughs rather than directorates. According to Dr Fisher's memo of 1st November 2004 the advantages of the new management arrangements include:

- *A management structure that provides strong operational management and strong clinical leadership*
- *The structure provides clearer lines of operational and professional accountability*
- *The provision of proper supervision, support and career development of those managerial (including clinical management) roles*

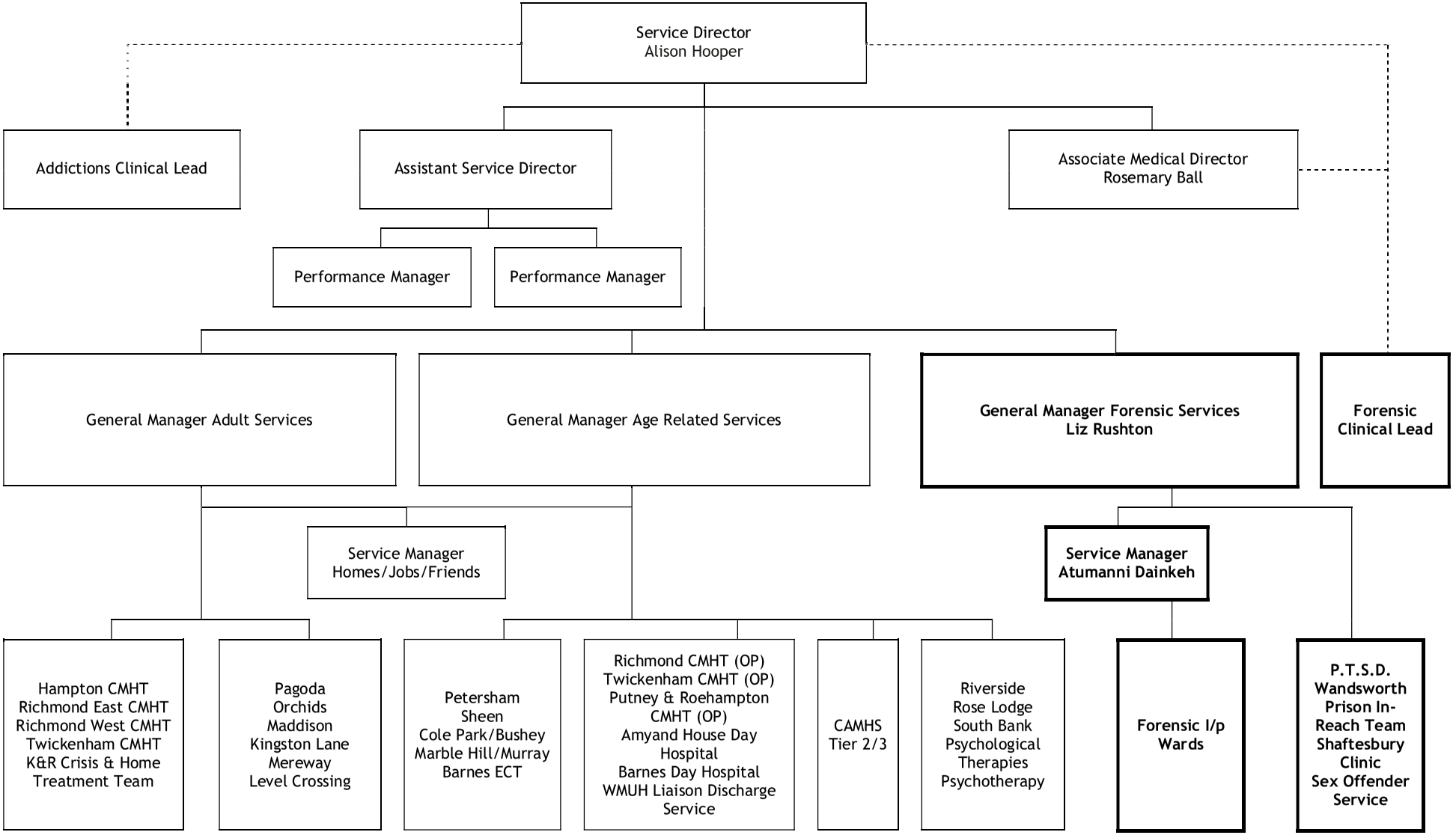
- *The management of clinicians will be brought into the main management framework with effective working between clinical services and corporate departments*

21. Dr Fisher left the Trust in December 2005 and an interim chief executive, Christine Carter, was in post from then until mid 2006. She came to the role with senior management experience, having been the chief executive of a Primary Care Trust, and with some knowledge of the Trust, having participated in an internal inquiry into a homicide on John Meyer Ward which occurred in June 2003. She was supported by Maresa Ness who was recruited as chief operating officer in November 2004 to plan and implement the reorganisation. Another key figure is the director of nursing, Professor Mary Chambers, who was appointed in February 2004 and has been particularly active in enhancing the role and performance of nurses across the Trust, an issue of particular relevance to the Forensic Service.

22. In the restructuring plan as originally conceived the Forensic Service came under the service director for Merton, Mr Clenaghan, who had been the service manager for the Forensic Service some years earlier. But in June 2006 responsibility was transferred to the service director for Richmond, Alison Hooper. She is supported by an associate medical director, who provides medical leadership, and an assistant service director, with responsibility for performance management. In addition a Forensic Service manager and a general manager are based in the Shaftesbury Clinic. The role of clinical director has been discontinued and replaced by a clinical lead. The role is now one of providing forensic advice, specifically in relation to access to the service and sharing best practice across the five boroughs it serves, and clinical leadership within the Forensic Service. The clinical lead has no line management responsibilities. Management of medical staff is now within the general management structure and is the responsibility of the associate medical director.

23. The Richmond Structure is shown in the following table:

Richmond Structure as of June 2006



24. The reorganisation offers the potential for better performance management within the Forensic Service by managers who are close to operational activity. The appointment of an associate medical director has provided an additional management layer for doctors. In Ms Carter's words, the aim is to *"engage the consultants in the local management arrangements"*.

25. The introduction of the new management structure has been accompanied by efforts to improve communication and multi-disciplinary working within the Forensic Service. We heard from Professor Chambers that multi-disciplinary workshops she has organised have been well attended by all disciplines. Efforts have also been made to engage consultant psychiatrists in decision-making. Mr Clenaghan told us of how this was being done when he was service director:

> *We agreed that we needed to have a forum where we all talked together, so we now have a very inclusive forensic management team; it is all heads of disciplines, all consultants. We have had one meeting and we have now committed to those meetings on a monthly basis. We discussed drafts of operational policies, standards within that, and it was an extremely difficult meeting… in order to get the ownership of that change there has to be an insight by all concerned that there is something wrong to change, and sometimes that is not clear.*

26. The new structure has facilitated the development of a nursing strategy with a requirement to develop nursing roles to include a nurse consultant post within the Forensic Service.[6] There is now a clear policy for clinical and managerial supervision of nurses and the development of personal development plans.

27. The Forensic Service has also reorganised in-patient teams. Each consultant's patients are now all on a single ward so that ward-based nursing staff are fully integrated into the multi-disciplinary teams. Everyone we interviewed commented favourably on this change, saying that it had led to improved multi-disciplinary working and enhanced the role of nurses within the Forensic Service.

[6] Refer to Chapter 2.1 paragraphs 40 - 42

Chapter 1.2 - John Barrett's Personal History

In describing John Barrett's personal history we have tried to protect the privacy of members of his family.

1. John Barrett was born in London on the 1st August 1963, the third of five children of his parents' marriage. His mother was of Northern Irish descent and his father came from Jamaica. The marriage ended in divorce when John Barrett was 14.

2. During John Barrett's childhood his father was violent towards him. John Barrett was first placed in local authority care at the age of six together with his four siblings. According to reports, this was because his parents could not cope. When he was discharged from local authority care, he went to live with his father who was then with a new partner. He later returned to local authority care because of conflict with his father's partner, and he remained in care for some time because his father was in prison. He was placed in a children's home in Leicester. Initially there were favourable reports – *"an integral member of the children's home, having a secure warm relationship with the members of staff in his unit"*. He was required to leave at the age of 16. John Barrett says that this was because he had reached the upper age limit for the home. Reports in the social services records refer to his aggressive and disruptive behaviour as the reason for leaving.

3. John Barrett's secondary schooling came to an end in March 1979, when he was suspended for attacking a teacher with a chair. He left school without qualifications. After a short period of unemployment he went to a college in Leicester to study dance and drama. His college education was disrupted because of the time he spent in custody for criminal offences but he completed the course and achieved a City and Guilds qualification when he was 22.

4. In his early twenties he started to write songs, and for two years was under contract with a recording company as a singer, composer and keyboard player. He released three records during this time, one of which got into the music charts, and he also performed. But the contract was not renewed and two subsequent attempts to make a career in the music industry, in his late twenties and mid-thirties, failed. His interest

in music was noted when he was detained in the Shaftesbury Clinic in 2002/03,[7] and he chose to pursue his musical interests following his discharge in 2003.[8]

5. After his music contract came to an end, John Barrett worked in a variety of short-term jobs, including periods in telesales and employment as a hospital porter and as a traffic warden. He last worked in 2001, when he was briefly employed in telesales.

6. As a young man John Barrett had several short-term relationships, and in his twenties he fathered two, or possibly three, children by different mothers.[9] He has also had two longer term relationships. The first was with a woman whom he met when he was 23. He moved from Leicester in his mid-twenties and they lived together in London where she was working. They married when he was 28 and divorced three years later. There were no children.

7. The second significant relationship was with JW whom he met in December 1994, shortly after being released from prison where he had served three years of a four year sentence for robbery.[10] They started living together and continued to do so until 2001. In September 2000 John Barrett was granted the tenancy of a flat by Wandsworth council because he was a user of mental health services and was regarded as vulnerable. He lived at the address with JW until 2001 when they separated. They remained close while he was in hospital in 2002/03 and they resumed cohabitation in January 2004. They continued to live together until shortly before his arrest in September 2004. There are no children from the relationship.

8. In the summer of 1995 it became apparent to JW that John Barrett suffered from a paranoid mental illness. She first noticed this when they were on holiday in Portugal:

> *That is when I remember things beginning to change with John and I noticed that he was worryingly paranoid. When we were in Portugal there were*

[7] We received the following report from the Head of Occupational Therapy at the Shaftesbury Clinic: *"I have enquired further and the OT Tech here who is also a musician on the popular circuits tells me he used to talk to John Barrett a lot about his music, helped him use a keyboard in his room, listened to the composing of a song – also after his discharge* [in October 2003] *came back to talk about composing"*.
[8] Refer to Chapter 1.7 paragraph 28
[9] John Barrett says he has only two children but psychiatric and other reports repeatedly say that records show he is the father of three children. We have not looked into this further.
[10] Refer to Chapter 1.3 paragraph 1

instances where, if the police were around, John would immediately think they were there because of him, which was just bonkers when we were abroad.

9. His mental illness became an increasingly important factor in their relationship. JW was his main carer, a role she resumed following his discharge from the Shaftesbury Clinic in October 2003. She was also the victim of serious domestic violence, which started on the same holiday in Portugal.[11] She linked the violence to his paranoia. According to JW the relationship was close and intense: *"we were very close - I suppose I was the only person he could really talk to"*. She also told us about the extent of his dependence on her when they were living together and he was mentally unwell: *"He couldn't work; he didn't have relationships… Our lives were completely and utterly mad. John couldn't have social relationships"*. She described the impact of his mental illness:

There was this part of him that could be well, and I suppose I spent most of our relationship fighting with the mental health services to help him…fighting with John as well. Battling with him to try to get him to understand that he wasn't well and needed help.

10. JW told us about the early months following John Barrett's discharge from the Shaftesbury Clinic in October 2003, when she considered he was mentally better than at any time previously during their relationship: *"For the first time… we were having a relationship that we had both always wanted – it was lovely"*. One aspect of this was that he was contributing financially, something he had never done before:

It was really important to both of us that there was some equality for us to have any kind of decent relationship, so John was giving me half his dole and doing it happily and willingly.

[11] JW told us: *"The violence started when we went to Portugal… when we got to Portugal it was the first time he hit me. We checked in at a hotel in Lisbon… sitting on the side of the bed, and him getting hold of my arm and punching my arm… I had a big bruise for the whole of the holiday …Throughout* [the period prior to August 2000] *the violence built up"*.

11. In interviews with psychiatrists John Barrett has repeatedly said that throughout the time they were together JW was supportive and very understanding towards him. When he was assessed by Professor Eastman in September 2004, following his arrest for killing Denis Finnegan, he described JW as his anchor but he also said:

> *She gets involved in my mental health issues to a degree that I find surprising… I'm pleased some of the time, other times a bit perturbed… she's a bit too 'in your face' but shows empathy… every slight thing that seems slightly out of kilter, she latches onto and starts questioning and probing… and starts making me feel a bit neurotic, but I know she means well and I care for her… but it would be nice if she could step back a little.*

This is probably an accurate reflection of how he regarded her role in the summer of 2004 when he did not share her concerns about his deteriorating mental health.

12. The losses and difficulties John Barrett experienced in his early life, including an offending history with his first criminal conviction at the age of fourteen,[12] are a common feature of the lives of people who become forensic psychiatric patients in later life.

[12] Refer to Chapter 1.3 paragraph 1

Chapter 1.3 - John Barrett's Offending History

This part of the report was compiled from computerised police records, of which we have a printout, and from the multi-disciplinary files of mental health professionals beginning in 1997. We include here reported incidents which did not result in a conviction.

1. John Barrett was first convicted of a criminal offence in 1978 when he was aged fourteen. The following table lists all his convictions up to 1992:

Date	Age	Offence	Sentence
31.05.1978	14	Theft	Supervision order 2 years
01.11.1978	15	Theft/Shop lifting	Attendance under 24 hours, supervision order to continue
28.11.1978	15	Theft/Shop lifting	Supervision order 2 years
06.03.1979	15	Theft/Shop lifting	Care order
26.07.1980	15	Theft/Shop lifting	Fined £15.00
23.07.1980	16	Burglary x3	Detention centre 3 months x 3
06.01.1982	18	Burglary, theft of non-dwelling	Imprisonment 2 months
27.06.1983	19	Obtaining property by deception x2, burglary, robbery, burglary with intent to steal (non-dwelling), breach of conditional discharge, 17 other offences taken into consideration	Youth custody 3 months, youth custody 12 months concurrent, youth custody 18 months concurrent, youth custody 6 months
28.01.1986	22	Theft/imprisonment obtaining property by deception x2, ABH x2	Imprisonment 6 months, partially suspended imprisonment 6 months concurrent, partially suspended and imprisonment 6 months concurrent, partially suspended imprisonment 6 months consecutive, partially suspended

31.07.1987	23	Handling stolen goods	Fined £250.00 plus costs of £21.00
19.04.1989	25	Affray	Imprisonment 6 months suspended for 2 years compensation £250.00
15.12.1989	25	Theft, breach of suspended sentence	Imprisonment 1 month, imprisonment 6 months concurrent
26.07.1990	26	Burglary with intent to steal (non-dwelling)	Imprisonment 6 months suspended 1 year, compensation £350.00
29.01.1992	28	Robbery x3, one other offence taken into consideration	Imprisonment 2 years concurrent, 4 years concurrent

2. We do not have full details of offences before 1992. Specifically, we do not know the degree or type of violence used in the offences against the person or the amount of money or value of property in the various offences under the Theft Act.

3. John Barrett's account of the 1992 offences, for which he was sentenced to four years' imprisonment, is that he robbed a post office by giving a cashier a note which had written on it a demand to hand over all the money in the safe. The cashier gave him £15,000. He has repeatedly denied that he was armed or threatened violence but other reports say that it was an armed robbery. He served three years of the four year sentence and was released in late 1994.

4. Between then and the index offences of January 2002 he came to the attention of the police many times but was not convicted of any further offences. The first occasion we know about was on 7th February 1997 when he went to Wandsworth police station to report that five years previously in Leicester he had had unlawful sexual intercourse with two 15½-year-old girls. The police officer who saw him on that date recorded him as saying he had gone to the police because: *"he has heard people are speaking about him, and the Leicester Old Bill are interested in him"*. The police made enquiries of their colleagues in Leicestershire and it was suggested that the

matter be flagged up in the Divisional Intelligence Unit. The record of his visit to Wandsworth police station on the 7th February includes the following:

> *This man is very worrying, he is very calm but the whole time you get the feeling he is going to flip in a big way… He is undoubtedly unstable and one gets the feeling he is a time bomb waiting to happen.*

5. On 17th February 1997 he was arrested outside his flat following a complaint that he had been: *"following and harassing a woman and a man who was with her"*. It was reported that he was carrying a flick knife. Police searched him but found nothing and released him without charge.

6. On 4th March 1997 he was arrested for breach of the peace. The circumstances, according to the police record, were:

> *That he followed 2 unknown males to their home address and wanted to fight with them, they were unable to calm him down and* [he] *was subsequently arrested. Whilst in custody it was felt that* [he] *was suffering from a mental disorder and* [he was] *examined by a Forensic Medical Examiner, who recommended that he be assessed by a psychiatrist and the duty social worker… Following a lengthy assessment by the duty psychiatrist and the duty social worker, it was decided to release him into the custody of his girlfriend who also attended to assist police… At this stage* [he] *decided that he wished to go to hospital and he was conveyed there by police along with his girlfriend.*[13]

The police record of the incident describes him as *"unstable and violent"*. It also shows that he was charged with an offence under section 4 of the Public Order Act 1986 in respect of this incident. He appeared at the South Western Magistrates' Court on 19th June 1997 and was bailed with conditions not to contact two men, who were named, and not to enter a named road. His next appearance at court was due on 9th September 1997 but there is no record that the case proceeded further. A somewhat

[13] Refer to Chapter 1.5 paragraph 2

different account of the incident is found in the multi-disciplinary notes, where it is recorded that he followed one man, not two.

7. In April 1997 police were called by the proprietor of a business, who complained that John Barrett:

> *Has been calling around the workshop shouting abuse at staff. Today he threw a bottle at the informant which fortunately missed… The informant states that Barrett appears to be becoming more and more volatile and fears he may cause serious damage to their property or injury to one of the staff.*

He was arrested and charged with threats to kill but the case was dismissed when the victim failed to attend court on the 9th September 1997. Another version of the incident which led to his arrest in April 1997 is to be found in a social circumstances report prepared in 2000. It states that: *"He is reported to have said 'You are dead' to employees of an employment agency who he again believed were part of a conspiracy against him".*

8. The police records show that on 24th April 1997 it was reported that John Barrett had assaulted JW but she was not willing to make a statement.

9. According to the multi-disciplinary notes, his psychiatric admission on 8th May 1997 was precipitated by an allegation that he had followed a man home and threatened to kill him.[14] This incident does not appear in police records.

10. In October 1997 it was reported that he had been involved in three further incidents with members of the public and that the police had been called, but there is only one police record of this.[15] John Barrett was arrested for threatening behaviour but no charges were brought as the victim did not want to substantiate the allegation in court. It is also recorded in the multi-disciplinary notes that in November 1997 he

[14] Refer to Chapter 1.5 paragraph 9
[15] Refer to Chapter 1.5 paragraph 14

had a fight with the manager of a factory in Cambridge where he had applied for a job.[16]

11. In January 1998 it is recorded in the multi-disciplinary notes that he was arrested for attempting to strangle JW, but was not charged.[17] There is no corresponding police record of this incident.

12. He next came into contact with the police in June 1999 when, according to the multi-disciplinary notes and corroborative police records, he was arrested for fighting. He was consequently charged with assault occasioning actual bodily harm on 26th August 1999 but the prosecution case was later withdrawn for reasons which we do not know. On 12th July 1999 he attended Wandsworth police station and told officers that he wanted to talk to them about a rape he had committed against his former wife when they were still living together, that is before he was sent to prison in 1992. He gave no details except that he had forced her to have sex with him. He went on to mention an earlier occasion when he had forced a woman friend of his then girlfriend to have sex with him. Again he did not provide further details. No action was taken on these reports but it was noted that he had previously reported to the police that he had committed sexual offences against under-age girls.

13. It is recorded in psychiatric reports and risk assessment documents that in April 2000, neighbours reported that he was behaving suspiciously, knocking on doors and that he had broken into their flat: objects had been moved around and the bath filled with water. There is no police record of this.

14. On 3rd May 2000, JW reported to the mental health team that the previous night John Barrett had attempted to break her arm. This was reported to the police as was the fact that JW was considering taking out an injunction. On 8th May John Barrett was admitted to Springfield Hospital under the Mental Health Act and on 20th May he assaulted a nurse and a patient, hitting each of them several times. The hospital reported these assaults to the police. On 10th June he assaulted another patient on a different ward, but this was not reported to the police. When Dr Michael Yates, in the

[16] Refer to Chapter 1.5 paragraph 16
[17] Refer to Chapter 1.5 paragraph 18

course of his forensic assessment,[18] spoke in June 2000 to a nurse on the ward where the May assaults occurred, he was told: *"both nurse and patient are pressing charges"*. In August 2000 John Barrett attended Wandsworth police station by appointment. He was formally arrested for the 20th May assaults and bailed from the police station. That appears to have been the end of the matter. It is recorded in the police computer printout that: *"No charge brought against suspect due to the summons exceeded 6 months"*. The explanation we have received from the police is that:

> *There was a delay in obtaining the doctor's report from Springfield Hospital. The report confirmed that the offence committed was a common assault only, in respect of which a summons must be issued within six months. The medical evidence was received out of time for this to be done and the matter was therefore classified for 'no further action' on 28th December 2000.*

15. The next police record is of an incident on 18th August 2001. By then John Barrett and JW were living apart. They met by chance in a pub. He threatened her and she reported him to the police. The account she gave was that:

> *He immediately became threatening, saying he was going to wrap a bar stool across* [her] *head and glass her. He then said she had better get out of London or he would get her.*

This incident was reported to the police on 20th August when JW said she did not wish a prosecution to be pursued.

16. The final incident, prior to John Barrett's arrest on 8th January 2002, occurred on 31st December 2001. He was standing on the pavement when a police car pulled up on the other side of the road. He threw a piece of chewing gum at the police car. According to the police, when he was asked to pick it up he became abusive and started flailing his arms in an aggressive manner. He was arrested, which he resisted, and while he was being restrained he spat at the arresting officer. He was charged

[18] Refer to Chapter 1.5 paragraphs 54 - 55 Dr Yates's report

with affray and assaulting a police officer. He was bailed to appear at South Western Magistrates' Court on 4th January 2002. When he attended court on that date he was carrying a lock knife which was taken from him. The case was remanded for a probation report and he was bailed to return on 25th January. The 31st December matter was not taken further because on 8th January 2002 he was arrested for three serious assaults and remanded in custody.

17. In summary, prior to 2002 John Barrett had a long criminal record. By the time he was 28 he had been convicted more than 25 times and custodial sentences had been imposed on eight separate occasions. Most of his recorded offences were for theft and burglary but he also had several convictions for offences of interpersonal violence, including robbery. Following his release from prison in 1994, at the age of 31, he was not convicted of any further offence until the index offences of January 2002. In the intervening period, however, he committed a number of assaults, at least some of which were in the context of abnormal beliefs related to an untreated mental illness. He was charged with several of these offences but none resulted in a criminal conviction.

Chapter 1.4 - January 2002 Index Offences

1. On 20th September 2002 John Barrett was convicted of three offences committed on 8th January 2002: one of wounding with intent (section 18 of the Offences Against the Person Act 1861) and two of unlawful wounding (section 20).

2. On Tuesday 8th January 2002 John Barrett attended the genito-urinary clinic at St George's Hospital Tooting. He arrived at about midday shortly before the principal victim. While waiting with his partner to be seen, the principal victim noticed that John Barrett was staring at them. Both he and John Barrett were called through to the male waiting area in the clinic at the same time, and as the principal victim was sitting down he noticed that John Barrett was standing about 10 feet away staring and smiling at him. He thought this was strange and he asked him whether there was a problem. John Barrett replied that there was a problem - between the two of them - and he asked the principal victim whether he wanted to go outside and *"sort it out"*.

3. John Barrett then left the clinic but the principal victim did not follow him. Instead he went to speak to staff. John Barrett then returned and shouted at him, again demanding that he go outside to fight. An argument ensued. The two men started shouting abuse at each other. During the argument John Barrett hinted that he had a weapon in his pocket. His demeanour was threatening and the principal victim was frightened. He punched John Barrett in the face. At this John Barrett stepped back, took a knife from his pocket and lunged at the principal victim's chest. He managed to avoid the first blow but John Barrett lunged again and this time the knife went into his chest. He tried to defend himself but John Barrett succeeded in stabbing him again in the chest.

4. The principal victim managed to move away but John Barrett came after him and stabbed him a third time in the chest. They wrestled each other to the ground and John Barrett stabbed the principal victim twice more in the back. He ended up on the floor on his back with John Barrett leaning over him trying to stab him again in the chest. He was able to avoid further injury by holding John Barrett's wrist. Staff and members of the public intervened and John Barrett got up and ran out of the clinic.

He was followed from the hospital and was seen to throw the knife away as he walked along. Police officers arrived and he was arrested.

5. One of the staff members who intervened was the senior sister at the clinic. She received a deep gash to her right arm and a cut to her right leg as John Barrett fended her away. The third person injured was a male patient. He tried to separate the two men and was injured when John Barrett sprang forward waving the knife in front of him in a slashing motion.

6. The three victims were taken to the accident and emergency department at St George's Hospital. The principal victim required emergency surgery to treat stab wounds to his chest. One of the wounds penetrated over 6 centimetres, coming close to his heart. He was a fit young man and it is likely that the injuries would have been even more serious had he not managed partially to restrain John Barrett. The member of staff who had intervened lost the use of her right hand because of damage to her ulnar nerve. The third victim also sustained serious injuries.

7. Witness statements taken at the time described John Barrett's unusual behaviour that day. The principal victim described his demeanour when he entered the clinic: *"he was singing and clicking his fingers as he walked along"*. He also described him staring at a woman who was in the waiting area and said that the woman clearly felt uncomfortable because she moved away. He said that a little later on, while they were waiting in the male waiting area of the clinic, John Barrett was shadow boxing. He said that he did this for a couple of seconds and afterwards he started singing and humming to himself. The principal victim's partner said in her statement that she first noticed John Barrett as they arrived at the clinic:

> *A man walked past us both and I noticed he was smirking at me. He continued to walk for about 20-30 seconds and in this time got about 2 feet in front of us. He then turned around to face us both and with his arms outstretched to his sides he began shouting in a loud chanting manner 'Leon', 'Leon'. He then turned around and continued walking, I thought that this was very strange and looked behind myself to see if he had been shouting at someone behind us,*

there was nobody at all. I immediately thought that the man might be on drugs due to his strange behaviour.

Another person who attended the clinic that day also noticed that John Barrett kept staring at people and *"moving his arms and legs as if he was dancing"*.

8. When John Barrett was interviewed about the assaults the following day, he claimed he had been acting in self-defence in response to an attack by the principal victim. He said that he had believed that the principal victim was carrying a knife. He could not explain the injuries to the two other victims. He said he had the knife with him because he feared being attacked by a man who had attacked him seven years before and whom he had seen again within the last few days.

9. In police interviews John Barrett explained the connection in his mind between the assault on the principal victim and previous incidents when he said he had been threatened. He described a confrontation with a man on a train who, he alleged, was threatening to kill him and JW. This was the incident before he was admitted for the first time to Springfield Hospital in 1997.[19] He explained that 10 days before the incident at St George's Hospital he had seen the man who had threatened him in 1997 and the man had again threatened to kill him. Following that threat he had armed himself with a lock knife. This was his explanation for carrying the knife when he attended the clinic on 8th January. He also said that on the night of 7th January he had consumed *"a fair amount of alcohol"* and smoked cannabis.

10. John Barrett was remanded to Wandsworth prison where he remained until he was admitted to the Shaftesbury Clinic on 16th April 2002, under sections 48/49 of the Mental Health Act 1983. In subsequent interviews with psychiatrists he disclosed paranoid delusions which he was experiencing at the time of the assaults, including the belief that the principal victim was a 'mate' of the man who he alleged had threatened him in 1997. He also disclosed his longstanding delusion that he was under police surveillance.

[19] Refer to Chapter 1.5 paragraph 2

Chapter 1.5 - Psychiatric History and Clinical Management
March 1997 - January 2002

Introduction

1. In this and the following two chapters we record John Barrett's history of psychiatric illness and treatment from his first known contact with mental health services in 1997 until he was arrested on the 2nd September 2004. We draw attention to reported abnormalities of mental state, to features of his behaviour which gave cause for concern and to the response of services, specifically the care and treatment interventions that were used to manage his illness and behaviour. This section of the report is descriptive. Our analysis is in Part 2 where in chapters 2.2 to 2.5 we discuss John Barrett's clinical management.

First Admission: 5th - 10th March 1997 (informal)

2. On 5th March 1997 John Barrett was seen at Wandsworth police station by the duty psychiatrist and an approved social worker (ASW), having been taken there by the police after he had followed a man to the latter's home. It seems that he felt threatened by this man who was a stranger to him. John Barrett reportedly stated that over the preceding two years there had been a *"covert operation"* against him, run by the police and *"the community"*. He said that the day before he had got off the tube and felt threatened by a man. The notes record: *"followed the man home, apparently he didn't want to but the other man was provoking him to fight"*. It is not clear whether his 'not wanting to' refers to the action of following home, or fighting, but the context suggests the former. He is reported as saying that he tried to talk to the man politely but was unable to do so, and that the man telephoned the police once he was inside his home.

3. When John Barrett was assessed on 5th March, the mental state examination recorded:

> *Thoughts illogical. Well encapsulated delusional system regarding the police and the community. Believes he has been followed for four years but was told*

that he was wrong. This time feels he has to go with a solicitor. Also feels he has to go to the Job Centre and find a job. Believes the police have been stressing him out for things that he did before going to prison. Insight – none. Impression – paranoid illness query drug related. Heavy cannabis usage was noted.

4. He was admitted informally on 5th March and a further assessment took place on 6th March to review whether compulsory detention was necessary. He agreed to stay informally to see Dr Gabriella Zolese, consultant psychiatrist. The notes state: *"Diagnosis unclear – query early hypo-manic illness query paranoid disorder query acute psychotic episode"*. The following is also recorded: *"will get girlfriend to see ward doctor this pm to discuss his normal mental state"*. The report of the ASW included the following assessment:

It was my view and that of both Doctors present that Mr Barrett represented a risk to the man he believed was persecuting him… Mr Barrett did not present as actively hallucinated but he told us that the voice telling him it would kill his girlfriend and himself was 'thrown' as if by a ventriloquist and also that his partner was capable of telekinesis.[20]

5. When reviewed on 7th March John Barrett repeated much of his previous account, and linked his beliefs regarding police surveillance to his having had sexual relations with girls under the age of consent.[21] It is also recorded that: *"Paranoid beliefs had resulted in domestic violence"* and that, according to JW:

The situation has escalated over a year and his beliefs have held him back in every area of his life. Has perceived events and people as part of the campaign against him including girlfriend [JW]. *Had felt that the flat was bugged. Has perceived her friends as being part of the conspiracy.*

[20] Telekinesis is the ability to influence the behaviour of physical matter by mental intention or activity.
[21] Refer to Chapter 1.3 paragraph 4

It was decided that he was not detainable. JW wanted him to return home but to remain in contact with the community mental health team (CMHT) and he was given trial weekend leave at home.

6. He returned to hospital on Monday 10th March for a review. The notes record:

> *Says that he is no longer under the impression that the police are following him. Quite guarded, suspicious during the interview. Advised about taking medication. Not very willing. Very irritable. Query paranoid personality disorder.*

The plan was that he should be discharged, to be seen about a week later in the out-patient clinic. A urine drug screen was to be done and he was advised to stay away from drugs.

Out-patient follow-up: March – May 1997

7. When reviewed on 18th March it was noted that:

> *He is rather circumstantial at interview. Still wonders if the police are keeping track of him. However, since stopping cannabis less so. No other paranoid/ psychotic ideation elicited. Keen to try and be off cannabis for 6 weeks – does not want to try medication – not sectionable. Remains vaguely suspicious. Diagnosis paranoid personality disorder with query drug induced delusional disorder.*

8. On 11th April there was a telephone call from the police stating that John Barrett had been arrested and charged with threats to kill. Dr Zolese, in a letter to John Barrett's GP, indicated that he had been arrested for threatening to kill a shopkeeper, and examined by a forensic medical examiner ('police surgeon') who did not think he was ill. Dr Zolese's opinion was:

> *Quite strongly that he is quite suspicious and that these paranoid delusions have been around for a number of years… given that his level of arousal is*

actually getting out of control and he has twice been in trouble with the police, I put it to him that he should take medication or we should consider taking him into hospital.

On 2nd May 1997 at an out-patient appointment he agreed to take an anti-psychotic drug, Risperidone 2mg daily.

Second Admission: 8th May – 6th June 1997 (section 2 of the Mental Health Act)

9. Dr Zolese saw John Barrett on 8th May and he was detained under section 2 of the Mental Health Act. He was reportedly very over-aroused:

Has met the man who he followed out of tube. He [the other man] *threatened to kill him. He told 'listen punk I know who you are'. Very threatening, wants to harm him. Difficult to interrupt – at times quite confrontational* [with social worker].

10. An entry in the notes on 8th May records that this detention was in the light of concern about the safety of others. It is not clear whether the two incidents (in March and May) involved one man or two separate individuals. The 8th May notes record the account he gave that his abnormal beliefs started two weeks before his release from prison in 1994:

Suddenly no one was talking to him and he believed the wardens had spread some malicious story about him. He did not fantasise what the malicious story could have been for fear of turning 'psychotic'. In the recent past he has been preoccupied with the 'semantics' 'little meanings', 'the fine print, the important things lawyers could use against you in court leading to million-dollar suits'. The 'semantics' leads to rows and fights between him and his girlfriend. He believed that the police had him under surveillance and got his girlfriend to watch through the curtains to prove that cars were driving away, and thought the police sirens were more frequent when he was in his flat. He was accused of threatening an employee at the employment agency – they

have exchanged 'fuck up finger signals and insults'. He was warned by the police to stay away from a shop.

11. On mental state examination, his speech was said to be guarded with plausible paranoid content and his thoughts were how he could get out of the mental health system. No hallucinations were elicited, and against the term delusions is a note: *"says if he wins three lottery numbers that's an odd experience, etc. fatuous grin".* The notes record that he had not taken medication at home after the March admission.

12. Over the weekend of 16th – 18th May 1997 there were two episodes of apparently aggressive behaviour. On one occasion he became aroused and removed a patient's clothes and belongings from the bed area; on the second he accused another patient of staring at him and his girlfriend. He also became threatening and abusive towards staff. It is recorded on 21st May that his behaviour and actions could be quite unpredictable at times and that he was not allowed outside the hospital grounds. It is noted on 4th June that JW, who was John Barrett's nearest relative under the Mental Health Act, was objecting to a further period of detention under section 3 of the Act. On the need for further detention the notes record:

We think there is no immediate danger (mainly homicidal) if he is going to leave the hospital. He did not think he was psychotic however he will comply and take all the medication we recommend for him. He refused to take a depot injection [22] for two reasons – 1. because his girlfriend thinks it is too early for him to take a depot and 2. he hates needles. Since the introduction of Droperidol [an anti-psychotic drug] *John's behaviour has changed dramatically. He is more able to control himself, less intimidating and challenging, less interfering and argumentative. He does not dispute diagnosis of paranoia but does not value hospital intervention. Convinced that police are monitoring him and using others to help. Remains paranoid but unwilling to stay in hospital.*

[22] This is a long-acting intramuscular injection

On 6th June immediately following the expiry of the 28 day period of detention under section 2, John Barrett discharged himself against medical advice.

Out-patient follow-up: June 1997 – January 1998

13. On 16th June he saw Dr Zolese and a CPN. It was noted that: *"John was a little over-familiar and inappropriate with Dr Zolese"*. Thereafter, he failed to attend a number of out-patient appointments. The CPN telephoned to rearrange these but again he did not attend. He was finally seen on 29th August 1997:

> *Appeared quite aroused, slipping from excitable to irritable. Signed a form permitting medical details to be released to the DSS* [Department of Social Security]*: was a little suspicious about this. Quite irritable and argumentative, didn't want to stay for long.*

14. On 17th October Dr Zolese and the CPN carried out a joint visit to John Barrett's home. JW was present. The notes record:

> *Stopped medication a few weeks ago, says he felt fine, today very guarded. Paranoid. The last three weeks he was involved in three different incidents with members of the public and the police were called. No charges pressed. Persuaded to restart medication.*

The next entry is on 20th October when he telephoned the CMHT: "*extremely difficult to follow what he is saying. No insight*".

15. On 31st October 1997 John Barrett was seen at the out-patient clinic. He was said to be "*calm and relaxed, remained guarded, thought blocking ++*". He stated that he was taking medication regularly. He repeated the same statement on 3rd November but it is evident that the person who made the entry in the notes doubted this was true. On 10th November he was "*no different. Remains guarded and lacks insight. Quite suspicious. Says he takes medication regularly but claims there is no need for it*".

16. Two contacts on 17th and 21st November 1997 record the view of JW that he was not taking medication regularly. On 24th November there was a meeting with JW, Dr Zolese and the CPN:

> *John Barrett was involved in another incident whilst in Cambridge looking for a job. Had a fight with one of the managers at the factory and was told to get out or* [they would] *call the police. JW feels that there is no improvement in his mental state. Remains quite paranoid and calls the police regularly.*

17. In December 1997 JW is recorded as stating that he was not taking medication. John Barrett had been calling the police again asking them to charge him, presumably with the sexual offences which he had reported to them. On 8th January 1998 JW telephoned to report that there was no change in his mental state, that he was very argumentative and paranoid and that she was frightened of him at times. It seems that during the Christmas period he had spent some time with his brother and he had admitted that he had smoked cannabis.

Third Admission: 27th January – 2nd July 1998 (section 3 of the Mental Health Act)

18. On 27th January John Barrett was compulsorily admitted under section 3 of the Mental Health Act, having been assessed at home by Dr Zolese and an ASW. He had apparently tried to strangle JW who was said to have bruising around the neck. On mental state examination, the description of John Barrett was "*rather odd, perplexed manner looked suspicious. Guarded answers*".

19. An in-patient assessment on 28th January described his account as "*rather circumstantial and pseudophilosophical*". Information from JW was that he had accused her of being a special agent on a mission to keep him under surveillance and that he had been accusing all his friends of being part of the plot: "*He has held these beliefs for the past three months – she has not told us because she feels she betrays him and feels guilty*". The violent incident began at a friend's house when JW asked him not to use the telephone. He became very angry and smashed the telephone against the wall, accusing her of being part of the plot.

20. The in-patient management plan incorporated the use of depot anti-psychotic medication. A strict abscond procedure was put in place which included informing JW if he went absent without leave (AWOL).

21. Circumstantiality and perplexity were again noted on 5th February. On 17th February he was provocative in an Occupational Therapy (OT) group. On 23rd February it is recorded that: *"after a period of a few days symptom free after taking the depot… he is still having the same persecution ideas"*. The dose of the depot was increased. There was further provocative behaviour, including sexually inappropriate remarks, at an OT group on 24th February.

22. By 19th March he had been allowed home on leave although seemingly experiencing some side-effects from the depot injection. He was perhaps improving: *"feels the police are too busy to keep an eye on him… girlfriend says he is no problem"*.

23. By 27th March, while still subject to section 3, he was granted a month's leave from the ward. It was recorded on that date: *"Very much better. Full insight. Says he feels ashamed of what he has been doing to people"*. However, his insight appeared variable as on the 24th and 27th April he is variously recorded as having *"some insight"* and *"partial insight"*.

24. On 26th May JW reported that she was pleased with his progress and that there were no problems with the relationship.

Out-patient follow-up: July 1998 – August 1999

25. On 2nd July 1998 John Barrett was discharged from section 3. It is apparent that medication was thereafter discontinued as by 13th July he reported that *"he feels fine without medication"*. He obtained work as a traffic warden and continued this from approximately September 1998 until early 1999. On 20th April 1999 the notes record that he felt very well and had a new job in telesales.

26. On 18th June 1999 JW telephoned to report that he had relapsed. For the preceding three weeks he had been very paranoid and had got into a fight while under the

influence of alcohol, and had been arrested. She was convinced that he was smoking cannabis again. This was what was recorded:

> *Yesterday he threatened her* [JW] *if she contacted me. Now he is talking about getting a hostage. Advised to inform police but refuses. Now John has moved out of the flat and* [she] *doesn't know where he is.*

This was discussed with Dr Zolese who advised that the police should be called. The custody officer was contacted: "*but he was too busy to talk to me and promised to call me back later"*. The notes do not contain an entry to indicate that the call was returned.

27. On 12th July 1999 he was seen at home: "*Appears quite suspicious with thought blocking"*. On 19th July JW telephoned and reported that John Barrett had accused one of the neighbours of having an affair with her. On 26th July JW and John Barrett were seen jointly by Dr Zolese. JW confirmed that he was very paranoid: "*Has been approaching members of the public accusing them of things, and trying to pick a fight with them"*.

28. By 30th July the team had decided that he should be assessed at home for admission under the Mental Health Act.

Fourth Admission: 3rd August - 8th November 1999 (informal and section 3 of the Mental Health Act)

29. On 3rd August 1999, John Barrett self-presented on the ward and, following assessment, he was admitted voluntarily. He said people had been approaching him and walking past him and giving *"ambiguous"* statements. He was said to be an abscond risk.

30. On 5th August mental state examination confirmed the beliefs previously noted, that he was insightless. He told the doctor that "*the fastest way out of hospital is to comply"*. He was said to be clearly suffering from a delusional disorder. After a short period when he was kept free of medication so that his mental state could be

assessed, he was started on Risperidone an anti-psychotic. On 9th August he was detained under section 3 of the Mental Health Act. The thinking behind this appears to have been that he could then be sent on leave while subject to compulsory treatment. Dr Zolese's entry on 9th August was:

> *Has been speaking about aspects of the supposed delusional system to staff – very vague. No particular concerns about his behaviour on the ward… Plan – Restart Risperidone after completing section 3 – then discharge* [from hospital on leave].

31. On 16th August in an OT session, sexually inappropriate comments were noted. By 23rd August he was described as compliant with medication. There had been a reduction of the ideation that JW was involved in a plot. He was sent on two weeks' leave.

32. On 2nd September JW telephoned to report that he was relapsing, again becoming paranoid and very argumentative. She could not be sure that he was taking medication. John Barrett did not return from leave as planned for the ward round on 6th September. Costas Michael, the CPN who had previously seen him at home, expressed concern that John Barrett might be relapsing. Mr Michael saw him later on 6th September. He denied having any problem with JW or any psychotic phenomena, but Mr Michael recorded that he was "*quite evasive and thought blocking"* and *"I feel he is covering up his symptoms"*.

33. A ward round review on 13th September recorded few concerns, but he was evasive and dismissive in relation to medication and had a humourless response to questions about delusions. He seemed more relaxed. He was sent on a further one month's leave.

34. On 15th October JW telephoned and reported that he was *"up and down"* and had been shouting at her, accusing her of plotting against him. Similar information was communicated during a meeting on 19th October.

35. On 20th October John Barrett initially refused to meet with staff but eventually did so. He was reportedly extremely difficult and argumentative. He refused to discuss anything. He was said to be paranoid and suspicious, and JW was frightened of him. His leave was rescinded and he was brought back into hospital.

36. By 25th October he was on anti-psychotic medication in liquid form. JW was spending a lot of time with him and said he was much better. A note was made that he could commence depot injection instead of the oral liquid, and that he should not go and live with JW again: "*because she just rings this hospital when she thinks he should come in. He will just yoyo between here in hospital and JW's flat*".

37. On 1st November there was a ward round which JW attended:

> *Has been settled in behaviour on ward. JW agrees that he has been settled and that he should be discharged. She says that relapses are sparked by stress following which he becomes non-compliant with medication, resulting in the development of paranoia. JW agrees that in future when she becomes worried about his mood/behaviour she will contact our team and will also be open with John Barrett about the fact that she has done so. No change to medication.*

38. On 8th November John Barrett was reviewed again at a ward round which incorporated a section 117 after-care planning meeting which JW attended.[23] It was agreed that he should be discharged.

Out-patient follow-up: November 1999 – May 2000

39. John Barrett was next seen on 3rd December and then again on 21st December when he said that he had "*weaned*" himself off medication. There were no immediate concerns about his mental state.

[23] Section 117 of the Mental Health Act imposes a duty to provide after-care to a patient who has been detained under section 3.

40. The next recorded contact was on 4th April 2000 when Mr Michael made an urgent home visit following a telephone call from neighbours to social services expressing concerns about John Barrett's behaviour. He had been knocking on doors, looking though windows late at night and harassing people.

41. He was reviewed by Dr Zolese on 10th April when she commented that *"it was extremely difficult to ascertain if he is actually ill"*. In addition to the information regarding doors and windows, Dr Zolese's letter to John Barrett's GP implies that the neighbour believed John Barrett had broken into the neighbour's flat two weeks earlier, moved objects around and filled the bath with water.

42. On 3rd May JW telephoned to report that the previous night John Barrett had become paranoid and angry, and had assaulted her. She did not want to report it to the police: "*She would like more help for John from our team and is happy to wait until tomorrow*". The note of the telephone call indicated that this would be discussed with Dr Zolese, and meanwhile JW's plan was not to return to their shared home that day. In the light of this information a Mental Health Act assessment was arranged. John Barrett was said to be very guarded. He denied that he had assaulted JW and he refused treatment or informal admission.

Fifth Admission: 8th May – October 2000 (section 3 of the Mental Health Act)

43. John Barrett was detained under section 3 and admitted to Bluebell Ward, Springfield Hospital on 8th May 2000. It was reported that he had stopped taking his medication some time ago and had relapsed:

> *He has recently assaulted his girlfriend… He has sprayed salt around his flat… He sprayed salt outside his flat to stop the demons coming in.*

When reviewed that day:

> *He was unable to answer questions and kept going* [off] *at a tangent, becoming circumstantial and remained guarded regarding any possible psychotic symptoms that he might have been experiencing recently.*

He was said to have reported a belief in telepathic powers. The content of this belief was not recorded. The initial plan was to observe him without regular medication. Thereafter he was noted to be hostile and paranoid. He expressed the view that doctors were lazy and could be part of the conspiracy, admitted to a recent fight with his girlfriend and said he did not need medication. By 11th May it was decided that he would be commenced on a depot anti-psychotic and that he would not be allowed any leave. The decision was also made to request a review by a forensic psychiatrist.

44. On 14th May he was reported to have made sexually inappropriate comments and to have been verbally aggressive. On 16th May he was disruptive in an OT session and referred to his ability to be psychic, stating that he had been "*psychic for two years*". On 18th May it was decided to increase the frequency of his depot injection, from four weekly to two weekly, so as to effectively double the dose. Over-familiarity with females and verbal abuse to nursing staff continued.

45. On 20th May, having threatened a fellow patient, he then attacked him and when efforts were made to break up the confrontation he also attacked a nurse. John Barrett later said that he had been provoked and had been in control of himself when he punched the patient. These assaults were reported to the police and he was transferred to John Meyer Ward, a locked psychiatric intensive care unit (PICU). On the same day JW telephoned the ward and said, among other things, that she felt no one listened to John Barrett and that he had never been assessed properly. She also commented that when he was very sarcastic this was a sign that he was unwell.

46. A ward round note of 23rd May records that John Barrett was calm and appropriately behaved on John Meyer Ward despite provocation from other patients, but that previously on Bluebell Ward his behaviour had been manipulative and that "*he assaulted the other patient without provocation*".

47. By 24th May he was seemingly viewed as sufficiently settled to be transferred from the locked ward to Seacole, an open ward. On 30th May he was said to show "*complete lack of responsibility for two incidents while on Bluebell"*. A referral had been made

on 26th May to Dr Jonathan Vince, consultant forensic psychiatrist, for a forensic assessment.

48. Thereafter he was commonly referred to as being calm, cooperative, appropriate, friendly and non-threatening, with occasional comments regarding suspiciousness and declining to talk about core details. As his presentation seemingly improved he was allowed leave in the hospital grounds. At 8.30pm on 4th June he was noted to be missing from the ward. After confirming with JW that she had not seen him, the abscond procedure was implemented. He remained AWOL on 5th June. On 6th June the CPN telephoned the ward to report that John Barrett had telephoned him and had asked for medication to be left at JW's flat, although he would not say where he was. That same day the ward manager visited the ward to advise nursing staff of the consultant's dissatisfaction that the team were not told that John Barrett had gone AWOL.

49. The nursing notes on 7th June, by which date John Barrett had been returned to the hospital by police officers who had found him on Battersea Bridge, indicate that he had absconded from the ward while on ground leave as he felt frustrated that he did not know how long he would be in hospital. He had been to stay with a friend – someone other than JW. He expressed the view that his asking for medication to be delivered to JW was an example of him being responsible. However, he seemingly had no comment to make about the fact of the police finding him wandering on Battersea Bridge. Leave was stopped and a plan made to increase the dose of his depot.

50. After seeming settled and calm for the preceding two days, on 10th June John Barrett was involved in an altercation in which he struck a fellow patient. He also issued further threats to a nurse whom he blamed for an assault. As a consequence he was transferred back to John Meyer Ward on 10th June. Following this transfer a mental state examination on 12th June described him as:

> *Suspicious, guarded, initially intimidating manner. Denies persecutory beliefs re. CID or police following him, said he held these beliefs in the past but no longer. When questioned about what he had told* [a member of staff] *today re. police and secret service etc. he denied this. However, admitted that on John*

Meyer ward he feels he is 'fighting the world'. Does not consider himself unwell or in need of being in hospital.

51. An entry in the notes on 12th June reads:

Dr Zolese believes he is deluded and as a result he is very dangerous. She has requested a forensic opinion from Dr Vince. Dr Moodley [consultant psychiatrist, John Meyer Ward] *suggests the request is also sent to Dr Oyebode. Plan: repeated mental state examinations aim to find evidence of delusions.*

On 13th June a member of staff observed John Barrett looking at him in a strange manner. When asked why, he said *"I got the power"* and that he alone *"is fighting the world"*. Asked what he meant by that, John Barrett said *"the national secret service"* was spying on him:

The secret service has special powers that they use to control people in the community. The police are watching him too, and [he] *said the reason for the police spying on him is because of some sexual misdemeanour which happened some fifteen years ago… He continued to say not until he gets some of the people in the community and put their hands behind them and break their feet before they will give some names and numbers.*

52. The record of the ward round on 13th June noted that Seacole, Yew and Bluebell wards were not prepared to accept John Barrett back because of his history of aggressive incidents while on those wards. He was also described as occasionally making snide comments about less able patients. On 13th June he attempted to scale the secure garden wall. He was described as physically threatening in body language when pulled down by staff. He said *"I wasn't trying to escape… I could do that whenever I want. I was just testing you"*. He implied that there was a conspiracy against him.

53. On 14th June his mental state was described as:

Friendly in manner, verging on inappropriate at times, speech content mostly appropriate although at times rather convoluted and verging on nonsensical (especially regarding semantics).

On 16th June he was noted: "*to be settled yet to be laughing to himself at times*". On 20th June a ward round decision was taken that he should not attend a planned dental appointment because of the abscond risk. An entry shortly afterwards on 22nd June, notes that he expressed some regret over past behaviour which had led to his transfer to John Meyer Ward.

54. He was seen by a forensic SpR, Dr Yates, on 19th June. Dr Yates wrote a report on John Barrett which is dated 27thJune 2000. On mental state examination Dr Yates described him as having:

A somewhat superior and grand manner but no disinhibition. He is guarded and circumspect. Wary and untrusting…

Dr Yates described John Barrett's beliefs:

His system of persecutory and referential beliefs are certainly intact in a historical sense if somewhat modified. On direct questioning he denies ongoing abnormal beliefs about present or recent past in the context of community, police, girlfriend, psychiatric personnel or other patient involvement in an ongoing conspiracy. However, he makes an expanded and detailed point that if there were he saw no reason to trust me or to admit anything that might count against him.

As for John Barrett's insight, Dr Yates described it as "*extremely limited*":

He does not acknowledge any illness or need for medication nor of any involvement with psychiatric services. He does not acknowledge that he may pose a serious threat to others. He reports that he would only ever react if provoked and only use violence if it was first used against himself.

Dr Yates's opinion was that:

> *Mr Barrett would appear to be suffering with persistent delusional disorder that has existed for some six years… There are associated paranoid features to his personality and it has proved impossible to engage him in therapeutic relationships. There are indications from his history… of associated antisocial personality disorder… His delusional system is extensive but well encapsulated. It has had a direct adverse effect on his global functioning but there is no indication of a more pervasive amotivational syndrome nor clear signs of first rank symptoms that would suggest an alternative diagnosis of paranoid schizophrenia*[24].
>
> *He quite clearly poses an immediate risk of provocative and relatively unprovoked violent behaviour. There would also seem to be a potential for more serious assaults, possible homicide, the likely victim being his long term partner, JW. This risk would seem to be associated with the intensity of his delusional system, his sense of self-justification, suspicions of partner's infidelity and involvement in conspiracy against him. …His psychosis is quite encapsulated and does not appear to impair other higher functions so that he is quite able to mask his delusional system on formal and repeated mental state examinations with experienced mental health professionals.*

55. Dr Yates recommended breaching John Barrett's medical confidentiality to warn JW about the risk he posed to her safety. He also recommended a supervised discharge order under section 25A of the Mental Health Act to manage John Barrett in the community following discharge from section 3. In view of John Barrett's past non-compliance with medication, he recommended that future anti-psychotic medication be prescribed in depot form. As for future management in the community, he advised:

> *Monitoring him with intensification of this monitoring when he stops his medication and sectioning him under the 1983 Mental Health Act at the first hint of psychosis.*

[24] Refer Chapter 2.3 for a description of the symptoms of schizophrenia.

His view, which he had formed in discussion with Dr Vince, was that all the Forensic Service could usefully offer was a clinical psychologist in Dr Vince's team acting in a consultative capacity "*especially in regard to engaging Mr Barrett's partner*". Dr Yates acknowledged that open acute wards were not willing to accept John Barrett because of his past violence, and recommended that he be granted home leave from John Meyer Ward forthwith:

> *There is little at present to indicate that the high risks for more serious violence offences against his girlfriend or others is anything but non-immediate*.

56. By 23rd June John Barrett's mental state was reported to have improved, with less suspicion and hostility, and he was said no longer to need John Meyer Ward, but rather transfer to an open ward. On 26th June he threw a cup of hot tea over a fellow patient.

57. On 30th June Dr Zolese telephoned the ward and a nurse made the following record of their conversation:

> *Asking me if I knew anything about John Barrett. Apparently a message was passed to Dr Walters by Daisy Choy that John Barrett should not be removed from John Meyer ward until Prof. Burns* [clinical director] *has been involved in this. Message was not received by Dr Walters at that stage*.

58. On 2nd July there was an episode of verbal abuse towards a female fellow patient. He remained essentially settled thereafter. On 4th July it was recorded that Dr Yates's report had been received and the recommendations noted in the ward round. Alterations were made to the dose of his depot anti-psychotic and leave given in the care of JW.

59. On 17th July at the ward round Dr Zolese "*discussed need for supervised discharge order – must see team and if does not comply can be recalled into hospital*".[25] John

[25] This is not strictly accurate as there is no power of recall to hospital under section 25A supervised discharge.

Barrett's settled mood continued through July and he remained at home on leave. He withdrew his applications for discharge from section 3 to both the hospital managers and the tribunal.

60. By 31st July John Barrett was described as reporting himself as well yet over-medicated. He is recorded as saying that treatment has helped "*giving me time to clear my mind of unhealthy thoughts*". He requested a dose reduction or a change to a less sedating treatment. He was given leave until 14th August.

61. On 4th August JW telephoned expressing concern that he was over-medicated, appeared drowsy, hot to the touch, and had been incontinent the preceding night. The call was transferred to a member of the medical team who advised that he return to the ward for assessment. That assessment found nothing of note. As a precautionary measure a blood sample was taken (for CK – an enzyme, the levels of which can rise in the event of a rare but potentially fatal reaction to anti-psychotic medication).

62. On 28th August, following the expiry of his agreed leave at 2pm, and perhaps given that he was due for a further depot injection that day, the AWOL procedure was implemented because of his failure to return to the ward. The police subsequently telephoned to say that he was at his partner's address. He returned to the ward the following day.

63. John Barrett apparently applied again to the tribunal following his withdrawal in July. A tribunal which convened on 25th September was adjourned until 16th October, primarily to permit time for the team to apply for section 25A supervised discharge. In an addendum report for the tribunal, dated 6th October 2000, Dr Zolese wrote:

> *Mr Barrett has been for periods of section 17 leave since the end of July. He has progressed well although he has no insight into his illness. He still does not see the point in continuing medication but he has nevertheless been compliant. He has taken Flupenthixol 40mg* [depot anti-psychotic] *every two weeks.*

In the event supervised discharge was instituted, John Barrett was discharged from section 3 and the tribunal was cancelled.

64. In September 2000 John Barrett was granted the tenancy of a flat in Putney which was in the catchment area of a different CMHT. It was arranged for Dr Zolese and Dr Rob Bale, consultant psychiatrist, jointly to visit John Barrett at home to discuss discharge and handover to Dr Bale. The visit took place on 12th October.

Out-patient follow-up: October 2000 – May 2001

65. On 16th October, the application for supervised discharge having been made and accepted, John Barrett was discharged from section 3 to the care of the Putney CMHT. Whilst subject to supervised discharge, and under the medical care of Dr Bale, his care co-ordinator under Care Programme Approach (CPA) arrangements was a social worker, Mark Veldmeijer, who was a member of the Putney CMHT. On 18th October a telephone discussion took place with John Barrett when he explained he had decided not to have any more medication. In November there was a CPA meeting at which Dr Bale suggested to John Barrett that he consider taking an oral anti-psychotic medication at times of increased stress.

66. On 5th January 2001 there was a telephone discussion between Mr Veldmeijer and JW. She told him she would be moving out of John Barrett's flat the following week:

> *Thinks his mental health is ok. She states that he has been using cannabis which makes him paranoid, also ecstasy. Does not want John Barrett to know this as 'he would kill me'. Had been worried about him in November, behaviour was 'over the top' – shouting a lot when out.*

John Barrett had embarked on a new relationship, with a Polish woman. Despite this JW remained a significant informant as to his mental state.

67. Mr Veldmeijer maintained contact in January and February 2001, although John Barrett repeatedly missed appointments which then had to be rearranged. The only

matter of concern reported was that on 21st February he was irritable with the team secretary.

68. On 7th March it is recorded: "*John Barrett informed yesterday that his father had died. Appeared tired. Says now living with new girlfriend*". On 4th April he was seen in out-patients by Dr Bale:

> *Problems with relationship with* [new girlfriend]. *Have been arguing, he has been 'aggressive' but would not expand on this. No clear signs of illness, no current threats. (Unsure as to this as no independent informant). However I remain concerned. On review I do not believe there are grounds to continue on Section 25 or that it will have an impact on his care – he has been off medication and poorly compliant despite Section 25. I note his past history. I have briefly discussed him with his GP who does not have prior knowledge. I have discussed him in the CMHT and there is a consensus that Section 25 is no longer appropriate. The plan – discharge Section 25. Mr Barrett remains at risk of further breakdowns with the potential for aggression despite our interventions.*

The section 25A was not renewed and thus expired in mid-April.

69. On 10th April Mr Veldmeijer spoke to JW:

> *She reports over the last two weeks she has seen John Barrett to have increased snappiness, increased verbal aggression, rent arrears, talking about the past more. Believes he is right at the start of relapse – can take two months from this point to relapse fully.*

On 18th April, when Mr Veldmeijer spoke to him, John Barrett was angry and complained about the team's continuing role: "*he does not want any assistance from CMHT*". On 26th April they spoke again. John Barrett had failed to attend the CPA meeting that day. He was apologetic about the previous conversation. However, he made clear that he wanted no further appointments with Mr Veldmeijer. The plan recorded on that date was for transfer of the care co-ordinator role to Dr Bale:

If information suggests John Barrett is unwell, consider need for Mental Health [Act] *assessment due to the risk of violence he presents when unwell.*

70. On 15th May, in a telephone conversation with Mr Veldmeijer, JW described John Barrett as threatening and aggressive, with symptoms of paranoia *"talk of conspiracy to ruin his life"*, with JW being the organiser of this *"tipped over the edge… dangerous… hates me… very frightening"*. She had left the flat because she was frightened. John Barrett then sent her three threatening text messages accusing her of being poison, a witch and a corpse, saying he hated her yet loved her. His Polish girlfriend had left him apparently because he was threatening towards her. Mr Veldmeijer advised JW not to see John Barrett again. He and Dr Bale discussed what JW had said and they decided to assess John Barrett for admission under the Mental Health Act. Anticipating that John Barrett would not allow access, Mr Veldmeijer obtained a magistrate's warrant under section 135(1) of the Mental Health Act which authorised him to enter John Barrett's home and remove him to a place of safety.

71. When on 18th May Mr Veldmeijer and Dr Bale attended with police John Barrett opened the door of his flat and co-operated with the assessment. He was conveyed to Springfield Hospital as authorised by the section 135 warrant.

Sixth Admission: 18th May – 29th May 2001 (section 2 of the Mental Health Act)

72. According to Dr Bale's note of the 18th May assessment, John Barrett was:

Aroused, irritable, guarded, questioned our presence. Says he is okay and just going for a job interview. Plan: recommend Section 3. Assess. Urine drug screen. Rapid tranquilisation is necessary. Restart Depixol.

An admission note by a junior doctor includes the statement: *"long history of paranoid personality disorder"*. This diagnosis is repeated later in the entry.

73. On 19th May the notes initially record him as settled and calm in mood, but subsequently on the 20th**:**

Demands in an arrogant and slightly grandiose manner. Appears more focused on communicating with female staff. Observed to be suspicious at times… Appeared suspicious and guarded.

During assessment for section 2 on the 21st he is described as:

Guarded, suspicious, taking a lot of time to answer questions and giving the impression of covering his signs of mental illness. Somewhat grandiose.

74. He was detained under section 2 on 21st May. He was said to be settled until given copies of the section 2 papers and an explanation of his rights. He was then described as very angry and trying to anger everyone on the ward. He was reported to be getting physically close to female nursing staff on the ward and as only wanting to deal with them, to the exclusion of male staff. At 9pm on 21st May the duty doctor was called because John Barrett had become involved in a fight with another patient some four hours previously. He refused to be seen. An incident report notes that he was found in the OT room standing over a fellow patient, the latter on the floor, having apparently been fighting. Later in the evening he spoke to his then girlfriend and was described as being evasive in answering her questions.

75. On 22nd May he was asked about the circumstances leading to his admission. He said that the reason for admission was that neighbours had made a complaint about him. He also said that his last girlfriend (by implication JW) had left him as she disagreed with him with about the treatment of his mental illness, and specifically his need for medication. He said that he was mildly paranoid about five years previously but he denied any other abnormal beliefs then or at the time of this admission. This same entry contains a detailed review of his past psychiatric history including: the first 1997 incident when he followed a stranger, the threat to an employment agency employee in May 1997, the 1998 detention following the attempted strangulation of JW, his involvement in a fight in June 1999 whilst intoxicated when an intensification of his delusional system was noticed, the April 2000 odd behaviour in relation to neighbours including moving things around a neighbour's house, and his belief reported in May 2000 about telepathic powers.

76. On 22nd May, having been told by Mr Veldmeijer that JW had been receiving abusive text messages from John Barrett, nurses acted to remove a mobile phone from him at which he became agitated. Later that day he was described as suspicious about other patients and staff.

77. On 22nd May Mr Veldmeijer documented a telephone conversation with John Barrett's mother, to the effect that an aunt suffered from schizophrenia for which she received monthly injections.

78. On 24th May he was calm and controlled, articulate, but guarded and suspicious in manner. He was said to be unhappy about taking any medication but prepared to accept it if he had no choice, and a decision was taken that he should recommence Depixol (an anti-psychotic depot injection), 60mg fortnightly. Later that day he challenged a junior doctor regarding the need for medication; and when his unusual behaviours were listed to him, particularly the threatening text messages, he became very suspicious and interrogated the doctor to find out how he had known this, concluding that JW had spoken about it to Dr Bale.

79. On 27th May he spent a long time on the telephone questioning JW. He was also observed to be talking about religious matters and it was noted that he did not appear relaxed. Although by 28th May he was described as interacting appropriately, on 29th May he was said to be quite guarded and not communicating much.

80. When he was reviewed on 29th May by Dr Bale, information was provided by Mr Veldmeijer that John Barrett's mother thought he was more settled and that JW had said that he was back to his old self. Dr Bale recorded that: "*that despite the history I can see no grounds for section 3 as he is willing to comply with treatment and follow-up*". The decision was therefore made to discharge him from detention under section 2. He was to have 60mg of Depixol that day and to be supplied with tablets of Olanzapine 10mg daily to take when he left hospital.

81. In his evidence to this Inquiry, Dr Bale commented on this short admission. He said that section 2, admission for assessment, had been used in preference to section 3, admission for treatment, because:

> *It was difficult to elicit any clear symptoms, but we decided to medicate him anyway. We used a section 2 rather than a section 3 because we weren't sure what we were dealing with at that point and felt we had to go for reassessment.*

Having admitted John Barrett to John Meyer Ward:

> *I think there were two occasions where people thought they'd got some symptoms but there was nothing very clear-cut. It was also a ward where he had been managed previously when he had been 'ill', and they found it very difficult to elicit anything in particular. He stayed longer there than normal; I would normally have put anyone else on an open ward. It was his history that made us go for the PICU, but we didn't get anything in particular.*

Of the decision on 29th May not to apply for detention under section 3, Dr Bale told us:

> *From the team's contacts, I think with mother and JW, that he was back to his normal self, whatever normal self was, so if we were looking for grounds for continuing a detention, at least for section 3, we had less grounds than we had two weeks previously. At that point, JW had been expressing concerns very clearly, and it was part of the rationale for some of our decisions when she said he was back to his usual self. He was 'agreeing to comply with some medication'. We knew it wasn't likely to carry on for a long time, but again it was an attempt to try and continue some form of engagement with him. He was challenging whether we had any grounds to keep him in hospital.*

82. Early in the admission Dr Bale had requested a further assessment of John Barrett by a forensic psychiatrist, but this had not taken place by time he was discharged and did not take place thereafter.

Out-patient follow-up: May 2001 – January 2002

83. On 5th June John Barrett attended an out-patient appointment and said that he was taking the anti-psychotic medication, Olanzapine 10mg. A further prescription was issued. He did not attend the next appointment on 12th June but did telephone the following day requesting a further prescription. He did not attend a further out-patient appointment on 26th June but he had been telephoned on 22nd June when John Barrett said: *"he was okay and coping, and that the Olanzapine was okay but slows him down"*. He did not attend an appointment on 27th June. A chase-up telephone call the following day indicated that he was working and was feeling fine and he said he was taking his medication.

84. An entry on 24th July indicates that Mr Veldmeijer conveyed John Barrett to out-patients. He was said to be still taking Olanzapine and he asked how long he would need to be on it. At an out-patient appointment on 23rd August John Barrett told Dr Bale that he was well and that he was taking medication. However, the note records a difficult interview and that: *"he appeared somewhat hostile"*. An entry by Mr Veldmeijer on 23rd August records a telephone conversation with JW in which she reported that:

> *At the weekend John threatened to kill her several times and was very malicious in his threats – also threatened to follow her to her family's home and get her there as well.*

A subsequent telephone call on the 29th August was made by Mr Veldmeijer to JW, a message being left to the effect that Dr Bale's view was that they were unable to use the Mental Health Act. Dr Bale explained this to us:

> *He was very difficult at any point to detect anything, but I couldn't detect anything so I was going to be doing a mental health recommendation on the basis of hearsay. We had done that once already and had to discharge him. You can always create an argument for those, but the likelihood of getting effective follow-up, if any, was diminishing further. He was making some tacit*

agreement to make some contact with us; it seemed better to try and work with that, so that's what we carried on with.

85. The next medical entry in the notes is dated 28th November. John Barrett telephoned to indicate that he could not attend an appointment as he had a job interview. He denied any current problems. He had not attended an out-patient appointment since August. However, he had been in contact with Mr Veldmeijer who recorded in an entry dated 29th September that John Barrett was seemingly well. It is also of note that John Barrett's GP's notes record that in September he collected a prescription for 30 days' supply of Olanzapine, although it is not known whether he was taking the medication. Dr Bale told us:

He may have taken some but I'm not convinced. He was astute enough to know to collect [prescriptions] *because he would know that we would check up.*[26]

86. Dr Bale summarised the difficulty of assessing John Barrett, in effect of knowing at any particular time whether he was mentally unwell:

He is one of those patients that sticks in your mind… not just because of what he did but because he was very hard to assess. He could also be quite seductive when you were attempting to assess him. He knew what answers to give you; he was – and I assume still is – an articulate, intelligent man, so he had ways of trying to engage people and avoid subjects – he was very good at that. On the one level he could be very engaging and quite persuasive; on the other hand you never got a straight answer from him. He was difficult to develop any real sense of a so-called therapeutic relationship.

He also told us that:

One of our difficulties was we had never seen John ill. We had taken him over after a period of treatment and when we saw him none of us was able to elicit

[26] See also what he told the social worker on 9th January 2002 – Chapter 1.6 paragraph 1.

symptoms or signs of illness; he didn't particularly acknowledge it, and [JW] *was our only source of information.*

Mr Veldmeijer commented:

However, there is a very real difficulty in assessing his mental state because of skills he seemed to pick up. I wouldn't generally use the term 'guarded', but he was someone who appeared guarded but also was evasive and seemed to have enough insight of the proceedings, whether that is a Mental Health Act assessment or community mental health team appointments, to know what things may get him into trouble in the sense of involvement of Mental Health Act or other professionals. That was always a difficulty in assessing John in that, perhaps because of our wariness due to the risk that is documented, we would seek to be involved as early as possible. The difficulty in being involved early, his symptoms may not be fully developed, therefore those symptoms are often easier to be masked or hidden. Being involved early to prevent risk to others meant it was more difficult to get a clear assessment of symptoms and his mental state.

87. At the time of the January 2002 index offences, John Barrett had not been seen by Dr Bale or any other member of the CMHT for more than four months. However, he was still in contact with the team. We have referred above to his telephone call on 28th November 2001. In early January 2002 he telephoned the CMHT again to make an appointment with Dr Bale which was arranged for 15th January, on Dr Bale's return from leave. As it transpired that appointment was not kept because he was arrested before that date.

Chapter 1.6 - Psychiatric History and Clinical Management
January 2002 - October 2003

Psychiatric assessments while on remand in HMP Wandsworth: January – April 2002

1. Following his arrest on 8th January 2002, John Barrett was seen by a forensic medical examiner who described him as mentally fit for interview and charge. On 9th January he was seen by a social worker, who was to act as the appropriate adult (a safeguard for those believed to be mentally vulnerable) during police interviews in relation to the assaults of the previous day. The social worker recorded that he was calm, although establishing a rapport was initially quite difficult and he was thoughtful in giving his answers. He told the social worker that he had stopped taking medication several months previously, with the agreement of Dr Bale.[27] He said that he had been drinking at least a bottle of wine daily, together with beer, and smoking a quarter of an ounce of cannabis per week in response to stresses brought on by unemployment and relationships. As a consequence of the alcohol abuse John Barrett thought he was experiencing withdrawal, and he described a number of physical symptoms, none of which were objectively apparent to the social worker. He denied experiencing any abnormal thoughts or perceptions and in particular denied feelings of persecution or paranoia. We have summarised in Chapter 1.4 the account he gave when he was interviewed by the police about the 8th January offences.

2. On 14th January he was seen in Wandsworth prison for the first time by Dr Oyebode, consultant forensic psychiatrist. John Barrett's account to Dr Oyebode was that:

> *He had been threatened by a man in the street and told he would be killed. He recognised the person as somebody who had previously threatened to kill him and JW. He started carrying a knife to protect himself. Two or three days after he purchased the knife he expected something untoward to occur and also presumed they knew who he was. In relation to the 8th January assaults, he said that the principal victim followed him and then returned to the waiting room. He said the two of them fell over and that he was on top. It was*

[27] This misrepresented Dr Bale's advice about medication.

only then that he realised that the man did not have a weapon, so he removed himself from the situation. He commented that apparently a couple of nurses or staff were hurt during this fight.[28]

Dr Oyebode found no significant abnormality in mental state.

3. The note of an interview in prison on 26th January gave the diagnosis as schizophrenia. An entry by Dr Oyebode on 8th February noted that John Barrett:

Still feels under stress, still feels traumatised by events which led to his remand, and does not accept that he suffers from any mental illness or needs treatment.

4. An entry in the inmate medical record on 22nd February described John Barrett as paranoid and guarded. He had threatened self-harm if staff did not get him tobacco. On 11th March an entry recorded him as having an infectious laugh, circumstantial in his speech and over-inclusive. A piece of his conversation was transcribed as: "*dentist/dental floss/nice tie doctor*".

5. On 8th April John Barrett was seen in the health care centre at Wandsworth prison by Dr Bartlett, consultant forensic psychiatrist, to assess whether his mental disorder warranted transfer to hospital under the Mental Health Act. Dr Elaine Chung, who at the time was Dr Bartlett's SHO, made detailed contemporaneous notes of what John Barrett said at interview.

6. The 8th April assessment noted the presence of a persistent delusional system, specifically that he was under surveillance because of his previous offending:

He has at times questioned the possibility that he is mistaken but fundamentally believes it to be the case. Incident 7 years ago, 5 years ago and index offence in which he believed himself to be in fear of his life. Therefore he carried a knife…

[28] This version differs in a number of respects from accounts given by witnesses: refer to Chapter 1.4.

He was described by Dr Bartlett as:

> *Difficult to interrupt. Slightly grandiose and dismissive. Psychotic coldness. Cold ideas. No signs of remorse re. index offence. Very minimal remorse re. injury of nurses. Regularly misusing words, using polysyllabic words inappropriately.*

7. A further entry for 8th April records the view of nurses in the prison, that:

> *At times he can hold it together and come across as being very rational although there is something that is difficult to pinpoint that seems wrong. Concern that he can be very dangerous.*

Dr Bartlett concluded that: "[he] *seems to be desperately holding it together"*. He was "*not averse to transfer to hospital"* and complained about the length of time he had been in prison as he thought he should have been seen and moved out sooner. He "*was very interested in the different types of section and their favourability"*. Arrangements were made for him to be transferred to the Shaftesbury Clinic under sections 48/49 of the Mental Health Act.

Treatment in the Shaftesbury Clinic before conviction: 16th April – 20th September 2002 (sections 48/49 of the Mental Health Act)

8. On 16th April John Barrett was admitted to Seymour Ward under the care of Dr Bartlett. It was noted that he had been taking no medication in Wandsworth prison and that he had commented that he always believed himself to be over-medicated and never felt he needed it. Mental state examination on admission showed:

> *Initially appeared to be laughing at* [the assessing doctor], *finding interview amusing, game playing, later rapport warmed but possibly a slight subtle flirtatious sexually inappropriate aspect – not overt. More expansive re delusional system. Irritable re medication. Speech circumferential at times*

using long words at times inappropriately. Affect slightly elated… grandiose re perfect body and unbelievable dancer. Persecutory delusional system.

9. The note of Dr Bartlett's ward round on 23rd April records the discussion as being a current provisional diagnosis of persistent delusional disorder with underlying narcissistic and antisocial personality traits. He was said to be apparently compliant with medication. By 29th April it was agreed that the dose of Risperidone, an oral anti-psychotic, should increase. At the ward round on 30th April it was noted that the psychologist only saw John Barrett for a brief period as the nurses were concerned for her safety. There was exploration as to whether he was really compliant with medication, as he had been seen walking off after receiving it. The question was posed: "*What is it about him that is making the nurses anxious?*" The answer proposed was: "*psychosis + underlying psychopathology + similarity to other patient*". We presume this refers to another patient who had caused the team concern. At a ward round on 7th May a number of abnormal features of his mental state were described:

Seizing every opportunity to engage in philosophical discussion, legend, Pope John Paul 1… said as police not carrying briefcase therefore not looking for him. Talking to and laughing to self loudly in toilet and corridor yesterday.

At this meeting it was recorded that Susan Sturdy would be his social worker.

10. A ward round on 14th May noted that he continued to be deluded, claiming to be a millionaire or to be Pope John Paul; and he had been observed talking to himself. At this ward round, attended by Dr Bartlett, John Barrett was said to be more guarded than when seen in prison, his speech was more thought disordered, and the impression was recorded that he was suffering from schizophrenia because there was a wider range of psychotic phenomena than previously suspected. On 16th May he had a fight with another patient. It was unclear who started it, as it was not witnessed. The following day he was noted to be grandiose and thought disordered.

11. On 21st May JW asked to talk to his key worker in confidence about some delusional remarks she said John Barrett had made. At the ward round on the same day it was noted that on 17th May he reported himself to be a millionaire and had said "*When I*

leave the ward in 5 months will go to the French Riviera" with his *"nubious beauty"*. This was viewed as delusional. The preceding day he had been involved in a fight during which he was overheard making boastful comments: *"I've got a blank cheque"*. The ward round notes for 21st May are extensive, running to more than three pages, with discussions and views from others recorded and conclusions noted – in particular that there had been four altercations over the preceding four weeks.

12. On 23rd May he was reviewed by Dr Bartlett's SHO who reported his mental state as including circumstantial speech and some neologisms[29] – there was a brief note as to whether they were true neologisms or just incorrect use of big words. He was described as still reluctant to discuss JW. John Barrett denied any current "*subversive*" phenomena *"if there ever was any"*, and he gave three possibilities by way of explanation of his past experience:

1. *John was suffering from mental illness when he first met this man seven years ago (though notably doesn't allow for the possibility that this man never existed) - no clear explanation for alleviation of symptoms.*
2. *The man is part of a government conspiracy – but doubts raised that the government would use someone so unhinged – no clear explanation.*
3. *John became stressed as a result of subversive phenomena.*

The entry continues:

> *He claimed to now think that the* [principal] *victim* [of the 8th January offences] *was an innocent bystander in which case John was 'disappointed' 1) that a verbal incident could result in this, 2) that he had been carrying a knife for ten days - a 'cruel twist of fate for me and him', and 3) that he had been involved in mental health services for seven years.*

John Barrett described the mental health services as adversaries. The possibility was raised that he was feigning illness superimposed upon an existing mental illness.

[29] Neologism – a new word or condensed combination of several words coined by a person to express a highly complex idea not readily understood by others

13. On 24th May there was further exploration of his attitudes in an interview with Dr Bartlett's SpR, Dr Colin Campbell:

> *In my experience of the mental health teams it is not honesty is always the best policy. If they know I'm being monitored, but say that the government is too busy to spy then honesty is not always the policy with regard to… - when asked if he meant he might not tell me* [Dr Campbell] *if he had any symptoms he denied this.*

The conclusion was drawn that he was thought disordered, guarded, over-controlled with suppressed irritability, and that there was evidence of paranoid ideation together with over-elaborate speech and idiosyncratic word use.

14. At the ward round on 28th May with Dr Bartlett there was discussion of JW's confidential disclosure of John Barrett's thinking about being a millionaire:

> *Refers to the reason for attacking the man, related to MI5 being after him, and believes police acknowledged they were wrong therefore* [they] *have deposited £60 million in his account.*

He had also admitted to JW auditory hallucinations lasting one minute several times a day. The preceding day he had reported that a white deposit was seen in his urine and said that he had *"a broken dick"* and that: *"he wanted a Chinese doctor to fix it"*. He was also overheard speaking on the telephone, saying that he might have prostate cancer. At the 28th May ward round the decision was taken to increase the dose of Risperidone and to change the prescription from tablets to syrup. He was subsequently described as more tense when discussing the team's decision to increase his medication. He denied experiencing any psychotic phenomena.

15. On 15th June, following a visit to him, JW reported to staff that John Barrett had told her he was being held illegally, believing that he was the only person who was held illegally and that he did not need to tell this to the psychiatrist as she already knew:

John believes that people know what is happening to him telepathically. John confessed [to JW] *that he has been having a battle with these telepaths (voices) because of the money they have to pay 'They have to knock it down' from 16 million to 12 million. John said when he is let out he is going to chop off somebody's finger because that's what differentiates a human from a chimpanzee… John said the telepaths had tried to help him kill himself in Wandsworth prison but he didn't. He was also going to kill a priest, probably one of the chaplains, because the priest was red when talking to him. John has asked his girlfriend to bring him a book so that he can write his thoughts. It is only by writing down his thoughts he can remember them. As the telepaths are always trying to erase his thoughts. John believes he is on telly a lot. Girlfriend stated that a similar thing had happened four years ago. When he believed he is on telly 24 hours a day and everything is about him.*

On 17th June he was reported to have behaved as if responding to auditory hallucinations and also to have displayed incongruous laughter.

16. On 18th June at a ward round with Dr Bartlett the question was asked: "*Do we believe girlfriend. He has attacked her… Is he getting any better*". The comment was also made: "*we want rapid resolution of the criminal case"*.

17. JW visited on 22nd June and on leaving she told staff that she was glad that he had not been granted unescorted ground leave because whenever he was granted unescorted leave he would abscond because his delusions were that his colleagues were making millions of pounds outside.

18. On 1st July an in-depth discussion explored a number of factors including the index offences of 8th January 2002. John Barrett described his perception of a threat from a man some five days previously, leading to his becoming increasingly concerned that he or JW would be attacked, such that he bought a knife in order to protect himself. He consumed alcohol and one joint of cannabis the night before he attended the genito-urinary clinic at St George's. He described the principal victim as becoming verbally abusive and punching him in the face. He described having had the *"forethought"* not to stab him in the chest, and that if he had lost the *"forethought"* he might well have

done so. [30] The note of the discussion also records: "*yet also states that he was not thinking during the attack*". It was concluded at Dr Bartlett's ward round on 2nd July that he should not attend the court unnecessarily as he was a very high abscond risk especially as the reality of his situation was dawning on him.

19. At interview with Dr Bartlett on 5th July he denied any link between covert operations and the principal victim of the index offence, and also denied the possibility that he could be mentally ill. On 9th July the team discussed persisting difficulties arising from John Barrett's interaction with a female member of OT staff which, they concluded, had echoes of his past behaviour in the community with his accusations about the neighbour having an affair with JW. The discussion concluded that the diagnosis was a well encapsulated delusional disorder possibly with more schizophrenic symptoms than previously suspected, and increasing evidence of antisocial personality disorder for which the results of a psychology assessment were awaited. In the light of the continuing concern regarding the female OT, John Barrett was to transfer to another ward.

20. Dr Campbell's report, for the Crown Court dated 9th July, provided an opinion on diagnosis and recommendations on John Barrett's fitness to plead and the relevance of any mental disorder to the alleged offences. Dr Campbell reported that in his opinion:

> *John Barrett was* [at the time of the offences] *suffering from a psychotic disorder characterised by non-bizarre paranoid delusions of more than one month's duration. These delusions centre on a man who has been a longstanding focus of Mr Barrett's delusional system. This presentation is consistent with a diagnosis of persistent delusional disorder (DSM-IV) and is historically similar to previous episodes of disturbed behaviour which have precipitated admission to hospital. More recently, behaviour observed in prison and on the ward has suggested he experiences phenomena beyond those described historically and which may be suggestive of a diagnosis of schizophrenia. This has included episodes where Mr Barrett has expressed ideas of reference and has been noted to be shouting and giggling to himself in*

[30] This version differs in a number of respects from accounts given by witnesses and is not consistent with the principal victim's injuries: refer to Chapter 1.4.

his room. However, no first rank symptoms of schizophrenia have been confirmed and there is no evidence of negative symptoms of schizophrenia.[31] *In view of this, it is my opinion that, at present, Mr Barrett is appropriately placed in conditions of medium security and that he must remain in hospital for a further period of assessment and treatment.*

21. In relation to John Barrett's personality, Dr Campbell's report said:

He has difficulty containing frustration and frequently resorts to violence. His menacing and provocative behaviour has been described both in the community and during periods of admission to hospital. There is also evidence that he shows little remorse and makes no attempts at reparation following episodes of aggressive or violent behaviour.

Dr Campbell concluded that:

The contribution of Mr Barrett's possible personality disorder to the alleged index offences has yet to be clarified. Mr Barrett is currently undergoing a series of personality assessments, the outcome of which will be available to the Court in due course.

22. The personality assessments to which Dr Campbell referred were being carried out by a chartered clinical psychologist at the Shaftesbury Clinic, Sharon Leicht. She reported in August that between 25th April and 13th August 2002 John Barrett had been seen on at least seventeen occasions "*for assessment regarding his suitability for psychological treatment*". Ten separate psychometric assessment measures were used. Ms Leicht reported that:

Although Mr Barrett responded to many of the written assessments in a guarded or biased manner, it would appear that over time the effect of medication, together with a secure environment, allowed him to explore psychological issues in a more realistic, less-defended manner.

[31] Refer to Chapter 2.3 for a description of the symptoms of schizophrenia.

She recommended cognitive therapy to address issues of low self-esteem, self-worth, emotional dependency and unresolved issues about relationships, particularly his early relationships with both parents. In addition she proposed participation "*in a programme to consider issues of relapse prevention of his mental illness*" and "*to address offending behaviour*".

23. On 5th August a discussion took place between JW and Dr Bartlett. JW had told staff that John Barrett had decided he was going to abscond on 16th August (when a court hearing was due to take place in his case). She reported that he had stopped talking about voices and she believed that his medication was dampening the illness down. He had asked her to arrange various things for him which might assist him after he had absconded. Dr Bartlett was concerned for JW's safety if he got out and a note was made that her mobile phone number needed to be in the action plan.

24. On 13th August a ward round with Dr Bartlett discussed information that John Barrett had asked his brother for assistance in advance of a planned abscond on the way to court, including his brother's passport and national insurance number. The ward round documented that he:

> *Still believes society owes him compensation of £15 million in bank. If money isn't there in bank account when he gets out on Friday would kill self + someone else, not someone specific, someone he believes is rich i.e. wearing a suit.*

The discussion of 13th August noted that it was clear that his violence was secondary to mental illness. Given his comments and the perceived risk of his absconding, a decision was taken to seek an opinion from Broadmoor Hospital, although it was recognised that he might not be accepted for admission. The results of Ms Leicht's psychology assessment were discussed. John Barrett had scored above average on planning and perceptual organisation. A personality profile in May had been invalidated by bizarre responses, and a further assessment of personality when more settled nevertheless had validity scores suggestive of an invalid picture. Assessment of anger indicated that angry feelings were likely to be situational and that he was able

to suppress them rather than expressing them. Impulsivity was described as almost zero. The comment was made that he knew how to respond to self-report, that is to say that he may have been able to fake the test results.

25. On the instructions of John Barrett's solicitors, Dr Tony Nayani, consultant psychiatrist, prepared a psychiatric report dated 15th August. He agreed with Dr Campbell that at the time of the offence:

> *John Barrett was suffering from a psychotic disorder that was characterised by paranoid delusions. These delusions were in the context of a longstanding delusional disorder… I consider that it is highly unlikely that Mr Barrett was taking medication at this time and to make matters worse, he was probably drinking too much; he admits to smoking cannabis.*

Dr Nayani's opinion was that John Barrett was fit to plead and stand trial and that he was appropriately placed in conditions of medium security. He concluded:

> *The defendant suffers from a chronic and enduring mental disorder, namely persistent delusional disorder that is characterised by intense fluctuating feelings of paranoia. I would recommend a section 37* [hospital order] *with a restriction order attached.*

26. John Barrett was seen by a psychiatrist from Broadmoor Hospital on 6th September. Following that assessment the Broadmoor admissions panel declined to offer a bed.

27. As described in Chapter 1.4 on John Barrett pleading guilty to three offences under the Offences Against the Person Act 1861 a restricted hospital order under sections 37/41 of the Mental Health Act 1983 was imposed on 20th September 2002. He returned to the Shaftesbury Clinic.

Treatment in the Shaftesbury Clinic after conviction: 20th September 2002 – 10th October 2003 (sections 37/41 of the Mental Health Act)

28. On 14th October John Barrett was assessed by Dr Campbell who recorded the range of matters they discussed. These included the outcome of his court appearance, the disposal by way of sections 37/41 and the size of the police escort to and from court. In respect of the latter John Barrett appeared to believe that the decision was made by the police while it had in fact been made by the multi-disciplinary team because of their concern that he might try to escape.

29. John Barrett's progress on the unit was discussed, including the gradual resolution of his grandiosity and sexual disinhibition. He disagreed that this constituted a clear improvement which reflected an underlying resolution of his psychosis, and he made some statements which claimed a reality basis and justification for his previous ideation. With regard to the index offences he made a clear connection between his long-standing beliefs about police surveillance and the man who he claimed had threatened him and JW on the tube in 1997, saying that this was the same man who threatened him five days before the index offences of January 2002. He believed that this man was connected with the principal victim but recalled thinking at the time that it was too much of a coincidence. John Barrett said that he would not have been placed in a medium secure unit if he had not been punched first and if he had not been carrying a knife. He was said to concede that his illness played a role in the index offences. He was recorded as remaining guarded.

30. With regard to progress since sentencing, John Barrett said he felt he was not doing enough OT, and he was keen to have ground leave. He was recorded as being aware of the lack of psychology input and keen to build on previous work. In this regard the transfer of his care to another team within the Forensic Service, that of Dr Gillian Mezey consultant forensic psychiatrist, was discussed and the rationale given was that this would facilitate access to a psychologist. John Barrett agreed with this suggestion. He was advised by Dr Campbell that the case conference scheduled for the following day would be cancelled and that a new date would be arranged following transfer to Dr Mezey's team.

31. The ward round minutes for 15th October record the diagnosis as paranoid schizophrenia. It was recorded that he still maintained some aspects of the delusional system and still made a connection between police surveillance and the index offences. He denied grandiose delusions about inheriting a large sum of money from his father. He said that he had only inherited a few thousand pounds. He mentioned that he had made a decision not to make sexually inappropriate remarks because it had got him into trouble in the past. The ward round minutes record that he appeared to have improved. It was noted that he no longer licked his lips as he used to. In discussion it was felt that he had been isolating himself as a way of avoiding getting into trouble. The team's OT thought there was some personality aspect to his inappropriateness. The ward round minutes record that he had been formally transferred to Dr Mezey's team that day. In the meantime the current management plan would continue until he had been reviewed by the new team.

32. On 16th October he was seen by Dr Scott Ferris, SpR in Dr Mezey's team. He was noted to be cooperative and pleasant, *"happy"* and relaxed on the ward with no problems. It was noted that he had moved teams for psychology input. Dr Ferris recorded that John Barrett saw his problem as "*fluctuating paranoia*", as had been described in Dr Nayani's report which John Barrett would have read. It was noted that his condition responded to medication but he had stopped this in the community as he did not think he needed it and he felt sedated. He told Dr Ferris that the onset of mental illness followed three major life events: his career in music had nose-dived in the early 90s, he had got divorced, and he had gone to prison for robbing a post office and had smoked a lot of cannabis in prison. Note was made that he became suspicious of the police. He had had sex with a 15 year old girl and therefore believed he was under surveillance and that people talking to him were spies. Note was made of his background and marital relationship.

33. John Barrett told Dr Ferris about the index offences. He said he was "*carrying knife due to threat from man in street; believed many people carried knives"*. He said that he and the principal victim had got into an argument "*maybe he'd just broken up with his girlfriend or something, he had a problem"*. John Barrett got punched. He

stabbed the man as he thought he might have a knife: "*concedes paranoid at the time*".

34. The note records Dr Ferris's impression that there was no evidence of mental illness currently. He recorded John Barrett as being "*dismissive of his impact/responsibility + impact of his life history*" and that his view was that "*things happen to him*". They discussed projective psychological mechanisms, with Dr Ferris using the example of John Barrett's thinking about other people carrying knives.

35. For 22nd October 2002 there are two sets of ward round minutes, one each for Dr Bartlett's and Dr Mezey's ward rounds. However, the contents of the notes of the former are identical to those of 15th October, and we therefore conclude that Dr Bartlett's team did not discuss John Barrett on 22nd October.

36. The minutes of Dr Mezey's ward round on 22nd October record the diagnosis as paranoid schizophrenia. The nursing report was that he had remained settled. There was no evidence of delusions. He requested a two hour visit from his then girlfriend – not JW. The medical report in the ward round minutes for John Barrett reads:

> *It has been reported that G* [another patient] *has been making sexual innuendos and comments to staff and that this might be as a result of his inability to read social cues appropriately, or to intimidate us. He was seen by Dr Ferris and was appropriate and appeared insightful*.

We do not know whether this entry was intended to refer to John Barrett. The plan was recorded as continuing his leave as one hour escorted garden leave per day. His girlfriend's visit was to remain at one hour per week. There was due to be an extended discussion by the team on 12th November.

37. The minutes of Dr Mezey's ward round on 29th October record the diagnosis as paranoid schizophrenia. The nursing report was that he had remained settled. A general discussion took place, noting the proposed extended session on 12th November and a proposed case conference on 12th January 2003.

38. On 29th October he was also seen by Dr Mezey. He was said to have a "*glib manner*". He was recorded as accepting the hospital order and a diagnosis of delusional disorder. He was prepared to take medication, but did not believe that he would relapse if he stopped taking it. Dr Mezey's entry continues:

> *Tends to minimise past violence/threats to girlfriend. Attributes most of his problems to the man who followed him in 1997 which he is sure was not delusional. Not feel needs more treatment.*

The entry records that: *"he was intending to start an Open University course from hospital with a view to finding employment in future"*. He was described by Dr Mezey as "*somewhat disinhibited, giggling when asked about girlfriend/sexual relationships*". It was also recorded that there was:

> *No current evidence of psychosis – partial insight into delusional disorder – believes was ill but tending to minimise the risk of relapse in the future. Believes the 'man' he saw in 1997 was real.*

The plan was to continue the assessment and to increase the OT programme.

39. He was seen by Dr Ferris on 2nd November when there was discussion regarding the OT with whom there had previously been a problem. The note records that:

> *He had a 'thing' for her – found her attractive. Wanted her to feel good by flattering her. Didn't think it would intimidate her. Sorry it did. No longer has feelings for her. Says he always has been flirtatious, likes fashion and style – comments openly about things said for instance he likes my glasses.*

40. The minutes of the ward round on 5th November record the diagnosis as paranoid schizophrenia. The nursing report was that he had been settled and appropriate. He was described as minimising his index offence in one to one discussion. He had been found smoking in his room and staff suspected that visitors had been bringing him lighters in spite of supervision of visits. The medical report, following Dr Ferris's assessment, was that he appeared to have difficulties meeting professional boundaries

and did not understand staff reaction when he paid them personal compliments. The discussion concluded that there was a real possibility of John Barrett splitting staff, and the whole team were encouraged to be aware of this and to minimise the opportunity as much as possible. Visits were to be more closely monitored.

41. On 10th November he was seen again by Dr Ferris and was described as *"presenting the same"*. They discussed work problems and relationship problems. He said his past violence towards JW occurred: "*because I was paranoid and she couldn't understand"*. He denied hostility towards women. He said he had been disinhibited, not aggressive, towards female staff. He told Dr Ferris that he considered himself "*on a level with staff not patients"*. Dr Ferris noted: "*? grandiosity hence the casual nature of rapport with staff"*.

42. The minutes of the ward round on 12th November record the diagnosis as paranoid schizophrenia. The extended discussion had been postponed to 3rd December. He was reported to be stable and behaving appropriately. Passport application forms had been brought for him by visitors.

43. The minutes of the ward round on 19th November record the diagnosis as paranoid schizophrenia. Nurses reported that:

> *He had been well in the past week. His passport application was still in progress. He was refusing his garden leave. He had requested a psychology assessment and sessions had been scheduled.*

It was noted that he was likely to have another personality assessment done as the previous one was invalid because his responses appeared biased. He was also described as "*quite insightful"*. Discussion took place as to whether the process of his passport application should be interfered with given the team's view that he remained a high risk of absconding.

44. The minutes of the ward round on 26th November record the diagnosis as paranoid schizophrenia. The nursing report was that:

He was well and stable. His reason for applying for a passport was that he believed he was going to be discharged in ten months and wanted to travel abroad.

It was recorded that the plan was to have an extended discussion the following week and that Dr Mezey wished to review his diagnosis.

45. The minutes of the ward round on 3rd December record the diagnosis as paranoid schizophrenia but state that the diagnosis was to be reviewed. The medical report at the ward round was:

It would appear that he has had psychotic episodes in the past which started around the age of 35 years against the background of his wife leaving him. His work being problematic as well as quite marked cannabis abuse. He also had an affair with a 15 year old and this has led to delusions about the police being after him. It is quite clear that he has a mixed personality disorder plus psychotic episodes. There is no evidence of him ever experiencing any first-rank symptoms at any time in the past.[32]

46. The minutes of the ward round on 10th December record the diagnosis as paranoid schizophrenia. A random room search turned up his passport application which had originally been reported by John Barrett as missing. Nurses reported that he had been settled on the ward and that he continued to behave appropriately. The plan was for the social worker (Ms Sturdy) to see John Barrett about the passport application and for nurses and other members of the team to ask him about the implications of the passport application having been found in his room "*with a view to getting his own perspective on the relevance of this*".

47. He was seen by Dr Ferris on 13th December. He denied any problems. They talked about the passport application and the team's reasons for suspecting his abscond risk was high. John Barrett said he thought the team's concern might have related to another patient with whom he associated:

[32] Refer to discussion of diagnosis in Chapter 2.3.

Talked in a very disparaging manner about him – disowned his own 'badness', manipulative tendencies + criminal behaviours - 'I was just mentally ill' – disappointed that we think he may not be what he perceives, became silent and troubled.

48. The minutes of the ward round on 17th December record the diagnosis as delusional disorder. This remained the diagnosis thereafter. The nurses reported that he had been fine on the ward and that his interactions with other patients were pleasant and calm. He continued to attend OT. During a 1:1 session with a nurse he appeared quite concerned that his application for a passport had raised so much suspicion amongst staff. He was therefore prepared to suspend his application until at least after discharge. Ms Sturdy had spoken to him regarding the passport application and advised him that when discharged, he was likely to be given a conditional discharge and it would be best not to think about leaving the country at that stage. The medical team reported that: "*he was well. His mental state was stable"*. There had been a psychology session during the preceding week. He had talked extensively about his offending and the occurrence of violence in his relationships. He was reported as trying to make sense of it all. Dr Mezey commented that it was possible that he might benefit from psychology work when he was discharged from hospital. The plan was that the clinical team would:

Explore issues about John's cannabis use and how much of the abuse he blames on his offending behaviour as this could impact upon his future compliance with medication.

49. In the absence of minutes of the ward round on 24th December, Dr Ferris's handwritten notes record John Barrett as being "*well, appropriate, interacting, polite, attending OT*". A decision on his request for escorted ground leave was postponed until the new year. The ward round minutes of 31st December record him as "*settled in mood*". However, he "a*ppears to disregard the barrier between staff and patients but was apologetic when this was brought up with him*".

50. At the ward round on 7th January 2003 he was reported by nurses to have been "*Settled over last few weeks. Available and generally co-operative*. The psychology report was that: "*he exhibited good insight and motivation to engage in psychological treatment*". The absconding risk was now considered to be low and therefore the decision was made to give him escorted ground leave for one hour per day. Dr Mezey's handwritten note of the ward round concluded that "*he was extremely well – no evidence of psychotic symptoms*".

51. At the ward round on 14th January the nursing report was that his mental state remained stable and his behaviour appropriate. On the same day he was seen by Dr Ferris who recorded that he was well with no psychotic symptoms: "*seems insightful and motivated to continue with Risperidone for as a long as we consider it necessary*".

52. On 20th January Julia Houston, consultant clinical psychologist, wrote a report for the forthcoming case conference. It summarised the six sessions of individual psychology work that John Barrett had undertaken with her since November 2002. She reported that:

> *He engaged and participated well in the sessions. His verbal and non-verbal behaviour had been appropriate at all times, without the intense eye contact that she had observed during the psychology assessments which had been completed the previous summer.*

The sessions had considered his relationships with women, including his violence towards JW. There was discussion of his cannabis use. He was able to question his paranoid ideas about police surveillance which "*he puts down to a combination of his imagination and smoking too much cannabis*". According to the report John Barrett did not consider himself to be in need of further treatment in hospital:

> *Mr Barrett is now looking forward very positively towards the future and is keen to set himself achievable, realistic goals… He is keen to reduce the chance of relapse as far as possible and is willing to continue to take medication. We have discussed the need to abstain from cannabis and looked at the factors which are likely to lead to relapse. He himself is keen now to*

focus on his move to the community and does not feel that he has the need for any further specific psychological work.

Ms Houston concluded:

Psychometric testing does not indicate the presence of any personality disorder or adverse core beliefs that are interfering with his life… There are therefore no recommendations for further individual psychological treatment at this time, although this could be reviewed at a later date should either Mr Barrett himself or the team identify a need for this… It would be useful for Mr Barrett to participate in the Drug Relapse Prevention Group if this runs whilst he is still at the Shaftesbury Clinic, but I would not see this as a pre-requisite that had to be completed prior to his discharge…

53. The case conference took place on 21st January. The minutes record Ms Sturdy's view that an unsettled family background, being in care, without clear boundaries within his family as he grew up and criminality within the family, all resulted in marked deficiencies in his upbringing. The psychology report was that: "*cannabis use and risk factors were highlighted and worked through"*. It was reported that he was able to discuss *"Issues about inappropriate behaviour and history of violence"* quite willingly: "*it would appear that his inappropriate behaviour and violence were conscious choices in his behaviour"*. It was felt that *"his risk of violence is on-going"*. The medical report was that he believed:

He might have been paranoid around the time of his index offence during which he was threatened by his victim. It would appear that John Barrett has only just had a first opportunity of adequate treatment as prior to now he tended not to comply with psychiatric input. His mental state however has been settled in the past month with no history of violence or assaultative behaviour since transfer to the Mezey team. He reports no psychotic symptoms and appears to have gained a large degree of insight into his difficulties which [he] *mainly attributes to cannabis abuse.*

The nursing report was that:

> *His behaviour had improved and he was more amenable to boundary setting, and was using his leave within the hospital grounds appropriately.*

The OT contribution was that:

> *Until recently he had been attending OT groups and managing to be appropriate within them. There was an issue where he would inappropriately stare at OT staff or make inappropriate comments with sexual innuendos to a particular member. These have subsided in the main but there appears to have been one or two recent occasions of this resurfacing. He has also been missing OT groups lately as he would prefer to go on ground leave.*

54. The case conference minutes record that:

> *He was told that he might be eligible to request a tribunal hearing in March 2003 and although John has said he has not quite decided what he intends to do it was made clear to him that the team might be in a position to support him in his request for discharge, albeit conditional discharge if the tribunal hearing is later rather than sooner.*

Under the heading *"Issues for Discussion"* it was recorded that the team "*would probably agree to a conditional discharge"*, that a drug and alcohol rehabilitation process should be undertaken by nursing staff, and that:

> *Further psychological work may be necessary on discharge as he would then probably face more stresses whilst in the community.*

The plan was to make an application to the Home Office for escorted community leave but it was also decided that he was to have no further leave until he engaged more in OT activities.

55. At the ward round on 28th January the nursing report was that:

> *He had been settled and appropriate, interacting well and engaging in OT activities. It was agreed that he could have one hour unescorted ground leave on two separate occasions in the coming week at nurses' discretion.*

56. At the 4th February ward round the nursing report was that:

> *His mental state remained stable with no overt signs of psychosis. He was behaving appropriately and socialising with other patients.*

The medical team reported that:

> *His mental state remained stable, but he seemed apathetic. He was said not to be in any hurry to leave Springfield. Although he was reported to have a few problems with taking medication, he was compliant.*

The plan was to initiate escorted community leaves, to allow him one hour daily unescorted ground leave, for John Barrett to apply for a tribunal in three to four months time; and for Ms Sturdy to see his brother.

57. The nursing report at the ward round on 11th February was that:

> *He had really settled and was displaying no features of psychosis. He was interacting appropriately, attending meetings, using his ground leave and using the telephone less frequently. He was attending OT regularly and was compliant with medication.*

58. He was seen by the team's SHO on 12th February. She recorded his history:

> *Background criminal behaviour. Seven years paranoid delusions that police were following him. No other psychotic phenomena.*[33] *Resulted in index*

[33] This is not accurate as a variety of psychotic phenomena had been noted in John Barrett's history.

offence – stabbed and assaulted medical staff in St George's A & E.[34] *Strong history of substance misuse – marijuana, cocaine, ecstasy.*

He was said to acknowledge that: "*Risperidone is beneficial and controlling paranoid ideation*".

59. At the ward round on 18th February John Barrett was again reported to be stable but he was requesting Procyclidine, which was prescribed to counteract the side-effects of Risperidone. The OT report was that: "*consideration was being given to discharge plans. He would be returning to his flat and was looking at college courses*". It was agreed that a follow-up call would be made to the Home Office regarding the application for escorted community leaves, and his unescorted ground leave would be increased to one hour per shift. Dr Ferris was to see him about side-effects from the medication. They met the next day when John Barrett reported no side-effects except occasional stiffness and salivation. He told Dr Ferris that he was on the waiting list for the drug awareness group. Dr Ferris said he would find out about this and also "*try to do individual work*".

60. At the ward round on 25th February there was no change in his presentation. There had been a negative urine drug screen. The OT reported that he was "*on the waiting list for a few classes which he wished to attend before leaving the unit, and that he planned to become a gym instructor*". It was agreed to pursue the Home Office about the request for escorted community leave, and it was said that he needed to be assessed with pre-discharge psychology input for use on discharge[35]. His unescorted ground leave was increased to two hours per shift.

61. At the ward round on 4th March the discussion is recorded as:

Need for escorted community leave remains paramount especially in view that he is applying for MHRT [mental health review tribunal] *soon. Need to write to the Home Office regarding leave and to apply for unescorted community leave*

[34] This is also inaccurate as the offences did not take place in A & E and two of the three victims were not medical staff.
[35] This is difficult to reconcile with Ms Houston's recommendations – see paragraph 52 above – and it may be that this entry is not an accurate record of what was agreed by the team.

in view of the long delay in response. Patient to meet with visitors on unescorted ground leave. Invitation to Dr Basson's team to the next case conference as he will require adequate support on discharge and they will be following him up on discharge.[36]

62. On 6th March he was transferred from Turner Ward to Waterfield Ward, which is a medium secure forensic rehabilitation ward outside the Shaftesbury Clinic but within Springfield Hospital. At the ward round on 11th March the nursing report was that his mood was settled and he had coped well with the change of ward. He was using his ground leave appropriately, interacting in groups and participating well. The medical report was that he was doing well and had applied to the mental health review tribunal. It was recorded that the team were not happy about the transfer to Waterfield which took place without discussion with any team member. This was fed back to the nursing team leader.

63. At the 18th March ward round it was reported that he remained settled and appropriate. He was interacting well with patients but minimally with staff. He was working constructively in the gym which was "*in keeping with his future plans to do a course in sports and recreation*". Home Office authorisation of escorted community leave was still awaited. This was "*to be utilised as per OT programme including swimming, visiting colleges and local shops*". At the next week's ward round it was reported that escorted community leave had been granted. There were no other changes.

64. On 1st April the ward round minutes record that John Barrett had applied to the tribunal and was likely to have a hearing in June:

We are likely to support a conditional discharge provided he remains mentally stable and insightful. We continue to await OT to arrange his escorted leave. In the meantime he is to have a one off escorted leave for two hours in Tooting. He is granted unlimited unescorted ground leave to report every two

[36] Dr John Basson was the consultant forensic psychiatrist with responsibility for Putney

hours. To consider applying for unescorted community leave in the near future.

He was seen by Dr Mezey on the same day. She recorded that he had applied to the tribunal and would be happy to be granted a conditional discharge as "*he wants to have continuing support after discharge from hospital"*. In relation to the offences of January 2002, she recorded:

Recognises he was ill at the time of the index offence. Was very suspicious, thought other people were involved with the police. Now recognises this was wrong. Recognises that response was excessive. In relation to leave… he wants to start escorted [community] *leave asap. Not yet seen the OT.*

65. At the ward round on 8th April it was reported that his escorted leave in Tooting had gone well. He continued to await his OT programme which would develop a schedule of escorted community leaves. The team discussion was that his next escorted community leave was to be arranged and that: "*he needs two community leaves a week"*. Dr Samantha Scholtz, the team's SHO, was to apply for unescorted leave from the Home Office upon her return from leave. A discharge planning meeting had been arranged for 20th May and Dr John Basson, who it was then believed would be John Barrett's supervising psychiatrist following discharge, was to be invited to attend.

66. It was reported at the following week's ward round that John Barrett had used his community leave to go to the cinema, without any problems. A urine drug screen was negative. It was also reported that he was being visited regularly by JW, who was identified as his girlfriend, and that his brother felt positive about his progress. The OT report was that: "*community leave programme has been installed"*. The psychology report was that it was felt pre-discharge issues would be more appropriately addressed by the keyworker and social worker and if there were any further psychological inputs required they could refer him to the forensic psychology service. There was no plan for psychological follow-up in the community.

67. John Barrett was seen by Dr Scholtz on 17th April when he told her that he had been using his escorted community leave: *"5 sessions to date – used mainly to go to cinema, swim and local shopping for self-catering"*. He was awaiting interview dates from several colleges. Dr Scholtz recorded that his plans for unescorted community leave were vague. She asked him what he would do if he encountered the principal victim of the January 2002 offences. John Barrett said he had decided he would not make contact at all. On mental state examination Dr Scholtz found no abnormalities.

68. At the ward round on 22nd April there was no change. On 29th April it was reported that the Home Office had asked for enquiries to be made about the victims of the January 2002 assaults before they would authorise unescorted community leave. The plan was to continue escorted community leave three times weekly.

69. John Barrett was seen by Dr Ferris on 13th May:

> *No problems elicited/expressed. Very happy, beaming smile. Talking about his 'wonderful flat', learning to cook etc. No evidence of mental illness. Strikingly dramatic contrast with past (from notes). Extent of passive compliance remains unquantified. Very intelligent. Notably able to mask symptoms in past but hopefully this represents a genuine improvement + motivation following a prolonged period on medication + away from outside stress.*

70. At the ward round on 6th May the nurses reported he was taking leave appropriately. He had been talking about his relationship with JW, whom he described as his ex-girlfriend, saying he did not know if there was a future for them. However, he had been observed to be intimate with her on visits. Medical staff reported that he had indicated in the past that the relationship with JW was over and that she was due to leave his flat on discharge. She had been living there while he was in hospital. The OT report was that he had difficulty keeping to his programme. He had not been attending activities regularly and was easily distracted from attending, for example if he met a friend in the hospital canteen. It was also noted that: "*he gives appearance that he is attending but on checking this hasn't actually gone. Also leaves groups early*". The team discussion resolved that he needed to attend OT regularly before he

would be allowed unescorted community leave. Concerns were expressed about him disengaging in the community following discharge: "*need to ensure he is engaged*".

71. On 8th May he met Ms Sturdy to discuss discharge plans. He confirmed that JW would be moving out of the flat:

> *They remain on friendly terms and will continue to have contact, and will see how things go. She remains supportive of him. He is happy for her to be involved in discussions about his care and agreed to her being invited to his case conference*.

72. On 12th May Ms Sturdy and Dr Mezey met JW. Ms Sturdy's record of the meeting includes the following:

> *JW has been concerned about John in recent weeks. Felt that he had been doing really well and no concerns until the last couple of weeks. Had suspected that he had stopped his medication and he was staying up late – only side-effect of medication was that he got tired early and went to bed. He disclosed to her that he had stopped his medication. She encouraged him to restart and he said that he would, but she felt that he was doing so for her rather than himself. He had also reported that he had been hearing the 'telepaths' again. JW is also concerned about the input he receives from Waterfield ward – feels there isn't any from ward staff. She feels that he still needs work on his understanding and acceptance of his illness and need for continuing treatment.*

73. At the ward round on 13th May the nursing report was that he appeared stable and quite pleasant. He was spending most of his time in his room, and not going to OT. The medical report included the information provided by JW the previous day: that he had reportedly not been taking his medication and was experiencing psychotic symptoms, the 'telepaths', and had changed his sleep pattern – staying up late at night. It was also reported that: "*On mental state examination, constantly smiling and incongruous, but not expressing overt paranoid ideas. In past has masked symptoms*".

It was agreed that the team needed to review his mental state and treatment in the light of this information, and that he would be monitored closely.

74. On 16th May John Barrett was seen by Ms Sturdy at his own request. He said that he had been thinking about the case conference which was to take place on 17th June. He told Ms Sturdy that he did not want JW to attend. She recorded:

> *When I asked why he'd changed his mind he said that he thought his brother would be a more appropriate person as his relationship with JW was a past one. He made no mention of their disagreement this week. I asked about his medication in reference to what JW had said. He said that he had not stopped his medication, but had asked her what she'd think if he came off it. He said that Dr Mezey had told him he could probably come off it in 6-12 months,*[37] *but he was thinking of earlier… He said that he would take her advice on the matter. Re the telepaths – he said that they'd previously had a discussion about what her interpretation of him hearing 'whispers' in his head was and if she believed in telepaths. She said 'no' and that it was voices. He said this discussion related to something that had happened in the past when he had been smoking weed, and not recently.*

Ms Sturdy recorded that despite her advice to the contrary he was adamant that he did not wish JW to attend the case conference. Ms Sturdy's record of their meeting concludes:

> *Reviewed pattern of illness as per his history – he agreed with my summary. I said that I still had some concerns in view of his history about his continued engagement and compliance.*

75. On 19th May he was seen by Dr Scholtz and disclosed to her that he had stopped taking medication the previous week and had stayed off it for one week. He did this because he wanted to see if the psychotic symptoms would return. He had believed the symptoms were induced by smoking cannabis and had questioned the need for

[37] There is no reason to believe that Dr Mezey had told him this.

medication. During the medication-free period he said "*he thought he might have had some 'whispers' but he wasn't sure"*. He denied any current psychotic symptoms. He felt no remorse for stopping the medication but he acknowledged that he should have spoken to the team. He said he was taking the medication again and he denied significant symptoms. He told Dr Scholtz that he and JW had agreed to "*rekindle*" their relationship.

76. He was seen later that day by Dr Ferris to whom he gave the same account of his reasons for stopping medication. Dr Ferris recorded that he was "*insistent that team shouldn't penalise him as he restarted* [medication] *himself and now realises the importance of medication – not just cannabis"*. They discussed the need for openness if community treatment was to work, and Dr Ferris warned him: *"our responses more likely to be draconian if we can't trust him or suspect he's withholding/masking symptoms"*.

77. At the ward round on 20th May the nursing report was that over the last week John Barrett had been compliant with his medication, which had been supervised. A meeting was held with several of the patients to discuss compliance and in this way John Barrett was not singled out. The psychology report was that there were no outstanding psychological issues to be explored. A relapse prevention plan had been discussed and John Barrett identified cannabis as a trigger. During the psychologist's interview with him when they had discussed medication he had given no indication that he was not taking it. He had said that in the past he had felt that he was able to manage his illness without medication but he acknowledged that his attempts to do so had failed. Ms Sturdy reported that John Barrett had referred to JW as a past contact who was no longer involved in his care. His account of events was inconsistent but his answers seemed very plausible. She pointed out that after their meeting he had given some indication of acknowledging the recurrence of symptoms and the positive role that JW had played in drawing attention to his non-compliance. The medical report communicated the account he had given Dr Scholtz and added that it had been fed back to him that symptoms could take weeks to recur after stopping medication. On mental state examination there had been no evidence of psychotic symptoms.

78. The record of the team discussion included the following:

It was seen by the team as positive that John was able to tell JW of his non-compliance, in that it indicates that he has support in the community and people that he trusts. However it needs to be fed back to John that the team has serious concerns that he has stopped taking his medication without consulting a member of the team. This leads to the question of whether a depot injection would be more beneficial and is to be considered in his risk management plan. Also John needs to be aware of what a conditional discharge would entail including the consequences of breach of compliance. In his next case conference there needs to be clear identification of risk as well as early signs of relapse and plans for monitoring this in the community.

The plan included monitoring of his attendance on the OT programme and the in-patient programme. OT was to assess whether a fuller programme could be instated. Enquiries were to be made about substance abuse groups on Rowan and Sycamore wards.

79. After the ward round a meeting took place attended by John Barrett, JW, Ms Sturdy and Dr Mezey. There was exploration of the fact that he had stopped his medication for a period without telling staff. Concerns were expressed by JW and by staff, which "*had been making the team reconsider the recommendation they would make to the mental health review tribunal*". John Barrett acknowledged that he had stopped his medication, he said for a maximum of ten days. According to Ms Sturdy's note, from the observed effects it seemed longer: "*If that was the case, it was concerning that changes were observable so quickly*". He said he had stopped as he had wanted to see what would happen. He had started hearing "*whispering*" in the area around his head "*not loud enough to hear what they were saying. Was able to refer to these as voices during the discussion*". He had already re-started his medication and the voices had gone. He was able to acknowledge the link between taking medication and the reduction of symptoms:

Thinks that now he has tried this, he is aware of the risks of stopping and won't do it again. Found it difficult to acknowledge that there might be

circumstances in future where he would feel the same way and try to come off the medication again – he felt that this would not happen.

It was reflected back to him that it was odd, as if he had wanted to be *"found out"*, that he had told JW about stopping medication and the return of symptoms, given that she had told staff in the past when she had had concerns. According to Ms Sturdy's note: "*He found it difficult to be confronted over the reports – had not had any idea that we were aware – bit shocked*". A discussion followed about the risks of stopping medication in future and the importance of openness with team. Reference was made to the risks in relation to JW. There was discussion of the adjustments that needed to be made because of having a mental illness. John Barrett felt that this was not an issue as things were much better than at the time of the index offences. JW disagreed. She felt he still struggled with the impact on his life and relationships. She repeated her concern about the lack of input on the ward and his limited activity programme. It was acknowledged by Dr Mezey and Ms Sturdy that he was on waiting lists for some activities he had chosen to pursue but they encouraged him to engage in other activities while he was waiting.

80. Ms Sturdy's report to the ward round on 27th May was an account of the meeting on 20th May. The nursing report was that there was no change in his mental state. The OT report was that he had only a limited OT programme and his attendance was variable. He was not attending the ward day programme despite this having been stressed as important. There tended to be a discrepancy between his expectations of his functioning on discharge and his engagement with the programme as an in-patient. It was agreed that there should be strict monitoring of OT and ward activity attendance.

81. Ms Sturdy saw John Barrett on 29th May when they discussed the meeting of 20th May. According to her note:

He reflected on this as a positive experience – that something positive had come out of something negative. Has also been able to discuss meeting with JW since and it's helped them to talk more about issues. Discussed issue of adapting to having a mental illness. The aspect he finds hardest is the stigma attached to it. Has also been thinking about whether/what he would say to

potential employers about it. He is still intending to pursue sports course on discharge. Discussed importance of maintaining a structured week without overloading himself.

82. He was seen by Dr Scholtz on 2nd June. She noted: "*rather incongruous affect when discussing* [the work he planned to do after discharge] – *laughing, intense eye contact"*. At the ward round on 3rd June concern was expressed that he appeared to feel that he would not need any extra support or structure when he left hospital:

Currently he will be having one day a week studying a sports and recreation course. Other than that he has not been able to identify other structured facilities in the community.

It remained "*an on-going struggle to engage him in any structured behaviour in groups whilst on the ward"*. The discussion concluded that there needed to be a balance between sufficient structure and daily activity against too much stress. The team would not support a conditional discharge unless the plan for community activity was in place and this needed to be reiterated to John Barrett. He was to be referred to the Rowan Ward day programme for drug rehabilitation and relapse prevention.[38]

83. On 7th June he was seen by Dr Ferris. John Barrett said he was not keen on depot medication. He talked about how he had changed, "*not going back to where he was*". He wanted to buy Dr Mezey flowers to show his gratitude but was told that was inappropriate:

Denies any special relationship but said he has moved through the system quickly?! Said if it was a male consultant he would buy a card, but not flowers – thought about how he relates differently to women.

84. At the ward round on 10th June no change was reported except that he had been referred to the Rowan Ward day programme. When seen by Dr Scholtz on 11th June he engaged in serious discussion but also made attempts at social chit chat and light-

[38] Rowan Ward was the drug misuse service.

hearted diversions. Dr Scholtz noted less inappropriate smiling and that he was not guarded. Despite extensive questioning no delusions were elicited. He denied hallucinations and said he wanted to take medication despite side-effects which he identified as occasional akathisia[39] and loss of libido. He said he saw his time in hospital as positive but he was vague as to why: "*same with medication – saying it was 'calming', kept him 'stable'. No reference to psychotic symptoms*". He referred to cannabis as the most important contributory factor in a possible relapse of his mental illness and said he wanted more help with this. He agreed that the referral that had been made to Rowan Ward was appropriate. They discussed structured activity in the community, about which he was ambivalent: "*sees himself shopping, drinking wine, going to gym*".

85. The case conference took place on 17th June as planned. The nursing report was that his compliance with medication had been carefully monitored and there had been no reports of non-compliance. Random drug urine screens had been negative. Ms Sturdy reported that in the last few weeks he had been talking more openly about his illness but he remained convinced of his own ability to manage it. She was concerned that when discussing medication with him he spoke in a manner which was almost inappropriate about the sexual side-effects he had experienced. Ms Sturdy was positive about JW's involvement in John Barrett's care and she suggested that:

> *Were he be to be discharged at a tribunal, a phased discharge would be more beneficial which would allow unescorted community leave to take place prior to a conditional discharge*.

The OT report was that there had been a change in the last two weeks with increased engagement and the setting of more realistic goals. However, there had been considerable difficulties with engaging him in daily structured programmes. The OT was concerned about the risk of him replacing one drug with another, i.e. alcohol for cannabis, and she felt that his awareness and motivation were at an optimal level for engaging him in relapse prevention. She said she would like to do a formal occupational history with him to identify what support he was receiving at the times

[39] A sensation of restlessness, especially in the legs.

he was coping best in the community and to help bring about some insight into the level of support he would be needing. The medical report was that, in the event of discharge at the tribunal which was due to take place on 8th July, he would require medical follow-up from a CPN and an SpR and he would remain on his current medication. It was reported that changing to depot medication had been discussed with him but it was refused. It was of concern that:

> *He has not had unescorted community leave and this is due to the Home Office requesting that the victims' whereabouts are known prior to allowing the unescorted leave.*

86. The record of the team discussion is as follows:

> *Progress has been rather swift in that he has only been an in-patient for a year and a half and has now reached the point of possible conditional discharge.*[40] *There was some concern amongst the team members about this but it was felt that at a tribunal there would be insufficient reason to detain him for a longer period. There was also concern that John does not see himself as a patient and that although on the one hand this means he will do what he can to stay out of hospital on the other hand he is also reluctant to engage in patient orientated activities. The main concern however is that it is not clear what sort of structured daily activity he will be engaging in on discharge. If he were to be discharged by the tribunal the management plan in the community on a conditional discharge would be regular medical follow-up, to remain on current medication, to have regular drug screens, and to engage in more structured activities including attending his college course one week (sic).*

The discussion then extended to include John Barrett himself, his solicitor and JW. The record continues:

> *Scott* [Ferris] *pointed out that the team had been discussing his progress since the last case conference and that they were concerned about his level of*

[40] He had in fact been an in-patient for fourteen months.

engagement. He discussed the proposed conditional discharge and asked John what activity he felt would be most appropriate to fill his day with if he were to be discharged. John talked about starting a college course, visiting his mother and brother [outside London] *and attending the gym and going to Richmond Park. When it was suggested that John attending Sound Mind (music focussed group), John said that he had attended 4 years previously and that he would be willing to explore this further. John asked whether he would be seeing Dr. Mezey in the community and Scott informed him that he would be under her care should he be discharged but that he would see Dr. Ferris and the CPN. Sharon* [Leicht] *pointed out that she was concerned that if John should have a lack of activity in his life then this would lead to boredom which would possibly lead to substance misuse and therefore have a detrimental effect to his mental health. John agreed with this and said that perhaps he would like to work 1 to 2 days a week as he had done in the past selling publishing space and doing market research. His girlfriend JW asked several times about what support John would be receiving in the community. His solicitor expressed her concern that John had not been granted unescorted community leave and that she felt that should he stand for a tribunal he would not be granted a discharge without having had some unescorted leave previously. Due to this she felt that it would be in his best interest that he deferred the upcoming tribunal and re-apply immediately to give a period of about 3 months to start doing unescorted community leave. The team felt that this would be in John's best interest as well as it would give us more time to set up an optimum package of activity whilst he was an in-patient which would go towards reducing the relapse risk. JW agreed with this. John seemed disappointed but did not make any comments. Solicitor questioned why he had not been granted unescorted community leave yet and it was explained that the Home Office had refused to date as they required more information about the victims.*

It was agreed that Dr Ferris would contact the Home Office again, that Ms Sturdy would contact the genito-urinary clinic at St George's Hospital to "*enquire discreetly about the feelings of the victims*" and that Dr Scholtz would chase up the referral to the Rowan Ward day programme.

87. He was seen by Dr Scholtz on 20th June. She challenged him on the lack of realistic goals on discharge. It emerged that:

> *He wished to spend the next twelve months 'taking it easy', 'partying', and not working. Sees work as something to engage in 12 months down the line. He thinks staying off cannabis and taking medication regularly would be the only things he would need to do to prevent relapse.*

Dr Scholtz stated her concerns that this was an unrealistic expectation and that without some imposed structure anyone in his position would be at high risk of relapse. She encouraged him to think very seriously about engaging in part-time work and to discuss this with JW too, commenting that she seemed to share the concerns of the team in this respect. John Barrett appeared to find the interview uncomfortable and attempted to make light of Dr Scholtz's advice and to change the serious tone by smiling excessively.

88. At the ward round on 24th June it was reported that he continued to have rather unrealistic expectations of what he would be doing once discharged, specifically in relation to his income and the amount of participation in leisure activities. The record of the team discussion was:

> *Discharge has been deferred awaiting the tribunal in approximately September. This is because of the fact that he has not been granted unescorted leave as yet. It is doubtful whether his engagement will improve in these further three months any more than it is at present. There is concern that deferring discharge will lead to further disengagement while he remains an in-patient. It remains of utmost importance that he is started on unescorted leave as this will give us a good opportunity to assess his ability to structure his day in the community. His skills are perhaps more sophisticated than the OT programme allows for. This leaves staff with a balance of advising him to engage in ward programmes and looking to activities which he would actually engage in on discharge. Currently the Rowan ward day programme has been suspended so this will not be an option.*

The plan was that Dr Ferris would reiterate to the Home Office that it was impossible to gauge how John Barrett would do in the community without unescorted community leave. The team were hopeful that this would be granted. It was agreed that it would be possible, even if he had not been discharged by September, for him to attend the course on which he had enrolled at Richmond College. It was noted that he was allowed unlimited unescorted ground leave but he had the responsibility to attend the OT programme as a priority.

89. At the ward round on 1st July no change was reported. JW was visiting frequently and they were planning to live together in his flat upon discharge. On 7th July John Barrett was seen by Dr Ferris and told him he was annoyed that his tribunal was not going ahead the next day.

90. At the ward round on 8th July the nursing report was that he remained settled and appropriate. He had expressed an interest in joining the illness awareness group. He wanted help with shopping and self-catering on the ward. He was maintaining to staff that he wished to remain compliant with his medication and stay away from cannabis. The OT report was that he was attending most of his groups. He had set up a proposed structure for his days in the community and he had identified staying in close contact with the team as the most important factor in preventing relapse in the community. Dr Ferris reported on a conversation with John Barrett during which he had acknowledged keeping his distance from patients and shutting off from others as a way of protecting himself. The team discussion concluded that it was positive that he was looking at activities in the community. There had been no decision from the Home Office on the application for unescorted community leave. The team thought:

> *It would be useful to increase his* [escorted community] *leave to four times weekly to encourage daily activities. However, it would have to be borne in mind that this is an artificial situation and could not be extrapolated to his behaviour once he was living in the community to the same extent that unescorted leave could be.*

91. On 14th July John Barrett was seen by Dr Scholtz. He told her he was frustrated that he was still in hospital and he was worried about not having received authorisation for unescorted community leave from the Home Office. He told her that he had started attending an illness awareness group the previous week. On the same day he was also seen by Dr Mezey. She recorded that: "*he was generally cheerful and relaxed*". She told him that the Home Office had agreed to unescorted community leave. On mental state examination Dr Mezey found no evidence of psychosis or mood disturbance. She noted that he claimed to be taking his medication.

92. At the ward round the next day the nursing report was that he was interacting well with staff and patients. He had requested to go to Covent Garden with JW on his birthday and had also requested leave to go shopping in the West End. The medical report was that he was more appropriate in his interactions with Dr Scholtz but seemed less so with Dr Mezey and in a group setting. It was suggested that his inappropriate behaviour, such as staring and inappropriate smiling, might have been related to anxiety in these situations. The OT report was that he was attending according to what interested him. He had attended the illness awareness group and had tested the boundaries with staring and behaving slightly inappropriately. In the team's discussion it was noted that the Home Office had granted unescorted leave, limited to the local community. It was agreed that the trip to Covent Garden with JW on his birthday would be appropriate. This necessitated a separate application to the Home Office for authorisation. However, other trips to the West End were not to take place until he had had some unescorted leave in the local community according to the OT plan. He was to continue with escorted leave while his unescorted leave was gradually increased and it had been stressed to him that he would need to continue to engage in OT. It was noted that: "*Currently, he is in a relationship with JW, but they will not live together when he is discharged*". The risk assessment was re-evaluated.

93. He was seen by Dr Scholtz on 21st July. He had been granted 2 hours' unescorted community leave twice a week to be spent on similar activities to those when previously on escorted community leave. He requested longer periods of leave and to be allowed to go further afield but this was not granted. He explained that JW had decided that when he was discharged she would move out of his flat. He was awaiting

a tribunal hearing date. It was agreed that he would start attending college in September while still an in-patient if his tribunal had not taken place by then.

94. At the ward round on 22nd July it was reported that he was "*using his leave, that his mental state was stable and his behaviour was appropriate*". He had planned unescorted leave to Covent Garden on 1st August, his 40th birthday. The team agreed that they would seek Home Office consent for this.

95. On 29th July at the ward round his mental state was reported as stable. The OT report was that his attitude had been pleasant in the illness awareness group, although he ascribed most of his illness to drugs and remained ambivalent about taking medication in the long term. However, he seemed more realistic about his level of functioning on discharge.

96. At the ward round on 5th August the nursing report was that:

> *His trip to Covent Garden had gone well. He had been somewhat anxious about the number of people in central London but otherwise there had been no problems. There were also no problems on the ward.*

He had requested an increase in the number of hours for unescorted community leave. The team discussion concluded that it was important to get JW's view on how the trip went as she had accompanied him. It was noted that his tribunal hearing was to take place on 10th October. Unescorted community leave was increased to three hours three times weekly with the suggestion of visiting his flat in the increased time period. At the next week's ward round he was reported "*to be stable in mood and mental state*". He was "*participating well in OT and self-catering*". Ms Sturdy said that she had completed her report for the tribunal, recommending conditional discharge. She had not yet been in contact with JW to enquire about John Barrett's responses during the Covent Garden trip. The medical report was that he had talked about spending more time with JW during his increased leave.

97. At the ward round on 19th August his mental state was reported to be stable and he was using his leaves appropriately. He was being visited regularly by JW. Dr Ferris reported that he had seen him and spoken about the index offences. He noted that:

> *John Barrett continued to see being provoked as a precipitant to the event, although he acknowledged his state of paranoia and that his reaction was in excess of the provocation.*

The OT report was that in the illness awareness group he attributed his mental illness solely to the influence of cannabis. In the team discussion it was agreed that:

> *His OT attendance is erratic but this is not a new problem with him. There is a sense that he sees himself of higher functioning than the other patients and is scared of the image of himself as a mentally ill person. However, he struggles to implement strategies that would prevent a relapse in his condition. It is felt however, that he would be likely to continue in taking medication as a provision of conditional discharge, and that this would be influenced by the threat of return to hospital as well as his girlfriend's supervision.*

98. On 19th August Dr Ferris completed his medical report for the forthcoming tribunal. Under the heading *'Current mental state'*, he wrote:

> *Mr Barrett is currently relaxed, pleasant and reasonably open at interview. He is not always as open as he might be which reflects his anxiety at being curtailed further if he says the wrong thing. He is very much looking forward to being discharged from the unit. He complains of mild stiffness from his medication and an increase in his sleeping pattern, otherwise he appears relatively free of side-effects. His mood is euthymic[41] and he denies all psychotic symptoms and displays no objective correlates of mental illness. Upon discussion of the index offence, he describes events in the same way. He believes that his behaviour was almost entirely as a consequence of his*

[41] In the normal range, which implies the absence of depressed or elevated mood.

paranoia due to cannabis use and his illness. He believes that this led him to carry a knife and led him to respond in a hostile way to provocation. However, he maintains that he was provoked by the victim and does not consider himself entirely to blame. He continues to minimise some aspects of the offence. With regards to his insight, Mr Barrett believes that his drug use is primarily the cause of his psychosis, but appears to appreciate that he has an underlying mental illness. There has been some evidence of ambivalence regarding his diagnosis and medication including his recent cessation of Olanzapine[42] and beliefs expressed in his illness awareness group. Nevertheless he seems well motivated to continue medication in the short term and receive input from the psychiatric team. He has a good understanding of the type of behaviour, symptoms and cognitions he begins to experience when he becomes unwell.

99. Under the heading *'Opinion'* Dr Ferris wrote:

1. *Mr Barrett suffers from a mental illness, namely delusional disorder. This is currently neither of a nature nor a degree that makes him liable to be detained under the Mental Health Act. Mr Barrett does not suffer from a personality disorder, as evidenced from our clinical observations and psychometric assessment.*
2. *It is our opinion that Mr Barrett should be conditionally discharged to his residence in Putney. The conditions of his discharge will include residing at his address and maintaining compliance with his medication, urine drug screens and follow-up from his social worker, CPN and medical members of the forensic psychiatric team.*
3. *There are aspects to Mr Barrett's past history and current presentation that lend us some degree of concern. Namely, his tendency to minimise the extent and severity of his illness and his risk of relapse, and he does not respect the need for medication at all times. In addition, in the past, he has masked his symptoms of relapse very well, resulting in insufficient and delayed management of his mental illness. Nevertheless, we believe that his insight has improved to an extent where the risk is reduced as much as possible during*

[42] This is a reference to May 2003 and should have referred to Risperidone.

this admission. In addition, having clearly identified these risk factors, it is our opinion that the team can sufficiently manage Mr Barrett's illness and risk in the community. Early relapse indicators would be best observed by those close to Mr Barrett, and close liaison with Mr Barrett's friends and family will therefore be paramount. From our experience of Mr Barrett on the ward, whilst his mental illness is quiescent, he is a reasonably placid man who does not present a risk to either himself or others. He has also preserved a high level of functioning and if he can engage with realistic fruitful long term goals this would be of further benefit to his future well-being.

100. On 26th August at the ward round the nursing report was that he "*remained stable with appropriate behaviour and utilisation of leave*". The OT report was that when:

He went swimming he was noted to be flirting with several women, and that he was consistently late for all his groups and less interactive than in the recent past. He was noted to be staring at staff during the group with intense eye contact.

The team agreed that it needed to be fed back to him that his level of engagement in OT was not satisfactory. It was also noted that his last episode of disengagement coincided with him stopping medication. Ms Sturdy was to discuss the decrease in engagement with him. However, when she went to the ward at 3 o'clock that afternoon she noted: "*Appointment with John did not go ahead as he had gone out on ground leave at 2.45pm. Unable to speak to him*".[43]

101. The nursing report at the ward round on 2nd September was that he had been "*pleasant and appropriate*". The team agreed that they needed to be vigilant because of the possibility of him stopping his medication, and consequent subtle signs of relapse. He needed to be made aware that if he stopped his oral medication "*we will need to switch him to Risperdal Consta* [a depot injection]".

[43] The same thing happened when Ms Sturdy next tried to see him on 11th September: *"He had gone out on ground leave. Not clear if he had been advised of the appointment"*. She then made a further appointment for 22nd September which did take place.

102. At the ward round on 9th September the nursing report was that he had been stable in mood, his behaviour was appropriate and he was interacting well with others. He had used his unescorted ground and community leave well. He had been reviewed by Dr Rajiv Dhar who had recently replaced Dr Ferris as the team's SpR. Dr Dhar reported that John Barrett appeared well and had said he felt ready to move on. The OT report was that John Barrett was felt to be at risk of using alcohol or illicit substances in the future: "*although it was highlighted that these were not implicated in his index offences*".[44] In team discussion it was re-iterated that John Barrett was likely to have poor recognition of any deterioration in his mental state, and that intramuscular depot medication would be necessary if he was non-compliant with oral medication.

103. The nursing report on 16th September was that John Barrett had been doing well. He had asked that the time of medication be changed so as to delay the onset of drowsiness. The medical report was that medication compliance had been discussed and he had confirmed that he was happy to continue taking oral medication if it kept him well and out of hospital. John Barrett had said that the side-effects he experienced (drowsiness and occasional mild limb stiffness) were a small price to pay. He also believed that cannabis had been involved in his previous episodes of mental illness and hoped that abstinence would reduce his risk of relapse. It was reported that he had disengaged from the OT programme and was looking at college courses. Concern was expressed that a lack of any kind of structure to his daily routine might render him more vulnerable to relapse.

104. The ward round on 23rd September was followed by a section 117 discharge planning meeting. The nursing report was that he had been stable in mental state and there had been no problems with community leave. He was spending much of his ground leave with JW. The OT report was that he had disengaged completely and was no longer attending any OT activities. The team discussion confirmed that at the tribunal on 10th October they would be recommending that John Barrett be conditionally discharged to his flat. He would need psychiatric and social work follow-up which would be provided by Dr Dhar and Ms Sturdy respectively. It was anticipated

[44] Refer to Chapter 1.4 paragraph 9 John Barrett said that he had consumed both alcohol and cannabis the night before the January 2002 offences.

that forensic involvement would continue for at least one year. The Putney CMHT consultant psychiatrist would need to be informed if he was conditionally discharged. The risk assessment documentation was discussed and updated, with zero ratings for everything except *"violence/harm to others"* where the risk was assessed as "*low apparent risk"*.

105. For the section 117 meeting which followed, the team were joined by JW, John Barrett and his solicitor. They were informed that a conditional discharge would be recommended. The proposed conditions were outlined, namely seeing a psychiatrist and social worker on a regular basis and continuing his medication. Compliance with medication was discussed and John Barrett said he was happy to continue with the oral Risperidone as he thought it was benefiting him and he did not feel over-medicated. The importance of filling his time with structured activity was discussed. He was due to start a sports and recreation course on 6th October which ran for two afternoons per week. He added that he could also get back into selling publishing space if he felt that he had time on his hands. JW was keen for him to be followed up by people who knew him well and who would thus be able to detect the earliest signs of problems. Finally, it was discussed that if things did not work out, readmission might be necessary and depot medication could be a consideration. By way of further management, a decision was taken to apply to the Home Office for overnight leave before the tribunal hearing. The CPA documentation that was completed at this meeting is described in the next chapter.

106. At the ward round on 30th September the nursing report was that he had had a settled week. He was spending a lot of his time on ground leave and when on the ward he played pool or watched television. The medical report confirmed that a request had been made to the Home Office for overnight home leave on 4th October. Under OT report it says only that: "*Mr Barrett has been left with an offer of further input, should he feel it would be helpful*". In the team's discussion his past history of disengagement with services was reiterated:

> *The team wondered how early we would be able to detect any relapse in the future. It was discussed that his girlfriend would be the first to notice any*

change, although we do not know what form their relationship will take from here on.

107. On 7th October, at the last ward round before the tribunal hearing, the nursing report was that he had generally been settled. Overnight leave had proceeded as planned and had gone well. A urine drug test on his return to the ward was negative. Ms Sturdy reported that John Barrett had missed his appointment with her. It was commented that this did not bode well for his follow-up in the community. In anticipation that the tribunal would discharge him, the management plan was discussed:

Make preparations for likely discharge this Friday – TTO's, [short term prescription for medication upon discharge] *follow-up appointments and discharge letter to GP.*

108. On 10th October he was discharged conditionally by a mental health review tribunal.

Chapter 1.7 - Psychiatric History and Clinical Management
10th October 2003 – 1st September 2004

Introduction

1. In this chapter we take forward the description of John Barrett's clinical management from his conditional discharge in October 2003 to his readmission in September 2004. The structure differs from the preceding chapters because here we relate the care interventions and John Barrett's progress to the care plans drawn up under CPA. The reason for doing this is that in considering the adequacy and appropriateness of the care and treatment during this period the care plans provide a description of what the team considered necessary and undertook to provide. They are therefore the obvious place to start.

Discharge

2. John Barrett was discharged from detention on 10th October 2003 by the tribunal. He left hospital the same day.

3. His discharge was subject to the following conditions, imposed by the tribunal:

1. To reside at [his home address in Putney].
2. To see a psychiatric team member as required but at least once a month and a community psychiatric nurse and social supervisor as required but at least once per fortnight.
3. To submit to drug screening and testing as required.
4. To continue to comply with prescribed medication.
5. To refrain from the use of illicit drugs.

4. These conditions remained in force throughout the period of conditional discharge until he was recalled by the Home Secretary on 2nd September 2004.

Care Plans

5. The discharge care plan had been agreed at the section 117/CPA meeting on 23rd September and recorded on the Trust's CPA form. The table that follows contains the main elements of the care plan.

Patient's need:	Objectives:	Method:	Responsibility of:
Mental Health	Maintain optimum mental health.	Regular monitoring of mental state, being alert for signs that John is not taking his medication\his mental health is deteriorating. Weekly social work contacts, with CPN support. Minimum 3-weekly out-patient appointments.	Susan Sturdy Colum Friel Dr Dhar
Medication	John to take 8mg oral Risperidone\day.	Encourage John to take medication as prescribed. Remind him of the importance of medication in remaining well.	MDT
Daytime Activity	Encourage the development of a structured week.	John to attend college – he has enrolled in a sport & leisure course. To support him in planning other activities as required.	Care Co-ordinator
Social network	Encourage maintenance of network.	Team to maintain regular contact with girlfriend & family.	Care Co-ordinator
Forensic History	Minimise risk of further violence.	Monitor mental state for re-emergence of paranoid delusions. Reinforce the need for medication to stay well. Liaison with MAPPP.	MDT
Alcohol\drug history	Encourage John to avoid drug use & excessive drinking.	Reinforce to John the negative impact that cannabis has on his mental state. Request regular drug screens.	CPN\Dr
Legal	Recommending Conditional Discharge at MHRT 10.10.03	Social and Psychiatric Supervision once discharged	SW\Dr

6. A note made by Ms Sturdy on 23rd September 2003 amplified what was provided for in the care plan. It included the following: "*regular meetings with John and JW would be helpful to them*". At the same meeting a risk management plan was formulated and recorded on the Trust's standard form. The form requires an assessment of risk under eight headings: violence/harm to others, sex offending, deliberate self-harm, suicide, fire setting/arson, hostage taking, escape/absconding, self-neglect. The assessment is on a numeric scale where zero is *"no apparent risk"* and four is *"serious and imminent risk"*. John Barrett was assessed as one, that is *"low apparent risk"* for the risk of violence/harm to others and as zero under the remaining seven headings. The form recorded a number of features from his history that were relevant to the assessed risk of violence, such as delusions and physical harm to others, and it recorded that none of these was current, meaning none had occurred within the past month.

7. The risk management plan was as follows.

Clear Statement of Anticipated Risk(s)

1. Risk of violence to others, particularly his girlfriend, in conjunction with a re-emergence of delusional beliefs.
2. Risk of deterioration in mental health, in association with disengagement with services and substance misuse.

Early Signs, Symptoms and Behaviour Suggestive of Possible Risk/Relapse
(including future circumstances likely to increase risk)

1. Increasingly avoidant\defensive manner.
2. Increasing intensity, staring, invasion of personal space.
3. Increasingly aggressive manner.
4. Evidence of drug (cannabis) & alcohol use.
5. Reduced engagement with treatment, including contacts with professionals & medication.
6. Re-emergence of delusional beliefs.

Action plan
(Including: people to be contacted, Professionals responsible for each action)

1. Regular random drug screens to monitor use: CPN.
2. Regular supervision & monitoring: MDT.
3. Regular contact with girlfriend: SW.
4. Team to offer assessment & rapid response in the event that any concerns are raised: MDT.

8. Within the CPA documentation was a contingency plan which was as follows:

> *If concerns that John is not taking his medication – encourage to do so; reinforce its importance; consider depot. If concerns re deteriorating mental health – arrange formal assessment; admit to hospital if necessary.*

The care plan was varied at the next CPA meeting, which took place on 27th January 2004. **The relevant changes are in italics in the table below**.

Patient's need:	**Objectives:**	**Method:**	**Responsibility of:**
Mental Health	Maintain optimum mental health & *monitor*	Regular monitoring of mental state, being alert for signs that John is not taking his medication\his mental health is deteriorating. *Social work contact – 2 weekly* *CPN contact – 4 weekly* *OPA's – 4-6 weekly*	MDT Susan Sturdy Dr Dhar
Medication	John to take 8mg oral Risperidone\day.	*GP to prescribe psychiatric medication. John to collect from local pharmacy.* Encourage John to take medication as prescribed. Remind him of the importance of medication in remaining well.	MDT
Daytime Activity	Encourage the development of a structured week.	*John is mainly concentrating on developing contacts & working on music projects. Support him in planning\accessing other activities, e.g. voluntary work, as required.*	Susan Sturdy
Social network	*Maintain.*	Team to maintain regular contact with girlfriend & family.	Susan Sturdy
Forensic History	*Minimise risk of further violence.*	Monitor mental state for re-emergence of paranoid delusions. Reinforce the need for medication to stay well. Liaison with MAPPP if concerns.	MDT

Alcohol\drug history	*Encourage John to avoid drug use & excessive drinking.*	Reinforce to John the negative impact that cannabis has on his mental state. Request regular drug screens.	CPN\Dr.

9. In other respects the completed CPA document, including the assessment of risk and the risk management plan, remained unchanged.

10. The only other CPA review took place on 18th May 2004, on John Barrett's discharge from a short informal admission to a general adult psychiatric ward in Springfield Hospital. **The relevant changes are in italics in the tables below.**

Patient's need:	**Objectives:**	**Method:**	**Responsibility of:**
Mental Health	Maintain optimum mental health & monitor	Regular monitoring of mental state, being alert for signs that John is not taking his medication\his mental health is deteriorating. Social work contact – 2 weekly CPN contact – 4 weekly OPA's – 4-6 weekly	MDT Susan Sturdy *Sarah Galloway* *Dr Mezey\Dr Dein*
Medication	John to take *10* mg oral Risperidone\day.	GP to prescribe psychiatric medication *(1 month's TTOs given on discharge today)*. John to collect from local pharmacy. Encourage John to take medication as prescribed. Remind him of the importance of medication in remaining well. *Spot checks on medication.*	MDT
Daytime Activity	Encourage the development of a structured & *balanced* week.	*John has recently finished a music project that has filled most of his time. Offer encouragement and practical support in accessing appropriate activities.*	Susan Sturdy

Social network	Maintain.	Team to maintain regular contact with *partner* & family. *Offer carer's assessment to partner*.	Susan Sturdy
Forensic History	Minimise risk of further violence.	Monitor mental state for re-emergence of paranoid delusions. Reinforce the need for medication to stay well. Liaison with MAPPP if concerns.	MDT
Alcohol\drug history	Encourage John to avoid drug use & excessive drinking.	Reinforce to John the negative impact that cannabis has on his mental state. Request regular drug screens.	CPN\Dr.

Clear Statement of Anticipated Risk(s)

1. Risk of violence to others, particularly his girlfriend, in conjunction with a re-emergence of *paranoid* delusional beliefs.
2. Risk of deterioration in mental health, in association with disengagement with services and *with* substance misuse.

Early Signs, Symptoms and Behaviour Suggestive of Possible Risk/Relapse
(including future circumstances likely to increase risk)

1. *Hearing derogatory voices, which start as indistinct 'whispers'.*
2. Increasingly avoidant\defensive manner.
3. Increasing intensity, staring, invasion of personal space.
4. Increasingly aggressive manner.
5. Evidence of drug (cannabis) & *significant* alcohol use.
6. Reduced engagement with treatment, including contacts with professionals & medication.
7. Re-emergence of *paranoid* delusional beliefs.

Action plan
(Including: people to be contacted, Professionals responsible for each actions)

1. Regular random drug screens to monitor *possible* use: CPN.
2. Regular supervision & monitoring, *including random checks on medication*: MDT.
3. Regular contact with *partner, JW* [her contact telephone numbers]: SW.
4. Team to offer assessment & rapid response in the event that any concerns are raised: MDT.

11. There was also a small change to the contingency plan, **indicated here in italics:**

> If concerns that John is not taking his medication – encourage to do so; reinforce its importance; consider depot. If concerns re deteriorating mental health – arrange assessment; *offer increased support at home; review meds in the first instance;* admit to hospital if necessary.

12. In other respects the completed CPA document remained unchanged. It gave the date when next CPA review was due to take place as 3rd August 2004. But subsequently it was changed to 7th September, so no further CPA meeting took place before 2nd September.

Interventions and Progress between 10th October 2003 and 12th May 2004

<u>Contacts with members of the Multi-disciplinary Team and implementation of the care plan</u>

13. In accordance with the care plan Ms Sturdy met John Barrett weekly for the first two months after discharge and thereafter every two weeks. One of her meetings each month was a joint meeting with John Barrett and a CPN. It took place at John Barrett's home. Otherwise they met at the Shaftesbury Clinic. Until January 2004 Colum Friel was the CPN and in March Sarah Galloway took over, after a brief interval when another CPN had provided temporary cover.

14. Under the care plan John Barrett was also to be seen every three weeks by Dr Dhar. There is only one medical entry in the notes in the six months between 10th October 2003 and 23rd April 2004. As we acknowledge elsewhere, it appears that some notes containing entries by Dr Dhar may be missing. That entry, by Dr Dhar, is dated 6th March 2004 and starts with the words "*File not located. Seen approximately every 1 month for review".* The notes of weekly referral meetings, at which contact with all out-patients was reviewed, show that Dr Dhar saw John Barrett as an out-patient in the week ending 11th November 2003, although there is no corresponding entry in the multi-disciplinary notes. There is no other record of Dr Dhar seeing John Barrett between discharge and the end of March 2004, when he left the team to take up a

post elsewhere. However, Dr Dhar told us that he saw John Barrett every 4 – 6 weeks during this period. This was corroborated by a handover note to his successor, Dr Kalpana Dein, in which he said with reference to John Barrett: *"I tend to see him on a monthly basis"*. It should also be noted that Dr Mezey saw John Barrett at the CPA meeting on 27th January 2004, although there is no corresponding medical entry in the notes.

15. On 23rd April John Barrett was seen by Dr Mezey. This followed a request by Ms Sturdy. He was next seen by a doctor on 12th May. We describe both these consultations below.

16. With regard to the rest of the care plan, we have seen no written evidence that he was tested for drugs during this period. He was collecting prescriptions from his GP and the team were satisfied that he was taking the medication as prescribed. There was no attempt to set up regular meetings with John Barrett and JW but there was telephone contact between her and Ms Sturdy, either to discuss specific practical matters affecting John Barrett or more generally his progress since discharge. Ms Sturdy also advised John Barrett about regular daytime activity and suggested that he should consider voluntary work in addition to the music project, which we describe below.

17. On 21st October 2003 Ms Sturdy telephoned a police officer at the Public Protection Unit at Wandsworth Police Station, the local contact point for MAPPP (Multi-Agency Public Protection Panel). She told him of John Barrett's discharge and that there were currently no concerns about him.

18. During this period Ms Sturdy, as social supervisor under the conditional discharge arrangements, sent reports to the Home Office on 10th November 2003 and 4th February 2004. Dr Mezey, as psychiatric supervisor, sent one report on 29th April 2004.

Progress

19. As an out-patient, routine consideration of John Barrett's progress by the multi-disciplinary team was at the weekly referral meeting. This took place at the

Shaftesbury Clinic every Tuesday immediately after Dr Mezey's ward round. Brief minutes of the meetings were made in a standard format. The following is a complete record from the available minutes of referral meetings at which John Barrett was mentioned.

Date of Meeting

23.10.03 *SS saw yesterday and reported John Barrett as being well.*

4.11.03 *SS spoke to JW this am. He does have medication. Will continue to monitor closely.*

11.11.03 *SS saw yesterday and confirmed that John Barrett has been collecting his prescriptions. Doing well although needs to occupy himself with some form of activity during the day time. SS offering advice on this. SS also fed back that she has informed John that random drug tests will be done which John confirmed would be acceptable.* [Dr Dhar] *saw at out-patients. Doing well.*

25.11.03 *Seen by SS last week. All well. Compliant with medication. CP/117 to be held on 27th January at 12.00 noon.*

30.12.03 *SS reported that he is well. SS to see on 31st December.*

20.1.04 *Doing fine.*

10.2.04 *GM attended CPA with SS and CF. Doing very well. Need date for another CPA. Team felt that it would be appropriate for John to be seen at Shaftesbury Clinic rather than Clare House in future.*

9.3.04 *Doing well. Seen by SS.*

16.3.04 *Due to be seen by SS and SG.*

23.3.04 *Due to be seen by SS and SG.*

30.3.04 *Seen by SS. Very well. Compliant with medication.*

6.4.04 *Very well at present. Dr Dein to see with Sue Sturdy. CPA date arranged. Appears to be keeping reasonably active.*

20.4.04 *SS received telephone call from John Barrett stating that he was hearing 'whispers' again. SS saw on Friday when he stated that he was feeling a bit stressed from doing his music. He assured SS that he was compliant with his medication. Due to see GM on Friday.*

27.4.04 *Seen by GM. Had episode of hearing 'whispers'. Much better now. GM to write to Home Office re annual statutory report.*

4.5.04 *Sue Sturdy saw last Wednesday. Very well. Will be going on holiday soon. SS to obtain details so as to inform Home Office. CPA on 18th May 2004.*

11.5.04 *SS will be seeing today. CPA next week.*

20. John Barrett cooperated with all aspects of his care plan during this time. Concern was expressed in early November because it appeared that he had not collected a prescription from his GP, but it turned out that he had done so.

21. On 6th March when Dr Dhar reviewed him in out-patients he noted that John Barrett was doing well generally and coping with the discharge. There was said to be no relapse of psychotic symptoms, his manner was appropriate, he cooperated, and he was recorded as being compliant with medication and happy to continue, with no illicit substance use. He talked candidly about his future and his ambitions to produce music. He was given advice about lifestyle issues and the avoidance of situations in which there might be encouragement to use illicit drugs. He was said to appear very rational and insightful about this. There were no relationship difficulties and no problem with mood or irritability. The current plan was to continue.

22. Ms Sturdy saw him on Friday 16th April and recorded that he remained well and that his involvement in music continued. A number of general matters were discussed with advice being given. But that same day he started hearing what he described as *"whispers"*, and on Monday 19th April he telephoned Ms Sturdy and reported this to her. He was worried about the return of the *"whispers"*. They had abated over the weekend and had not occured again since. He stated that he would like to see someone that week and that he had been taking medication consistently. Ms Sturdy's note of their conversation raised the suggestion that it might be a stress-related phenomenon. She agreed to discuss the issue with Dr Mezey and return his call. This was done and an offer of an appointment was made. In a telephone call to JW that same day Ms Sturdy was told that John Barrett had informed her about the whispers and that, after having had initial difficulty in contacting a suitable person at the Shaftesbury Clinic, JW had been given the number for Crisis Line to whom she spoke, receiving support. JW commented that John Barrett was scared by the experience and had asked her if she would be able to manage if he had to go back into hospital.

23. John Barrett saw Dr Mezey on 23rd April. She noted:

> *Concern about 'whispers' he heard last week – similar to when he was ill. Made him feel anxious – not clear what they were saying. Several voices. Difficult to ignore.*

She advised him that she thought it was probably stress-related, the stress arising from the music project which is described below. She noted that the *"whispers"* had only lasted for 48 hours and were not associated with any other mental state abnormality, that his mood was good, he was sleeping well and his appetite was normal and his weight steady.

24. On 28th April, when John Barrett was seen by Ms Sturdy, he attributed the re-emergence of symptoms to the intensity of the music project and *"the pressure to produce creative ideas to order"*. But he was feeling positive about the project and referred to the possibility of making some money from it. He felt reassured by contact with the team. They discussed the importance of keeping some structure to his week without putting himself under excess pressure. A proposed holiday abroad was discussed, with an agreement to sign his passport photographs at their next meeting. This was discussed with Dr Mezey on 4th May when she raised no objection provided that dates and an address could be supplied to the Home Office.

25. On 11th and 12th May JW telephoned Ms Sturdy several times with concerns about John Barrett. On 11th May she described him as having been depressed over the past couple of weeks: *"feels low, that he's got no future, wants her to leave as nothing to offer her"*. She thought the lack of structure in his life was a problem for him. She had decided to go away for a few days because of their difficulties but was very concerned about him and she wanted Dr Mezey to see him. The last time John Barrett had seen Dr Mezey she had asked him if he was depressed. He had not been then but JW believed he had since become so. JW also observed that she was worried that he would deteriorate if he was not active. She thought he had withdrawn a bit and was stressed.

26. Within a matter of hours JW telephoned again to say that she had heard from John Barrett and that he had told her, on 12th May, that: "*he had been hearing voices again for the last few days and he feels he needs to come back into hospital*". John Barrett saw Ms Sturdy that day for one of their regular fortnightly appointments. In the absence of Dr Mezey and her SpR, Ms Sturdy arranged for John Barrett to be assessed by Dr Kiran Patel, an SpR from another consultant team in the Forensic Service. With Dr Mezey's assistance, Dr Patel arranged for John Barrett to be admitted that same day to Jupiter Ward, an adult acute general psychiatric ward at Springfield Hospital. In a letter dated 12th May to the consultant psychiatrist for Jupiter Ward, Dr Patel described John Barrett's mental state:

> *Mr Barrett describes a 2-3 week history of deteriorating mental state. His auditory hallucinations have re-emerged and have become increasingly distressing. They consist of two voices, one male and one female. They talk directly to him and say things like, 'We're going to kill you' and 'You're going to die'. He states that they are not commanding but intrusive and worrying. His concentration and attention are affected as well as his ability to carry out his usual activities. He is unsure as to whether medication helps with his symptoms. In addition he describes his mood as being low… He states that his thoughts are being 'interfered with' by the voices but denies thought withdrawal, insertion, broadcast or echo phenomena.*

It was noted that he was pleasant and compliant with the assessment, with no signs of self-neglect, anxiety or agitation.

27. There are other significant matters from this period. First, JW moved back to his flat in January 2004 and they resumed cohabitation. Second, within four weeks of leaving hospital John Barrett had given up the sports and leisure course which was referred to in the discharge care plan. The reason, as reported by Ms Sturdy to the Home Office on 10th November 2003, was:

> *He found some of the course work different and more difficult than he expected. He has therefore decided not to continue with this course. He is currently considering alternatives, including music related courses. He has a*

serious interest in music and spends a significant portion of the week writing. He is doing some work on a collaborative music project informally.

28. In January 2004 John Barrett started meeting regularly at his flat with a professional musician called Mr A who was a former partner of JW. Mr A told us about their collaboration:

> *I worked with him, writing material together, from about 8 January through to the end of April, pretty much four or five weekdays, generally for eight or nine hours a day – seven, eight, nine hours a day, it varied. …We were working as I said at a fairly phenomenal rate, very rapidly. Within about two or three months we must have recorded about 35 tracks, of which about 20 had vocals, which from my experience in the business is an astonishing turnover of material. We were working very rapidly, we seemed very well-suited in the sense that we were not only working through the day together, but at nights I would go home and work musically on the material and he would be writing lyrics, working out vocal melodies, harmonies and things, we would come back the next day, compare notes, move on to the next thing.*

29. Dr Mezey wrote to the Home Office on 29th April 2004, in her capacity as psychiatric supervisor under the conditional discharge. She reported positively on John Barrett's progress since discharge. The following points are taken from her report:

- *He has found employment working freelance in the music industry and, although the work has been stressful in recent weeks, he is extremely positive about the experience and we feel it has benefited him in terms of his confidence and his self-esteem generally.*
- [The resumption of cohabitation with JW] *seems to be a very positive development which suits them both. JW appears to be a stabilising influence on Mr Barrett.*
- *Mr Barrett is… extremely insightful about his illness. He has been fully compliant with his medication… he appears keen to continue this as he believes that it helps him to remain well.*

- *There has been no illicit substance use (drugs or alcohol) since his discharge from hospital.*

Dr Mezey also reported on the *'whispers'* and gave her opinion, as set out in paragraph 23 above.

Interventions and Progress between 12th and 17th May 2004

Contacts with members of the multi-disciplinary team and implementation of the care plan

30. Between 12th and 18th May John Barrett was a voluntary in-patient on Jupiter Ward, Springfield Hospital. We describe below his progress during the admission. He was seen on 13th May by Ms Sturdy and Dr Anakwue SHO. On 14th May he was seen by Ms Sturdy and Dr Dein, who had recently taken over from Dr Dhar as Dr Mezey's SpR. On 17th May he was seen by Dr Mezey.

Progress

31. John Barrett was seen by a doctor on admission to Jupiter Ward who recorded that he was experiencing *"atypical auditory hallucinations"*. John Barrett reported the content of the hallucinations as *"voices which are talking directly to him saying e.g. You're going to die, We are going to kill you"*. No other abnormality of mental state was recorded. The assessing doctor noted:

> *If the patient wants to self-discharge (being on conditional discharge) he needs to be reassessed and if necessary held on section 5(2) of the Mental Health Act.*[45]

32. On 13th May Ms Sturdy recorded a conversation with Dr Mezey in which it was stated that John Barrett could take unescorted ground leave. Ms Sturdy noted that she

[45] Section 5 (2) of the Mental Health Act 1983 – is a temporary holding power pending a more detailed assessment.

would see John Barrett that day with Dr Ken Anakwue, and that Dr Dein would review him on Friday when Dr Mezey would be on annual leave

33. Dr Anakwue and Ms Sturdy assessed John Barrett later. Dr Anakwue recorded: *"appeared relaxed. Appropriate. Felt much better today"*. He had taken some ground leave. John Barrett said that prior to admission he had sometimes felt bored and wanted something that would help occupy his time. While he thought that Ms Sturdy's suggestion of voluntary work was a good idea, he wanted to have a fulfilling career. He saw himself as a musician but not as a professional musician. He thought of music as a hobby. He denied being depressed and denied any thoughts of harming himself or others. The voices had reduced to *"whispers"* and he was not at that time overtly disturbed by them. He acknowledged the protective nature of the ward. When he had started hearing voices some three to four weeks earlier, the voices had stopped when on his own initiative he briefly increased the Risperidone to 12mg daily. It was agreed that his medication should be reviewed the following day by Dr Dein, that he should remain in hospital, that he could have unescorted ground leave and staff were to continue to monitor his mental state.

34. On 14th May Dr Dein saw John Barrett, this being the first occasion they had met, and she recorded a number of recent stress factors:

> *A music project – the project is now finished; feeling bored; as voice got worse, he got anxious about the effect it would have on his relationship.*

He told her that since admission the voices had abated. He described them as "*one male and one female, inside his head… and* [as] *causing him distress and anxiety"*. He reported no other psychotic symptoms. He confirmed that he had continued to take his anti-psychotic medication (Risperidone) as prescribed and that he had found it helpful. He denied substance abuse. Dr Dein recorded her impression as: "*?pseudohallucination brought on by stress"*. She increased the dose of Risperidone from 8mg to 10mg daily. It was agreed that he could have overnight leave and that if he continued to make progress he would be discharged at the CPA meeting scheduled for 18th May. John Barrett's case was discussed with nursing staff who reportedly viewed him as no

management problem. The risk to himself and to others was considered low. Nursing observations over succeeding days reported no management difficulties.

35. On 17th May John Barrett was reviewed by Dr Mezey. He appeared well and was said to be generally relaxed. She recorded his account that for seven days before admission there had been voices inside his head, whose content was "*we'll kill you - going to die*". These were upsetting and distracting and "*he couldn't do anything – felt totally useless, dependent… might as well be in hospital*". There was no precipitant cause identified but it was noted that he had been bored. He was said to have continued to take Risperidone and not to have consumed either alcohol or drugs. He denied any suicidal thoughts or thoughts of self-harm and there was no paranoid ideation. His appetite and sleep were good. He said he was still experiencing occasional *"whispering"*. He could not make out the words. He had experienced one such episode on the day he was seen, but said that he could cope with it. He said he was feeling much better and was ready to go home. It was noted that he had had ground leave over the weekend. He was granted an overnight leave and if all was well he would be discharged the following day at the CPA meeting.

Interventions and Progress between 18th May and 6th August 2004

<u>Contacts with members of the multi-disciplinary team and implementation of the care plan</u>

36. John Barrett was duly discharged at the CPA meeting on 18th May. JW also attended and afterwards Ms Sturdy gave her a Carer's Assessment form to complete. Following discharge he was seen by Ms Sturdy on 21st May. On 26th May John Barrett was seen by Ms Galloway at the Shaftesbury Clinic. This was the only time she saw him on her own. Thereafter the previous pattern of contact was resumed, with Ms Sturdy seeing him every two weeks, alternating between seeing him alone at the Shaftesbury Clinic or at home jointly with Ms Galloway. It appears that in late June/early July two appointments were missed when John Barrett cancelled and it did not prove possible to arrange another convenient date.

37. In her report of 18th May to the Home Office Ms Sturdy reported that the music project had come to an end and that:

> *Since then he has not had any structure in his week, which has led to him feeling bored and has had an impact on his well-being… I will continue to address the need for a balanced structured week as an important factor in maintaining his mental health.*

In late May John Barrett had an appointment with the Volunteer Bureau but they could offer only occasional work at an old people's lunch club, which did not interest him. A referral was made in early June for him to attend a gym group but there were no vacancies. Ms Sturdy then corresponded by email with one of the Shaftesbury Clinic's OT staff and by 22nd June she had secured a place for John Barrett. On 10th June JW contacted Ms Sturdy and, among other things, pointed out that John Barrett had not had an out-patient appointment with a doctor since being discharged on 18th May. Ms Sturdy said she would check with Dr Mezey's secretary which she did. Ms Sturdy then raised the issue at the referral meeting on 15thJune.

38. On 27th July, John Barrett's brother contacted Ms Sturdy. He reported his concerns that: "*a pattern was emerging similar to how* [John Barrett] *was before coming into hospital. Some 'wildness' coming back"*. John Barrett's brother told us that, understandably, he and John Barrett did not generally discuss John Barrett's psychiatric illness and the care he was receiving. He did, however, communicate with JW from time to time when he had concerns. On this occasion he was prompted by JW to contact Ms Sturdy in what he agreed was a concerted effort to make the multi-disciplinary team aware of concerns that John Barrett was deteriorating and that in their opinion there was insufficient medical input into his care. Ms Sturdy telephoned John Barrett's mother for further information. She told Ms Sturdy that she spoke to John Barrett by telephone every week. She had noticed that he had been low for the past couple of weeks, taking a long time to answer. His mother said she knew that something was wrong and she felt he needed to be seen more often. Ms Sturdy also received a number of telephone calls from JW in some of which JW expressed her concerns about John Barrett's mental health. We describe these below.

39. John Barrett was not seen by a doctor from the multi-disciplinary team after the 18th May CPA meeting until 2nd August when he was seen by Dr Mezey, together with Ms Sturdy. Ms Sturdy attended only the first part of the consultation because she had to leave early to go to another appointment. JW came to out-patients with John Barrett on that occasion and was invited in for the last part of the consultation. At Ms Sturdy's suggestion Dr Mezey had also spoken by telephone to JW on 30th July in anticipation of the 2nd August out-patient appointment.

40. Dr Mezey started three weeks' annual leave on 6th August from which she returned on 31st August.

Progress

41. We start with the references to John Barrett in the minutes of referral meetings.

Date of Meeting

1.6.04 *SS to see on Friday. SG saw last Wednesday. No feedback.*

15.6.04 *Seen by SS. Well. Very happy. Is looking for voluntary work at present. It was suggested that* [the groundsman at Springfield Hospital] *be contacted to enquire whether John can do some work with him. SS to look into this. GM to arrange o/p appointment to see John.*

22.6.04 *Remains well. However, still hears whispers which are not intrusive. Attending OT project. Sue Sturdy due to see with Sarah Galloway on 23rd June.*

29.6.04 *Feedback from SS. Not seen on Wednesday as he had a recording session with Mr A. Sounded ok on telephone. Referral has been made to community gym and* [the organiser] *will be contacting John direct. Out-patient appointment with SS on 6th July. Also due to be seen by SG on 21st July.*

6.7.04 *SS due to see today.*

13.7.04 *SS has spoken on telephone with John. Is well, voices have now stopped, is doing small amounts of work with Mr A which he is coping well with. Will be seen by SS and SG next week. GM to make o/p appointment.*

20.7.04 *Due to be seen on the 21st by SS.*

27.7.04 *Seen by SS and SG. Mental state appears to be ok.*

3.8.04 *Dr Tim Green* [psychologist] *to see. 'Voices' are the problem with his relationship. Everything relates to voices.*

42. The CPA review on 18th May was attended by Dr Mezey, Ms Galloway, Ms Sturdy, John Barrett and JW. It is recorded that he had felt fine since admission and had spent most of the time off the ward. He was still experiencing some *'whispering'* but it was not constant. He said that the voices which he distinguished from the *"whispering"*, had been present for 10 days before admission and that when he was hearing the voices he felt "*useless"*. JW had noticed this and thought he was depressed. It was agreed at the meeting to leave the Risperidone at the higher dose of 10mg per day. It was also decided that John Barrett would go to the Volunteer Bureau to find a voluntary job and that there would be increased contact with Ms Sturdy and Ms Galloway until the end of the month. Thereafter the pattern of contact would revert to what was stated in the care plan.

43. The only substantial entry in the medical or social services records which describes his progress thereafter, at least until late July, is that made by Ms Galloway on 26th May. She recorded:

> *No evidence of any symptoms other than 'whispers'. Experiences these every day, 1-2 minutes duration, twice daily. Feels he is coping with these. Feeling that he is doing well, 'good'. Not too bored – now song writing 3 hours a day. Feels this is very positive.*

On 10th June Ms Sturdy made a note of a telephone conversation with JW who told her "*John ok at moment; still small whispers couple of times per day*". As the referral minutes of 15th June and 13th July show, Ms Sturdy raised the lack of out-patient appointments.

44. For the second half of June and the first three weeks of July there are no entries in the multi-disciplinary notes of appointments with John Barrett. The best account we have of his progress comes from a written statement made by Ms Sturdy in March 2005.

On 22nd June John Barrett cancelled his appointment with Ms Sturdy and, because of a misunderstanding, she did not see him again until 21st July when she visited his home with Ms Galloway. They had no concerns about his mental health but he did mention that he and JW were "*having a few problems*".

45. JW was becoming increasingly concerned at this time. She told us:

> *I've put June… when his behaviour changed. It's very easy for me and I know it's very hard for them, because I just see his behaviour goes back to how it used to be and it feels to me how it used to be. No violence, not particularly aggressive, but all those other symptoms and signs coming in. The main one for me with John has always been that I've always had difficulty in getting anyone to take seriously because I'll just say John changes. He changes with me from being a very loving, very caring, really sensitive person, to someone who is very cold, very flat, almost unable to understand that, after being together all this time and what we've been through, this is hard for me.*
>
> *Those sorts of changes started happening. I put in these notes here that throughout the period of June there was significant change. There was all that emotional flatness with me. There was other stuff as well, other significant changes in John's behaviour. John was getting his dole of £75 a week, of which he was giving me half, because previously one of the things I know you'll all be aware of was money and the effect that has when John's ill and what it's always had on me. It was really important to both of us that there was some equality for us to have any kind of decent relationship, so John was giving me half his dole and doing it happily and willingly. Then in June £2000 worth of debt built up – he got a credit card, a bank account, I don't know how or why. He wasn't out at night, we were in together every night, but all the stuff came in about me thinking he was going out, being unfaithful, sex with other women, so that possibly also made me think he might be smoking weed. He lost a stone in weight, his whole sleeping pattern changed, all that sort of stuff changed, so John went back to this person that I'd seen before when he was ill. I don't know what was going on with the voices, but this is what he used to be like when he was ill, before he ever had the voices, these symptoms were always there.*

Although JW dates the start of her increased concerns to June, this is not corroborated by entries in the multi-disciplinary notes until that of 28th July (below).

46. Ms Sturdy's conversation with John Barrett's brother on 27th July – see paragraph 38 above – was followed on 28th July by a telephone call to Ms Sturdy from JW. She described recent difficulties in her relationship with John Barrett. She had moved out on 19th July – something John Barrett had not mentioned during the home visit on 21st July- and had returned the previous day. She acknowledged that it was difficult clearly to separate their relationship from her concerns about his mental health. But she told Ms Sturdy that she had concluded the changes she had noted in his behaviour and demeanour over the previous six weeks were caused by deterioration in his mental health. She said that he had acknowledged that he was hearing voices again and had said that he had been doing so for a couple of weeks or possibly longer. She felt he looked bad. One observation she made in connection with his mental health was that the previous evening John Barrett had said that she had never accepted the factual basis for his past *"suspiciousness etc."* but had always attributed it to mental illness. JW understood the implication of his remark to be that, unlike her, John Barrett did not attribute his past paranoid beliefs to mental illness. JW also mentioned that she believed John Barrett had recently used cannabis and she was not sure that he was still taking the prescribed medication. According to Ms Sturdy's record of their conversation JW said that he was feeling "*bored\useless\lack of self-esteem*".

47. On 29th July JW telephoned Ms Sturdy again and reported that John Barrett had "*acknowledged he was hearing voices again – says he has been for a couple of weeks (?longer)"*. Ms Sturdy then telephoned John Barrett who confirmed he was hearing voices which he described as "*whispering – a little bit more than that – can't make out what* [they are] *saying"*. He described them as manageable and said he was not concerned. He confirmed that he was still taking his prescribed medication. He considered that he did not need any additional input from the multi-disciplinary team, and in any case he was due to see Dr Mezey on 2nd August. He told her he had not mentioned JW's moving out because he had not wanted to talk about their relationship when he saw Ms Sturdy the previous week. Ms Sturdy acknowledged that he might not want to talk about relationship problems but told him that there was a

need to discuss *"risk issues"* and that sometimes she thought he was not forthcoming about these. She stressed the importance of being open about what was happening in terms of his risk. Ms Sturdy's entry continues:

> *Says he is taking his medication – 'don't have a problem with the meds'. Has discussed with JW about possibly increasing these a little bit if feeling unwell. He doesn't think this helps. Still spending several days per week at Mr A's. Discussed how to proceed. John does not feel the need for additional intervention over the next few days; not concerned about the weekend. Have stressed the importance of being open with us and seeking help early, rather than waiting until things are really bad. To see Dr Mezey on Monday (+ Sarah Galloway?) to see me on Wednesday at 10.00am at the Shaftesbury Clinic.*

48. On Friday 30th July Dr Mezey, at Ms Sturdy's suggestion, spoke to JW. Dr Mezey's record of what JW told her is as follows:

> *Concern about John. Also John's brother and mother expressing concerns. 'Should have spoken earlier'. Left John 2 weeks ago to get some space to think about relationship. Stayed away for a week then went back to be with him. No aggression or threatening behaviour. Last 6-8 weeks seems to be changing – saying that not want to be in a relationship – can she leave. Wants to be on his own. Has been seeing other woman. Came back to find another woman in the lounge. Easily bored getting into debt – got himself a credit card which has cut up now, irresponsible. Would leave most spending money. Not 'over-drinking' – occasional – Thinks taking marijuana although he denies this.*
>
> *Music started going wrong - less work around. Very little. His partner doing all the technical stuff. Now just 1-2 days/week.*
>
> *John not think he is unwell. Says he is taking the medication – between 4mg and 8mg but seems to be taking every day.*
>
> *His friend Mr A sometimes noted decreased mood when goes into work but otherwise has not particularly expressed concern.*
>
> *Re specific symptoms – whispers disappeared altogether around 4 weeks ago – recently re-emerged but very 'faint' and he can ignore them. Only returned to live with him at beginning of week and* [illegible word] *when he told her this*

week had been hearing voices. Not go into detail – concern [illegible word] *that very up and down. Feels that nothing can be done.*
Feels that appointment can be delayed until Monday - able to manage over the weekend.
Bored and negative nothing working out – no work or anything to stimulate him. Planning to come to out-patient appointment on Monday. Has affairs with other women because he is unwell. Interested in some psychological therapy to help manage and understand his symptoms.
No specific paranoid symptoms noted or described.

The entry continues:

To see on Monday: Complicated picture girlfriend very concerned but relationship problems ++ and not clear yet whether this is indicative of a relapse. No evidence of risk to girlfriend or of increased risk to others more generally. No indication for admission to hospital - either voluntary or as a recall.

49. On Monday 2nd August John Barrett saw Dr Mezey with Ms Sturdy present for the first part of the consultation. Dr Mezey's entry reads:

Last few weeks – been OK. Most of the problem between me and JW - personal problem – but working out. [illegible words] *– fed up with having to put up with… medication not a problem, but voices a problem fed up with it.*
Talking to JW about living apart – have met a girl – trying to push JW away
Smoking a lot of marijuana last couple of weeks - last couple of occasions got from a friend.
Made me more frightened to leave the flat. Nothing positive. Relationship with JW broke down – she left for few days. Cause of unhappiness. The voices - good outweighs the bad in the relationship – voices give me low self worth.
Having a relationship with someone not really committed to, than having a stable relationship with responsibility.
Voices – last few days just in the background.

Can hear them but still think my own thoughts - when worse no space to think my own thoughts
Music going well – 3 – 4 times a week.
Due to attend sport group – once a week.
Attended voluntary bureau but only offered something once a month.
Sue Sturdy offered User Employment Programme.
Medication – taking 8mg daily from GP
Sleeping well. Appetite good – eight steady.
Birthday yesterday spent with JW, Mr A and brother.
Had a good celebration.
Mood – feel good – feel positive about things.
Only if the voices got a lot worse could I start feeling as bad again.
At end of meeting JW came into meeting – said that things had been better over the last few weeks. Not consider John currently unwell – explained to her what we have discussed with John –

1 *Concern re marijuana*
2 *Continue taking the medication*
3 *Referral to Tim Green Psychological help re management of voices and issues around relationship.*

50. A urine test was administered on 4th August at the Shaftesbury Clinic. It was positive for cannabis. Ms Sturdy saw him briefly and recorded: "*John appeared v.upbeat. Felt the meeting had gone well on Monday*".

Interventions and Progress between 7th and 31st August 2004

<u>Contacts with members of the multi-disciplinary team and implementation of the care plan</u>

51. John Barrett was seen by Dr Dein, together with Ms Sturdy, on 19th August. Ms Sturdy and Ms Galloway saw him at home on 23rd August. He was seen again by Dr Dein on 26th August. Ms Sturdy met JW on 9th August. With JW's agreement Ms Sturdy spoke to Mr A on 11th August. On 18th August Ms Sturdy left a message for JW and they spoke

on 19th August. Ms Sturdy sent her three monthly report to the Home Office on 10th August. John Barrett's brother telephoned Ms Sturdy on 26th August.

Progress

52. We start with the references to John Barrett in the minutes of referral meetings.

Date of Meeting

10.8.04 *Seen by SS* [on 4th August]. *Drug screen taken which was positive for cannabis. Prior to test John Barrett did admit to smoking. John Barrett's partner has telephoned with concerns about John, feels he is slightly manic, not sure if he is still taking drugs. SS has spoken to her about this. It was felt that John should be seen by Tim Green. Mr A (person he does music with) apparently has concerns about him also. KD to see at out-patients.*

17.8.04 *Tim Green to send out-patient appointment. CPA to be held on 9th September 2004. Appears to be more settled. KD to see with SS at out-patients on 19th August.*

24.8.04 *SG and SS saw at out-patients*[46]*. Slightly flat, irritable, negative drug screen (taken monthly). KD to see on Thursday. Increase in medication appears to have had no effect. SS due to see him again next week.*

31.8.04 *More guarded recently. Possibly relapsing. Increased Risperidone recently, distractibility. Due to be seen by Sue Sturdy on 1.9.04.*

53. JW requested the meeting with Ms Sturdy which took place on 9th August. She told her that she continued to be concerned about John Barrett's mental health. She mentioned that he had come home late smelling of alcohol and that he was spending a lot of money which had got him into debt. He was also asking her to move out. She described him as talking at her, "*not interruptable*", and as verbally aggressive and threatening towards her. She also said that he had become disenchanted with the music he had been working on with Mr A and *"started talking about a completely different approach"*, and that Mr A felt he had *"lost insight"*.

[46] This is inaccurate. They saw John Barrett at his home.

54. Ms Sturdy telephoned Mr A on 11th August. According to her contemporaneous note of their conversation his concerns were: *"since last week* [John Barrett] *seemed a bit more excitable"*. He was *"not sharing as much – has talked re symptoms in the past. Not now"*. As far as their work was concerned he said that John Barrett seemed to have had an *"epiphany"* on his birthday (1st August) and in the following week *"seemed to have gone off previous material and* [was] *saying we need to start again*". He confirmed that John Barrett was still coming to his flat on two or three days a week to work but that the project had now reached the stage of *"fine tuning"* which was something John Barrett was not used to and possibly found boring. However, Mr A thought John Barrett was a little better than he had been in the previous week but he *"was not wanting to sing as much"*. Mr A mentioned *"a couple of incidents in the flat – turned round and looked as if reacting to something not there*. [But] *nothing recently"*.

55. We have seen Ms Sturdy's handwritten notes which she made while on the telephone and we accept they are an accurate record of what Mr A said to her. We draw attention to this because when we interviewed Mr A he gave a vivid account of a number of incidents not recorded in Ms Sturdy's note, when John Barrett's behaviour caused him concern. We refer to his account in Part 2.[47]

56. On 19th August when he was seen by Ms Sturdy and Dr Dein, John Barrett said that he was breaking up with JW, that he had been smoking some cannabis and that he was working on a dance record. On examination of his mental state Dr Dein recorded: "*some grandiose belligerence, slight irritability, defensive, denies difficulties in his mood"*. She increased the dose of Risperidone to 10mg[48] and decided to see him in a week's time, depending on how he appeared when seen by Ms Sturdy and Ms Galloway on 23rd August.

57. When we saw Dr Dein she commented on the 19th August consultation:

[47] Chapter 2.4 paragraph 57.
[48] Although in May 2004 John Barrett had been discharged on a dose of 10mg, between then and August this appears to have reverted to 8mg.

I thought it was more a sign of deterioration in his mental state. The problem was that it wasn't very hard symptoms. I was basing my assessment on what he was not saying rather than on what he was saying or what he was doing. I was basing my assessment on the quality of our own relationship in that interview. It wasn't based on him actively talking and responding to voices or admitting to anything, which is what made the assessment difficult, and I wrote that … He was very difficult to assess because he was not giving anything away, and I was more concerned as to why he was not giving anything away rather than what he was telling me.

Dr Dein was concerned that:

He was not talking because I felt in the worst case scenario he has incorporated me into a persecutory delusion and he thinks I am part of it. The next possibility was he was very concerned that I would admit him and he wanted to avoid that. The impression I had was that he was trying to avoid an admission and he was very concerned that seeing me might lead to an admission of some form. On the third level that he was, as some patients are, very suspicious and uncomfortable with psychiatrists, who have a certain amount of power to take away their liberty. Those were the three possibilities I considered, and I more or less thought it was the second, that he was getting very concerned that I might admit him.

58. On the afternoon of Thursday 19th August Ms Sturdy spoke to JW who said she was planning to move out by the following Monday. John Barrett had said he wanted her to leave by then. JW thought John Barrett was still using cannabis and she described him as very erratic and as paranoid towards her. She suspected "*he's not at all OK, and not letting on*". She referred to two recent incidents:

1. They were out last weekend. He walked past a man on a mobile phone – he turned round to the man and made a comment and pointed at him. When JW asked why he'd done it, he said 'Well, he obviously knows me'. Fortunately the man just looked surprised and didn't react. 2. When they were talking

about her moving out and him managing his money, he told her that she didn't have to worry, as he'd be getting plenty.

She also mentioned that John Barrett had asked Mr A about the price of houses in Belsize Park, as if he was thinking of buying one - such an unrealistic proposition as to lead her to question whether once again he was believing that he was very wealthy.

59. As Ms Sturdy and Ms Galloway arrived at John Barrett's flat on 23rd August JW was leaving. She told them she would be moving out and the relationship was effectively over. John Barrett appeared subdued during the visit and attributed this to the ending of his relationship with JW. A urine drug screen was negative for cannabis and other drugs. Ms Sturdy reminded him of his appointment with her and Dr Dein at 10am on 26th August.

60. The only record we have seen of John Barrett's meeting with Ms Sturdy and Ms Galloway on 23rd August is the entry in the referral minutes for 24th August. However Ms Galloway told us:

When we got to the flat, he was polite and amenable. He was a little down because he reported the nine-year relationship break up, which would fit very well with his presentation. As far as we could see he wasn't paranoid, grandiose or flirtatious, as he can become. There were no symptoms. We spoke to him about the mobile phone incident, which I think he had reported a day or two before to Sue. It was at the point of the mobile phone reporting that Sue and I – Sue more than me, because she was involved more – began to feel that this was taking a new turn where we had to do something differently. That is why the medical cover was increased and she approached Dr Dein to see him more regularly.

61. Shortly before 10am on 26th August Ms Sturdy was telephoned by John Barrett's brother. He reported that John Barrett had spoken to his mother the previous evening and she had reported that he had said a few things from which she inferred that he believed his previous delusional beliefs had been justified. Ms Sturdy informed Dr Dein of this conversation. John Barrett did not arrive on time. When Ms Sturdy contacted

him at 10.15am he said he had forgotten. Ms Sturdy thought he sounded a bit distracted. He agreed to see Dr Dein at 11.45am instead.

62. When John Barrett arrived he apologised for being late. The following is taken from Dr Dein's entry in the notes:

> *His ex-girlfriend* [JW] *is leaving on Sunday. He says he has been preparing himself mentally for a while. Says he would contact us if he needed extra support.*
> *Does not feel any different following the increase in dose* [of medication] *no side-effects either. Urine drugs screen on Monday (23.8.04) was negative – says he does not like the mental state that cannabis puts him in – says it makes him more paranoid, therefore he avoids it, except when bored.*

The entry notes that Ms Sturdy had informed Dr Dein about her telephone conversation that morning with John Barrett's brother. The note records that this was discussed with John Barrett, who said that these were thoughts he had had when psychotic and that they were not true. Dr Dein's mental state examination recorded:

> *Sat arms and legs crossed, seemed v. guarded, appeared to be telling me what he thought I would like to hear. Flat affect, no pressure of speech/flight of ideas.*

Her impression was: *"Very difficult to assess as he is so guarded"*.

63. Dr Dein then telephoned JW who told her that they were splitting up "*mainly due to his deterioration in mental state"* and that she would be moving out over the weekend. JW said she thought he had deteriorated because he was bored and had started using cannabis. She considered that he was showing early signs of relapse. Dr Dein recorded JW's specific concerns:

1. *Increased paranoia – the weekend before last he spoke to a stranger in Putney because of his feelings of paranoia about him*
2. *Increasingly guarded, especially with mental health – she says this is a normal pattern when he is unwell*

3. *Sleeping at 9.00 am and waking early*
4. *Lost one stone in weight in less than two months.*
5. *Up and down in his mood. Said on one occasion that he was getting a lot of money. Got very verbally abusive three weeks ago - she felt so frightened she went to stay with a friend. At other times* [he] *seems very concerned and withdrawn.*
6. [He] *appears at times to be distracted and to be responding to voices.*

64. Dr Dein recorded the following plan:

1. [JW] *has agreed to get in touch with the mental health services if she gets concerned about him when she sees him.*
2. *Continue Risperidone 10mg – consider increasing it further if required.*
3. *Continue regular ('random') urine drug screens.*
4. *CPA with Dr Mezey on 7.9.04.*
5. *I have left a message with Sue Sturdy to discuss the possibility of more support at this time.*
6. *To monitor his compliance.*

65. When we asked Dr Dein about her impression of John Barrett on 26th August, she told us:

> *I was sure he was deteriorating in his mental state, but I also had the impression in the second week that the introduction of Risperidone had done something. I wouldn't say I was convinced at that point he had a full-blown relapse.*

66. Dr Dein then spoke to Ms Sturdy who said she would be seeing him the following Wednesday, 1st September. She agreed to pass on information about John Barrett to duty social services in case he or someone else on his behalf contacted them over the Bank Holiday weekend. Dr Dein and Ms Sturdy agreed:

> *Low threshold for offering admission, as much as possible as an informal patient; duty doctor to see him* [if there are concerns]*; to consider a Mental*

Health Act assessment, if signs of further deterioration, in view of his past history.

Ms Sturdy duly faxed the Wandsworth out-of-hours social worker and the crisis team with information about John Barrett, in case there was any contact from him, or from others about him, over the weekend. She then telephoned JW with contact details for the out-of-hours service.

67. There was no contact over the weekend. On Tuesday 31st August Dr Mezey returned from leave and John Barrett was considered at the referral meeting which she chaired. Among those present were Dr Dein, Ms Sturdy and Ms Galloway.[49] We have been told that the referral minutes (paragraph 52 above) do not record accurately what was agreed. According to Ms Sturdy's entry in the multi-disciplinary notes, it was agreed to admit John Barrett the following day:

Discussed in team meeting. Given recent reports re concerning behaviour and observations during recent contact with team, agreed that he should be readmitted. When sees me tomorrow morning, to ask to come in. If not willing to do so, would need to contact Home Office to discuss recall.

Ms Sturdy drew our attention to the clarity of this entry. She also told us that it is her practice to check the accuracy of her recording where, as in this situation, she is required to take action.

68. That afternoon JW telephoned Dr Dein with the following report, which Dr Dein conveyed to colleagues in the multi-disciplinary team by email at 2.11pm:

She is extremely concerned about his deterioration. Behaving strangely in public, strangers try to avoid him. Concerns also expressed by his friend Mr A that he is acting like a 'lad', something he does when unwell. He is also quite upset about the break-up of his relationship with JW.

[49] The referral minutes record that Dr Tim Green (psychologist), Ms Debbie Chard (occupational therapist), Dr Serat Ozdural (SHO) and Mr Sankoh also attended the meeting.

Ms Galloway replied to Dr Dein within 20 minutes "*Can you let me know who is dealing with this as he probably needs to be seen*". Ms Sturdy replied to Dr Dein, copying her email to Ms Galloway and Dr Mezey:

> *Will see him tomorrow morning as planned and offer informal admission to? Waterfield* [Ward].[50] *If refuses, will have to discuss with Home Office. Gill* [Mezey] *has spoken to Atu* [Dainkeh – nurse with responsibility for bed management in the forensic directorate] *about a bed. Will ring JW to let her know.*

Ms Sturdy did then telephone JW to tell her about the plan. Ms Sturdy told us that JW was happy with what was proposed and agreed not to tell John Barrett. According to Ms Sturdy's note of their conversation, JW mentioned that John Barrett had begun talking very negatively about the hospital and mental health professionals. As recorded in Ms Sturdy's email, Dr Mezey had spoken earlier to Mr Dainkeh, the bed manager, to make a bed available for John Barrett.

1st and 2nd September 2004

69. We confine ourselves here to describing the events as they developed within the Shaftesbury Clinic and the actions of mental health services staff. We describe elsewhere John Barrett's state of mind and what he did after leaving the Shaftesbury Clinic on 1st September.[51]

70. On 1st September John Barrett was due to see Ms Sturdy at the Shaftesbury Clinic at 10am for one of their regular meetings. Shortly after 9am his mother telephoned Ms Sturdy in a distressed state. She reported a recent incident when he had been out with his brother: *"Two policemen walked past – John reacted as in past* [when ill]". She also said he *"got nasty"* with her when she talked to him about not using cannabis or carrying weapons. She said he was swearing a lot, which he had not done before. She told Ms Sturdy that the family were very concerned.

[50] Waterfield ward is a locked forensic rehabilitation ward at Springfield Hospital.
[51] Refer to Chapter 1.8.

71. John Barrett did not arrive on time for his appointment. When Ms Sturdy telephoned him she was initially unable to get through. She then spoke to JW who managed to speak to John Barrett by telephoning Mr A. John Barrett told JW that Ms Sturdy could reach him on his mobile phone. When Ms Sturdy called back John Barrett said he was working with Mr A and had been unaware of the appointment. He was reluctant to come and asked to postpone the appointment to the following week. At Ms Sturdy's insistence he agreed to come in at midday. During the course of their conversation he denied feeling paranoid. When she asked him if he had thought about carrying weapons he appeared shocked that she had asked him such a question.

72. While waiting for him to arrive Ms Sturdy telephoned Dr Mezey. They agreed to wait and see whether he would come to the appointment. If he did not attend, according to Ms Sturdy's note of the conversation, the Home Office would be asked to recall him. Otherwise the plan remained that he would be offered informal admission and Dr Mezey would see him later that day.[52] Ms Sturdy tried to find out if a bed was available for him and was told that arrangements were being made to vacate a bed on Halswell Ward within the Shaftesbury Clinic.

73. John Barrett arrived at 11.40am and was seen by Ms Sturdy and a senior social worker in the Forensic Service. The following is Ms Sturdy's account of the meeting, which she gave in a statement dated 2nd September 2004:

> *Mr Barrett said that his voices remained at the level of indistinct whispers. He attributed his difficulties to his relationship break-up rather than his illness. He denied having paranoid feelings or thoughts of carrying a weapon. His answers were all meant to reassure, but felt too glib and my assessment remained the same in relation to his need for re-admission. I voiced my concerns about him in relation to the observations of myself and other team members when he had been seen in the last week or two, along with reports of his behaviour that were worrying. I told him that I thought he should come back to hospital for a period of assessment. He said that he would prefer not to if possible. I told him that I was sufficiently concerned that I would want to*

[52] Dr Mezey was at the Home Office that day but hoped to be able to get to the Shaftesbury Clinic later to see John Barrett.

discuss the situation with the Home Office if he was not willing to come in, and that they may choose to recall him. We discussed the pros and cons of each approach, e.g. likely lengths of admission in each case. He agreed that he would be admitted. I commented that it might seem like overkill to him, but that it was better to be safe than sorry. He said that he felt it was overkill, but that he appreciated my care and concern.

74. The way Ms Sturdy put it in her contemporaneous note was: "*He would prefer not to* [come into hospital] *but agreed to do so as preferable to being recalled*". She wrote out the following plan immediately after her record of the interview:

1. *Remain on unit until assessed by Dr Mezey.*
2. *Can have unlimited garden leave* [in the secure garden of the Shaftesbury Clinic].
3. *If wants to leave, s. 5(2)* [of the Mental Health Act 1983] *and we will pursue recall..*
4. *I will contact JW to ask her to bring items for John later today.*

75. John Barrett was then put through the standard admission procedure for the Shaftesbury Clinic. He was searched and items such as his mobile phone, keys and bank cards were removed. A nurse, Mike Boyce, arrived from Halswell Ward to escort him to the ward. In Mr Boyce's presence Ms Sturdy told John Barrett that he would have to remain on the ward, with access to the secure garden area, until Dr Mezey could attend later in the day to assess him. She also made a note of clothing and personal effects which he wanted JW to bring to the hospital. John Barrett was admitted to Halswell Ward shortly after midday.

76. When Ms Sturdy, having written up her notes, went to the ward with the multi-disciplinary file, nurses queried the decision to admit John Barrett informally. Ms Sturdy, who had been a party to that decision, reassured them that she would try to get Dr Mezey to see John Barrett that afternoon.

77. At about 1pm John Barrett had a conversation in the kitchen on Halswell ward with Dr Anakwue. Dr Anakwue had known John Barrett in September 2002 when he had

been a member of Dr Bartlett's team. He had also examined him on one occasion during the May 2004 admission to Jupiter Ward. Having established that he was speaking to a doctor, John Barrett asked why he had been admitted to the Shaftesbury Clinic rather than to an open ward, as he had agreed to come in voluntarily. Dr Anakwue said he did not know the reason because he was not a party to the decision. He told him that possible reasons were that no bed was available on an open ward or that that the team believed he was so ill that management on an open ward would be inappropriate. John Barrett responded that he could not accept the second possible reason because "*I am taking my medication, going about my usual business and not fighting with anybody*". He went on to say what the team were interpreting as a deterioration in his mental state was in fact stress brought on by the breakdown of his relationship with JW. He mentioned that he had asked her to leave the flat they had shared. Dr Anakwue described John Barrett during this exchange as "*appropriate, cooperative though slightly irritable and sounded frustrated*". John Barrett thanked Dr Anakwue for taking the trouble to speak to him and they shook hands.

78. As Ms Sturdy was leaving the ward John Barrett came up to her and said he was unhappy being on a medium secure ward and asked why he had not been admitted to an open ward. Before leaving the Shaftesbury Clinic to go to her next appointment Ms Sturdy spoke to Dr Mezey's secretary and asked her to tell Dr Mezey that nurses on the ward were querying John Barrett's informal status and that John Barrett was unhappy about being on a secure ward.

79. At 1.45pm Mr Sankoh, nursing team leader on Halswell Ward made the following entry in the notes:

> *Call from Dr Gill Mezey:*
> *Dr Mezey and I discussed my concerns of admitting informally (John) on the ward. She clearly stated that technically he is not informal. However the plan will be:*
> 1. *To be granted 1 hour unescorted* [leave] *to the grounds per shift.*
> 2. *If he fails to return to contact Dr Gill Mezey and Sue* [Sturdy] *immediately, she will initiate and contact Home Office for a formal recall.*

3. *If he attempts to leave the ward to be placed on 5(2).*
4. *Dr Mezey to see him tomorrow.*

80. Dr Mezey accepts that this is a reasonably accurate note of what she said, but there is disagreement about the process by which the plan was made. Dr Mezey spoke to Ms Sturdy before her conversation with Mr Sankoh. In a statement she made on 2nd September 2004 Dr Mezey said:

> *I informed Susan that, if Mr Barrett appeared settled on the ward I felt it would be appropriate to give him one hour leave in the grounds, per shift, provided no concerns were raised by the nurses or the ward doctor after he had been clerked in. Susan agreed with the plan and I told her I would phone the ward manager, Alpha Sankoh, to discuss this with him. At about 12.30 I telephoned Alpha Sankoh, Nursing Team Leader on the ward and informed him that, although John was being officially admitted on a voluntary basis, we would have a very low threshold to recall him to hospital. He was to be seen and clerked in by the Senior House Officer,[53] who was told that he could contact me after his assessment, if he had any concerns. It was agreed with Alpha Sankoh that Mr Barrett could be given 1 hour unescorted ground leave that afternoon. However, I told Alpha that, if Mr Barrett did not return to the ward after one hour, the nursing staff should immediately contact myself or Ms Sturdy and we would then issue formal recall proceedings through the Home Office to bring him back into hospital. This discussion was recorded in the ward notes by Alpha. I also told Alpha that I would be coming to the ward first thing the next morning to speak to John myself.*

81. Dr Mezey acknowledged to us that this represented a change of the agreed plan that she would assess John Barrett that afternoon:

> *I knew on the day we discussed admission that I had a meeting at the Home Office. I had hoped to be able to see him that afternoon following his admission. I agreed with Sue Sturdy that I would see him on the afternoon of*

[53] Clerking in is the routine procedure, comprising interview, physical examination and documentation, that needs to be done by a member of the medical staff of the hospital shortly after admission.

1st September after he came in, but by the morning it was clear that I wasn't able to get out of this Home Office meeting, so I knew by early afternoon that it was going to be very difficult for me to see him. I talked to all the members of the team and at that point I informed Sue and Alpha, the charge nurse, that I couldn't go that afternoon but I would go first thing the next morning.

In relation to the nurses' concerns about informal admission, Dr Mezey told us:

I understood there was some concern or uncertainty about what it meant having an informal restricted patient. My thinking at the time was as the senior nurse responsible for managing nurses on the ward and talking to them, that the discussion I had with Alpha would be conveyed and if there were any further concerns they would talk to me again. Sue Sturdy also spent some time talking through what the contingency plans were and the fact that he wasn't truly informal.

82. In the statement he made at the time, Mr Sankoh referred to Dr Mezey outlining the plan to him, rather than agreeing it with him after discussion.[54] Similarly, Ms Sturdy does not accept that the changed plan was one to which Dr Mezey had sought her agreement. In her statement of 16th March 2005 she said that before leaving the Shaftesbury Clinic that day:

I spoke to Dr Mezey briefly before going out. During the course of this conversation, I indicated to her that I had understood from our conversation that morning that she would see Mr Barrett the same afternoon. She said that she would see him the following day. She also said that she thought he could have one hour's ground leave, which I took to be her decision on the subject. Any further discussions about leave or action to be taken in the event of his failure to return to the ward took place between Dr Mezey and Alpha Sankoh. I was not aware of what had been agreed until the following day.

[54] Mr Sankoh did not tell Dr Mezey that he either agreed or disagreed with the plan.

83. In the meantime, John Barrett was on Halswell Ward waiting to be allocated a bed. According to the nursing entry made by Mr Boyce:

> *John appeared slightly irritated and when I spoke to him, he explained that he had expected to be taken to an open ward. He had previously been asked by the social worker and myself that we would like him to stay on the ward until seen by Dr Mezey. However, we got the message as documented above that he would be allowed some leave. I explained this to him and that Dr Mezey would see him tomorrow. He asked when this would be. I told him we would call the secretary tomorrow morning. He appeared to be appeased by this. He was seen by the SHO and then utilised his unescorted ground leave. It was explained to him that this would be the only* [ground] *leave he could utilise today but hopefully he could utilise some* [secure] *garden leave later. He appeared to accept this and agreed to co-operate with what we wanted him to do. He has been placed on 5 minutes observations. Appeared a bit tense in his mood. Did not exhibit psychotic symptoms. Behaved appropriately.*

84. Dr Anakwue returned to the ward at about 2.45pm for the purpose of clerking in John Barrett as part of the normal admission process. He did this at the request of Dr Mezey, conveyed to him by her secretary. By this time the message from Dr Mezey had been relayed to John Barrett that he would be allowed unescorted ground leave. This is the entry Dr Anakwue made in the multi-disciplinary notes:

> *Known patient of Dr Mezey's team with a diagnosis of paranoid schizophrenia.*[55] *Agreed to come into hospital voluntarily after he was told by his social worker that she was concerned about his mental state.*
> *Does not believe that there is any problem with him, thinks he has been behaving himself, not fighting with anybody. Later he said that whatever people may think is wrong with him is all down to stress of breaking up with his girlfriend after 10 years.*
> *Unhappy that he has been admitted to a locked ward as against an open ward even though he came in voluntarily. However willing to remain in hospital.*

[55] This statement is not correct, the diagnosis had been delusional disorder since it was changed in December 2002

Denied any physical health problems.
Current medication: Risperidone 10mg Nocte.
Allergies – Nil known.
Mental state examination
Middle aged Afro-Caribbean male, looking a bit emaciated, anxious, slightly irritable, good eye contact, reasonable rapport. Looked well-kempt.
Speech normal in all respects.
Denied any formal thought disorder.
Admitted to hearing whispering voices, unable to characterise the voice but claimed not to be distressed by the voice.
Nil delusions elicited.
Nil plans to harm self or others.
Insight not very well
Declined physical examination.
Impression
Relapse of mental illness (early stage).

85. After examining John Barrett and making his entry in the notes Dr Anakwue spoke briefly to Ms Sturdy by telephone. This was the end of his involvement. He did not speak to Dr Mezey about John Barrett that day.

86. Following Dr Anakwue's examination, just after 3pm John Barrett was escorted by a nurse off the ward and to the door of the Shaftesbury Clinic to take one hour's unescorted leave in the grounds of Springfield Hospital.

87. In the meantime, between 1.30 and 2pm there had been a nursing handover, from the morning to the afternoon shift, which was immediately followed by a staff support meeting, from 2 to 2.30pm. The handover was between the respective shift-coordinators, Mr Boyce and Loveness Hassan. The handover meeting took place before Dr Mezey's telephone conversation with Mr Sankoh, when it was still Mr Boyce's understanding that John Barrett would be staying on the ward until seen by Dr Mezey later in the day. Between the handover meeting and the staff support meeting, Mr Sankoh told Mr Boyce he had spoken to Dr Mezey. According to Mr Boyce he was told only about the decision to allow John Barrett one hour's unescorted leave and not

about other elements of the plan. Mr. Sankoh, on the other hand, believes that he not only told Mr Boyce about the leave but also specifically mentioned the stipulation in point 2 of the plan (paragraph 79 above). Ms Hassan told us that Mr Boyce did not draw that point to her attention during or after the handover. In any event, the note made by Ms Hassan on the handover sheet was:

> *John Barrett Admitted today – Due to break-down. Informal . Dr Mezey to see him. Not to leave until seen. Dr Ken* [Anakwue] *saw pt. S/N Mike Boyce handed Pt can leave ward on 1 hour unescorted.*

This note combines elements of the original plan – Dr Mezey to see him that day - and the amended plan, that he was to be allowed an hour's unescorted ground leave.

88. For the sake of completeness, we need to record that after his conversation with Mr Sankoh, Mr Boyce explained the change of plan to John Barrett, as recorded in his entry in the notes from which we have quoted in paragraph 83 above. It was at this point that Dr Anakwue arrived on the ward and examined John Barrett, as described above. At the conclusion of the examination Mr Boyce duly made an entry in the leave book at 3.05pm and John Barrett was escorted from the ward by another nurse. Mr Boyce made an entry in the multi-disciplinary notes before leaving work, from which we have quoted. This was on the same page as, and immediately below, the entry made by Mr Sankoh which recorded the four points. Mr Boyce's entry specifically referred to the message from Dr Mezey *"as documented above"*. Mr Boyce says, however, that he had not read Mr Sankoh's entry. This was because he was in a hurry, as he should have left work at 2.30pm when his shift finished.

89. John Barrett left the Shaftesbury Clinic at 3.05 pm. When he did not return after an hour, Ms Hassan, who was shift co-ordinator, decided to allow him another 10 minutes before starting the AWOL procedure. She thought this was normal practice, at least in respect of an informal patient who was late back from leave. In fact she allowed him more than 10 minutes because by her own account she did not start the procedure until 4.30pm.

90. Ms Hassan was familiar with the procedure and knew that it required nursing staff to go through a checklist, on a standard form, of actions to take and people to contact. There was some confusion because in the file on the ward she found two versions of the form. She started using the old version and then realised her mistake and went over to the new version. It appears that this mistake did not of itself cause any delay in the process.

91. The checklist requires the nurse to initial the form and to note the time each specified action is taken. Ms Hassan completed the form in such a way that it is not possible to rely on the times she wrote down. However, from her own account and that of others, together with the entries on the forms, the sequence of events is relatively clear. The timings are unreliable and not mutually consistent. We report them as given to us.

92. When Ms Hassan had found the forms, she next took out John Barrett's file. She found a number for JW and telephoned her between 4.30 and 5pm. JW had not seen John Barrett but said she would let the ward know if he contacted her. She also gave Ms Hassan his mobile phone number. Ms Hassan called this number and left a message, not realising that the mobile phone was in the Shaftesbury Clinic, having been placed in a secure locker when John Barrett was admitted. Ms Hassan believes she also left messages for John Barrett's mother and brother.

93. At about 5.30pm Ms Hassan contacted the duty senior nurse, David Obamakin to notify him that John Barrett had not returned from leave. He was based elsewhere in Springfield Hospital and said he would come to the ward. He asked Ms Hassan to contact John Barrett's next of kin immediately. (It is possible that Ms Hassan only then telephoned John Barrett's mother.) Mr Obamakin arrived on the ward within 15 minutes. He had some prior knowledge of John Barrett because he had nursed him as an in-patient in 2002. He advised Ms Hassan to contact the police and to explain that although John Barrett was an informal patient he had a history of violence. This was intended to alert the police to the need to try to find him. Mr Obamakin also told Ms Hassan to contact Dr Mezey. As both these matters were covered by the checklist they should have been done without his intervention. In order to give the police the information they would require, specifically John Barrett's index offences and when

they were committed, it was necessary for Ms Hassan to refer to the file. Mr Obamakin told us that he remained on Halswell Ward while Ms Hassan contacted the police and Dr Mezey. Dr Mezey's contact details were not kept on the ward so Ms Hassan telephoned the Gate Lodge at Springfield Hospital. They gave her a pager number and she left a message with the operator for Dr Mezey to telephone the ward. Ms Hassan recorded the time she left the message as 7.15pm, but it may have been earlier. Ms Hassan also telephoned Dr Moodley, the duty consultant, at about the same time and he advised her to follow the normal procedure under the AWOL policy. She also telephoned the police, although it is not possible to determine exactly when. Ms Hassan said it took a long time to get through and it was necessary to telephone the number repeatedly. Mr Obamakin says Ms Hassan telephoned the police while he was on the ward, that is before 6pm. Two different times are entered on the checklist: 6.45pm and 7.20pm. The police records give the time they were contacted as 7.05pm. Ms Hassan did not contact Ms Sturdy as she did not consider this necessary because John Barrett was an informal patient. The Trust's AWOL checklist of people to contact says: *"Social worker (if applicable)"*. Ms Hassan had not read the entry in the notes that both Dr Mezey and Ms Sturdy were to be contacted if John Barrett failed to return from unescorted leave. Ms Hassan went off duty at 9.45pm. At that time she still had not heard from Dr Mezey. Indeed, Dr Mezey did not receive the message because she had switched off her pager.

94. At 11.30pm JW telephoned the ward to say that she had heard from John Barrett. He was staying with a friend and had told her he would return to the Shaftesbury Clinic in the morning. JW knew he was staying at Mr A's flat in Belsize Park but she did not tell nursing staff.

95. At 3.30am police came to the ward in response to the report that John Barrett had absconded. They had been to his home, but there was no one there. They explained to nursing staff that as John Barrett was an informal patient they could not bring him back to the ward if he was unwilling to return.

96. At about 9am on 2nd September JW telephoned the Shaftesbury Clinic and spoke to Dr Mezey's secretary. JW asked her to contact the police. She told her that John Barrett had left Mr A's flat in a mini-cab with a knife and duct tape. She also gave her

details of the mini-cab company. This is all that she and Mr A knew. She did not know where John Barrett was going. Dr Mezey's secretary telephoned Dr Mezey at about 9.15am. She then spoke to Ms Hassan, who was back on duty on Halswell Ward, and asked her to contact the police. According to police records, Ms Hassan telephoned the Missing Persons Unit at 9.30am to pass on the information that John Barrett had left Mr A's Belsize Park address in a mini-cab with a knife and duct tape. She also provided the telephone number of the mini-cab company. The police officer who took the call telephoned the mini-cab company. They said they had picked up John Barrett between 8.15 and 8.30am and taken him to Richmond.

97. Dr Mezey arrived at the Shaftesbury Clinic at about 9.30am and contacted the Mental Health Unit (MHU)[56] at the Home Office to ask them to issue a warrant for John Barrett's recall. Her letter requesting recall was faxed to the Home Office at 10.21am and stated that John Barrett had failed to return to the ward after being given one hour's ground leave. The warrant was issued and faxed to Dr Mezey at 2.16pm.

98. In the meantime Ms Sturdy, who had also been contacted by Dr Mezey's secretary, arrived at the Shaftesbury Clinic at around 9.50 am. After discussion with Dr Mezey, she telephoned the Public Protection Unit at Wandsworth police station just before 10.00 am and they issued a report making police officers aware that John Barrett was missing and was carrying a knife.

[56] The Mental Health Unit is responsible for carrying out the Home Secretary's functions under Part III of the Mental Health Act 1983.

Chapter 1.8 - The Homicide

Introduction

1. Shortly before 10am on 2nd September 2004, as Denis Finnegan was cycling through Richmond Park John Barrett lunged at him with a kitchen knife and stabbed him in the back. Denis Finnegan fell to the ground and John Barrett stabbed him again in the back and once in the abdomen. He died from his injuries later that day.

2. In this section of the report we describe what John Barrett did between leaving the Shaftesbury Clinic at about 3.00pm on 1st September 2004 and his arrest the following morning after he had attacked Denis Finnegan. We also describe his state of mind during those hours. For this we rely on what he told the police after his arrest and on the reports of two consultant forensic psychiatrists, Professor Eastman and Dr Edward Petch, who interviewed him on 6th and 14th September 2004 respectively. We acknowledge that the account he gave them could be seen as self-serving, in that he said he was compelled to act in the way he did by auditory hallucinations commanding him to kill. However, we are satisfied that he has told the truth about this, both because we find his account convincing and because he has been consistent in what he has said since his arrest and throughout the criminal proceedings, and since being sentenced and detained in Broadmoor Hospital. We conclude this section of the report with a brief account of the criminal proceedings in connection with Denis Finnegan's death.

John Barrett's actions on 1st September

3. As described in the previous section, John Barrett was escorted by a nurse to the door of the Shaftesbury Clinic just after 3.00pm on 1st September. He went to a nearby railway station from where he travelled to Earls Court. He tried to get a hotel room for the night but was unable to do so because he could not provide proof of identity. He then went by bus to Kensington. He drank half a pint of beer in a pub and travelled by taxi to Wandsworth where he bought a pack of three kitchen knives at Homebase.

4. He then went to a pub in Wandsworth for a few drinks, leaving there at about 9.30pm. He had a meal in an Indian restaurant and went by taxi to Richmond Park, intending to spend the night there. It was cold in the park and he realised he would not be able to sleep. He decided instead to ask JW if he could spend the night with her. He telephoned her at about 11.00pm. As she did not agree to his suggestion, he telephoned Mr A who did agree to let him stay. He went by taxi to Mr A's flat in Belsize Park, with the pack of knives in a carrier bag. Before he went to sleep he told Mr A that he would return to the Shaftesbury Clinic in the morning. Mr A telephoned JW to let her know that John Barrett was with him and that he had said he would be returning to the Shaftesbury Clinic. JW conveyed this information to Halswell Ward, but without disclosing John Barrett's whereabouts.

John Barrett's state of mind on 1st September

5. John Barrett told police after his arrest that when he was given one hour's unescorted ground leave from the Shaftesbury Clinic he decided to abscond:

> *They say you can have an hour per shift, on the grounds, yeah, I think to myself that's not enough for me, you know, I can't really spend 23 hours out of a day, 22 hours out of a day, that's the decision I made and I walked out.*

6. He said that when he left the Shaftesbury Clinic in the afternoon he was hearing whispering voices, but these were no worse than they had been for much of the preceding four months. He told the police "*they just went 'shoo'*". While he was trying to get a room in Earl's Court, the voices, one male and one female, became much louder and they were commanding him to kill. He told police:

> *The male voice might go 'Kill' and the female voice would go 'Kill!'… I could never emulate the volume that I hear them because it's kind of, sounds like it's in a bit of a room in your head and everywhere you turn, it's still there. If you put your head under the water in the bath, you still hear them, you just can't get away from them, so you're constantly trapped by them…*

When asked by the police to rate the volume of the voices on a scale of one to ten, he said they were at two when he left the Shaftesbury Clinic and at about seven when they became commands. This was the first time he had experienced command hallucinations. He told Professor Eastman:

> *A voice started, saying 'kill, kill', really loudly… it is the very first time that ever happened, I was scared, I didn't know what to do about it.*

When asked by Professor Eastman why he did not contact the mental health team, he replied:

> *Because I didn't feel I'd be able to survive in the Clinic, with that going on… I didn't know <u>what</u> would have happened, perhaps I'd have killed <u>myself</u>.* (Emphasis in Professor Eastman's report)

7. It was while John Barrett was in the pub in Kensington that he felt he had lost control and was not able to resist the voices. He went to buy a knife with the intention of using it to kill someone in obedience to the voices. He told Professor Eastman "*I tried to resist but it was impossible because it was so loud.*" By the time he left the pub in Wandsworth at about 9.30pm, he had already decided that he was going to stab someone and that he would do it in Richmond Park. He was not able to give a rational explanation for choosing Richmond Park but he said that it had important associations for him.

8. The voices persisted at loud volume and were still there when he arrived at Mr A's flat later that night. He had a brief conversation with Mr A before going to sleep but did not tell him about the voices.

John Barrett's actions on 2nd September

9. After getting up at about 8.00am, he telephoned a local mini-cab firm and ordered a taxi. Before leaving the flat he asked Mr A for some duct tape. Using his teeth, he tore some off a roll and put this in the carrier bag with the pack of knives.

10. The taxi dropped him at the Richmond Gate entrance to Richmond Park at about 9.30am. Once in the park he opened the pack of knives and threw away the two smaller ones and the duct tape, retaining only the largest knife which he put in his pocket. He roamed about the park for about 20 minutes, looking for a victim. When he saw Denis Finnegan coming along a cycle path he went to the side of the path and crouched in wait for him. He stabbed Denis Finnegan as he cycled past. He then put the knife back in his pocket.

11. He walked over to a nearby café in the park where he ordered a cup of tea and a sandwich. After he had finished eating and was walking away from the café he was conscious of a helicopter overhead and he saw police officers coming towards him. He threw the knife away as they approached. He was arrested and taken into custody.

John Barrett's state of mind on 2nd September

12. When he woke in the morning the voices were as loud as the previous day and were still telling him to kill. He knew when he left Mr A's flat that he was going to kill someone. He told Professor Eastman: "*I thought to myself if I didn't kill someone I'd kill myself… because the voices were just driving me crazy*". He was trying to resist the voices: "*talking to them in my mind, saying 'why? …why me?' …I knew it was wrong to kill, which was why I was scared*". He told the police: "*I basically thought to myself that if I didn't carry out that command, the voices would've carried on continuously, regardless*". John Barrett's account is that on his way to Richmond Park he decided that the person he would kill would not be a child or an old person or a young man or a woman. He therefore had to find a middle-aged man.

13. He had asked Mr A for the duct tape to wrap round the knife handle so as not to leave fingerprints. He threw it away when he got to the park because this no longer mattered to him.

14. He told Dr Petch that once he had selected Denis Finnegan he experienced a sudden feeling of fear and adrenalin, but he felt calm as he waited for him to approach. The voices started to subside as soon as he had stabbed Denis Finnegan. He told Professor Eastman:

He fell off his bike and I leaned over him and stabbed him in the stomach twice… and then he said 'what have I done?' and I just walked off. As I did, they got quieter, back to a whisper, within five minutes, no longer saying 'kill…' but I don't know what they said, because I can't understand the whispering voices.

He told the police that he had felt "*relief… I'd done what I'd been goaded to do*".

15. He told the police interviewers that he had no wish to escape:

It doesn't matter how much detail I've gone into about how to approach the situation and put myself into Richmond Park with a knife, at the end of the day once I'd carried out the act, I didn't want to get away with it.

He said the reason he threw the knife away as the arresting officers were approaching was because he felt embarrassed by what he had done.

16. After he was arrested the voices did not return in the form of command hallucinations but remained as indistinct whispers. A doctor examined him at the police station and considered him fit to be interviewed.

Criminal Proceedings

17. John Barrett was charged with the murder of Denis Finnegan and was remanded in custody. While awaiting trial he was transferred to Broadmoor Hospital on 21st December 2004.

18. On 25th February 2005 John Barrett's plea of guilty to manslaughter by reason of diminished responsibility was accepted. On 25th March he received an automatic sentence of life imprisonment under section 109 of the Powers of Criminal Courts (Sentencing) Act 2000, with a tariff of 32 years. On 8th April the Judge reduced the tariff to 16 years. The specified period was 7½ years, being half the tariff less time spent on remand. The effect of the sentence is that John Barrett's case can first be

referred to the parole board in August 2012 for consideration of whether he should be released on life licence. We explain this further in Appendix A.

19. John Barrett did not go to prison after sentencing but instead returned to Broadmoor Hospital under sections 47/49 of the Mental Health Act.

PART TWO

Discussion and Analysis

Chapter 2.1 - Management and Organisation Issues

Introduction

1. The primary focus of forensic services is to manage risk, including risk to the public. That risk should be mitigated by good clinical practice. Clinicians who practise well, however, should not have to compensate for organisational issues which impair the overall service quality, efficiency, and safety. It is therefore relevant to consider the management and organisational arrangements within the Forensic Service.

2. At the start of this Inquiry we quickly became aware of different methods of working between consultant led teams in the Forensic Service. There were discrepancies in the way documents were being completed and poor compliance with Trust policies. We were concerned about governance arrangements and the supervision and management of staff. Early interviews confirmed these concerns and individuals referred us to two reports on the Forensic Service arising from reviews that had been carried out in 2003 and 2004. The findings within these reports concurred with our emerging judgements. We sought additional information from the Trust and subsequently interviewed senior managers and executives.

3. This chapter looks first at those two reviews. We rely on the reports to show that some of the problems we have identified are not peculiar to John Barrett's case. We then describe what we consider to have been the weaknesses in the management and governance arrangements at the time and we relate these to John Barrett's care and treatment. In the final part of this chapter we comment critically on the changes since 2004.

External Reviews of the Forensic Service

i) HASCAS

4. In 2003 the NHS London Region commissioned the Health and Social Care Advisory Service (HASCAS) to review the seven medium secure units within the Region against

agreed quality standards. The multi-disciplinary review team visited the Shaftesbury Clinic for two days in December 2003 and produced its report in March 2004.

5. The following extracts concerning management factors and clinical governance arrangements are taken from the report:

Managerial Factors

The unit has a new management structure with the relatively recent appointment of new members of the team including clinical director, head of psychology and general manager. This local management team is proactive and has a positive attitude towards the large and demanding agenda, striving hard to manage the day to day operational issues.

Many staff within the unit felt that they did not have a voice and cannot alter the prevailing strong medical model with its clear hierarchical structures. There is scope for greater emphasis on nursing leadership within the unit. Clinical governance has not been sufficiently developed at a local level, although this reflects in part the diffuse complex nature of the Trust wide strategy.

The impression gained by the review team was that the lack of a clear strategic direction for the unit and its services reflects difficulties in its relationship with the Trust Board of the South West London and St George's Mental Health NHS Trust. It appeared that adequate resourcing and support, particularly for the management team is seen as a low priority within the context of major problems within the general psychiatry service. Whilst the current focus of the Trust is understandable with the recent homicide currently under investigation[57], there is concern that failing to provide stronger support from the 'centre' for the forensic service management team jeopardises the potential value of the forensic clinical service and its ability to provide support to other services within the Trust.

Standard 7: There are procedures in place to address workforce planning and development

This standard was partially met, but work was needed to improve the current position

Generally the unit was sufficiently staffed. The review team was concerned about the

[57] This refers to a homicide committed in 2003 by a patient of the Trust's general adult psychiatric services.

apparent lack of a senior nursing structure with senior nurses and nurse managers, and the lack of a nurse consultant. Such a structure would help drive forward the nursing agenda, and ultimately help to improve the experience, outcomes and quality of care for service users. An improved senior nursing structure would provide additional support to staff at ward level and more fully represent them at senior management level within the Trust. It would also bring additional management and clinical expertise to the unit and allow the senior operational management team to move the service forward by developing strong links with other Trust services and external agencies. The lack of planned service developments could be a de-motivating factor for staff.

It was felt that communication within the unit could be improved and that better arrangements should be made to cover for the long-term absence of staff. An example was given of a consultant being on extended sick leave meaning that in the absence of clinical cover the social worker and the CPN effectively ran the team. Formal cover arrangements were arranged but were not always effective.

Relationships between multi-disciplinary colleagues are reasonably good although there is a clear hierarchy of power in terms of influence and opportunity. Each of the ward areas works primarily within their own boundaries, and as a result there is no common purpose nor shared vision amongst the nurses. Staff have learned to become self sufficient and there is a resignation and expectation that they should not expect support from their senior clinical colleagues. Nursing leadership is not sufficiently strong, and the Trust Nursing Service contribution is not visible at the direct care giving level.

The unit needs to support its new management team and to concentrate on the core business of delivering forensic psychiatric services within a medium secure unit. There is a need to develop better, more trusting relationships with the wider Trust and the role and influence of medical staff needs to be reviewed. There should be a greater emphasis on creating a more inclusive workforce who can work together and thereby deliver better experiences and outcomes for service users.

The Trust was perceived by forensic service staff to be somewhat distant from the Forensic Service and does not appear to regard it as a major area of concern. This is partly due to its size but also the fact that there are greater concerns within the Trust, including the adult acute services. The management team are very new and whilst enthusiastic, will require considerable help and support.

The overall impression gained by the review team was of a unit that lacked heart. There was no visible desire or enthusiasm to challenge the norms of an organisation that has created an excessively hierarchical service. The relatively new management team will need to be well supported to challenge the current power base, and to win back the confidence, trust, and hearts and minds of the staff.

Recommendation 7

The Senior Management Team should examine the management and career structures of all disciplines within the Shaftesbury Clinic and seek to develop an organisation which maximises the opportunity for each to fully contribute to the running of the unit and its strategic direction.

Recommendation 8

The Senior Management Team should work closely with the Trust Board to identify ways in which they can work more closely together, and identify how the potential of the forensic service can be developed.

Standard 11: The unit has comprehensive clinical governance arrangements

This standard required considerable work to make the clinical governance process meaningfully impact on the work of the unit.

The Trust Board has the responsibility for implementing clinical governance across the Trust and ensuring it is fully developed within each Service. Four priority areas have been identified and each service has to report on how it is contributing to each area, and the effect this is having on practice. The four areas are:

- *Clinical and non-clinical audit*
- *Evidence-based practice*
- *Performance and appraisal*
- *Risk assessment and management.*

The unit used the external and internal sources of information as listed in Standard 11.1 but the review team was unsure how the lessons learned from both external review and internal

audit were made known to all staff. Many staff interviewed did not know about the progress of investigations into incidents nor the outcomes of audits. It is felt that work needs to be undertaken to ensure that lessons learned from within the Forensic Directorate and from the wider Trust and beyond are made available to staff, and that discussion of their potential benefit to existing practice should be regularly organised at ward level.

The operational policy for the unit is clear and detailed, and is reviewed annually. The operational policies listed in Standard 11.4 were seen by the review team, and staff were aware of them and knew where they were stored should they need to consult them.

The Assistant Director of Governance had recently assumed responsibility for the complaints process. A copy of the policy was seen by the review team and whilst clear and straightforward was in fact out of date. Audits have been undertaken in conjunction with the Community Health Council and the Complaints Monitoring Group but have been disbanded. Staff felt that they did not receive support if they were involved in a complaint or an untoward incident, and thought that if "anything goes wrong we will be assumed to have made a mistake." Despite documents and policies to support the existence of a 'no blame culture' staff felt that they were blamed and did not receive support when anything went wrong. They were particularly concerned that in general the medical staff were not supportive and did not help to understand how incidents arose and to begin to contribute to discussions on how they might be prevented in future.

Recommendation 12

The Senior Management Team should review the clinical governance arrangements within the unit to ensure that they are 'joined up' and enable lessons to be shared with all appropriate staff. Specific workshops at ward level should be considered to enable lessons to be given within the ordinary work environment to all staff.

ii) Mental Health Management and Consultancy Limited

6. The review by Mental Health Management and Consultancy Ltd was conducted by Jim Mc Donald, a senior psychiatric nurse with a wide range of forensic service related experience gained over many years. He had been a member of the HASCAS review team and was commissioned by the Trust in the summer of 2004:

To undertake a general overview of the Forensic Service… there would be a strong focus on nursing and how the challenges facing nursing within the [Forensic] *Service could be managed.*

He carried out the work between October and December 2004 and produced a report in December 2004. The following extract is taken from a section of the report called 'The Service in Context':

The present configuration of services within the Forensic Directorate does not lend itself to delivering an effective, value for money, patient centred service. The current initiative to re-design the organisation and functioning of the Forensic Directorate will provide opportunities for delivering a service that is more patient focused and which views things through the users eyes (patients/staff).

Key to this is effective communication which is the cornerstone of good clinical practice and is crucial to the successful management of any organisation. There are considerable deficits with communication within the Forensic Directorate. These are observed with staff to staff as well as staff to patient interactions, and are clearly evident in various reports, reviews, critical incidents etc. Developing and establishing communication will require that the patients and staff feel they have a voice and a contribution to make, and for the workforce to have self esteem, confidence and feel valued. The culture of the organisation in which patients live and staff work needs to empower and be respectful of patients and all staff groups, and should aim to promote growth and learning.

The culture within the Forensic Directorate inhibits the ability of staff and patients to learn. The quality of the discussion, dialogue and involvement, and the way people communicate with each other are all cause for concern. Creating a culture where staff work closely together to provide the best possible care to patients can best be achieved through the effective MDT working. There is a commitment within the Directorate to the principles and values of MDT working, there is also recognition that there is considerable scope for improvement.

Much of the improvement relates to the perceived lack of empowerment expressed by some staff groups, and the lack of true dialogue between various professional groups. The expectation of staff, particularly nursing staff, of the psychiatrist's role of clinical leader is

not being realised. The perceived absence of consultant leadership in carrying out their primary role i.e. in-patient care, is demoralising and has a detrimental effect on MDT working and on the service as a whole…

The Forensic Service at the present time faces considerable challenges. The ability and capacity of the staff to respond to those challenges will depend on the commitment of the Service to provide continued professional development that goes beyond the provision of mandatory training. A commitment to support and develop the staff is necessary, not only to meet statutory and professional obligations, but also to reap benefits in maintaining and enhancing competence and improving patient care.

The current very big agenda in forensic mental health and the workforce and training requirements for nursing will require a considerable investment in training. It is important that any resource allocated to training is done equitably, and that the needs of those staff working directly with patients are met…

The findings outlined in this section of the document… represent a manageable challenge for the [Forensic] *Directorate. The support of the Trust will be crucial in helping the Forensic Directorate manage these changes. It should be stated that many of the issues highlighted are common to other similar services. The two main tasks of the Directorate are firstly to achieve greater involvement of the consultant psychiatrists in the core day to day business of the unit with a greater priority given to direct patient care and with consultants assuming the role of clinical leaders, and secondly to recognise the challenges facing the nursing service and develop strategies to allow the nurses to move away from providing custodial care as perceived by the patients to a much more therapeutic role where they can develop positive relationships with the patients, and directly affect patient experiences and outcomes. The remainder of this section of the report describes the nursing service in context and the challenges they face.*

7. Specifically in relation to nursing, the report contains the following section on the need to develop a nursing strategy and infrastructure:

The Forensic Directorate at the present time has no nursing strategy unique to the needs of nurses working in a forensic unit, nor does it have the kind of nursing infrastructure which would be common in other similar units and which is necessary to create a modern nursing workforce fit for now.

The absence of these key components within the Forensic Directorate makes it extremely difficult for the nurses to contribute in the way and to the extent that would be expected. The result is that nursing staff cannot move at the same pace as other disciplines and find it hard at times to contribute equally with any degree of confidence. There are a multitude of deficits within the nursing strategy that sets out a clear vision for nursing and provides leadership through the appropriate infrastructure. Many of the current problems around apathy, indifference and motivation would be successfully challenged if the right conditions were created.

The Forensic Directorate should develop a nursing strategy for the management and care of forensic patients which conforms to national initiatives and the Trust strategic plan, but which takes detailed consideration of the needs of nurses working an a forensic unit. The Forensic Directorate also needs to review the nursing structure, taking account of the developments of other similar services as well as recognising the very big agenda in forensic mental health, and the workforce development needs for the future. Developing and restructuring the nursing services will have a resource attached and this has to be viewed against the nurses unique role in being able to directly affect the experiences and outcomes of patients.

8. The report finished with a section on communication:

Good communication is crucial to the successful management of an organisation, in healthcare settings it is the cornerstone of good clinical practice. Striving to improve communication is a key challenge for all organisations. The Forensic Services Directorate provides healthcare in a secure setting to a complex group of patients, maximising communication and the ability to extract, organise and interrogate information will dictate how effective and safe the organisation could become.

Communication channels and initiatives within the Directorate have been established for many years and have sufficient value to allow the service to function. There are however considerable deficits with failed communications a feature of daily life in the unit. This is observed with staff to staff communications as well as staff to patients. Failed communications are continually identified within various reports including critical incidents. Communication failures are also observed within the unit with the lack of meaningful communication forums.

The reasons for these problems are many and are discussed and alluded to in every section of this report. There is an urgent need to improve communication within the unit and develop a culture for communicating which looks at "how people talk to one another and the quality of their conversations" The ability of staff and patients to communicate freely in an open and honest way with each other is central to the establishment of a healthy working environment for staff, and a healthy living environment for patients.

Communication needs to become a more dynamic process. There is a need to make communication a two-way process by building interactions into the communication creating dialogue not monologue.

Developing and establishing effective communications will require the workforce to have self-esteem, confidence and good morale, only with these do staff function at their very best. In many parts of the service these are missing.

9. As the extracts we have quoted from his report show, Mr Mc Donald's criticisms of nursing in the Forensic Service were linked to what he considered to be the poor functioning of multi-disciplinary teams and the lack of effective leadership offered by consultant psychiatrists. All those whom we asked welcomed this report, but they had differing interpretations of what it said. Doctors tended to see it as drawing attention to weaknesses in nursing, while nurses emphasised what they understood to be criticisms of the role of doctors within the Forensic Service.

> *The general gist of what he* [Mr Mc Donald] *was saying was that his feeling was generally that it was very much a medically-led organisation. I would have to agree with that. There were issues, but I would have to agree with the general gist in terms of the medical input within the service… It was very refreshing to have someone to come in from the outside, to review the service. Within the service, it is very difficult to be heard… It is something that will probably lead to some self-reflection about the organisation and how we can empower nurses, and make the service much more transparent. I agree very much with what he says, although I am not sure that a huge amount has changed with regard to that since then… To be honest, I cannot recall a huge amount of discussion about the report. Some elements of the report were picked up, such*

as the focus on action plans. One was about nursing leadership. I suppose, in terms of the report, that was one of the easiest issues to deal with. Generally speaking, however, there was no looking at the report and coming up with a comprehensive, service-wide action plan. Jim actually came back, since the report, to speak to everyone about it. He spoke to a group of about 30 people, many of whom were ward staff, all grades, but I do not think there was a consultant in the room.[58] (Mr Hever)

I totally agree [with Mr Mc Donald's report] *because sometimes the way senior clinicians come across, it is like 'You do what I tell you.' That was more or less the norm… So that was the kind of relationship that was more or less existing. The staff were quite disempowered at that time, and I felt that staff were not there to say what they feel about certain decisions being made, and about certain things they had been asked to do. It was more like giving instructions rather than asking people's views about certain things.* (Mr Sankoh)

Caroline [Leveaux] *and I commission*[ed] *a nursing review which… makes interesting reading. It is by Jim Mc Donald who had been part of the HASCAS team, a very experienced nurse with a lot of wisdom I think, and he pointed out problems in nursing leadership. We wanted someone from outside to say that, really, because it was easier than us saying it and we hoped it would produce leverage in terms of the Trust's response, which had been singularly lacking at that point. He also pointed to the problem of the gap between the nursing staff on the ward and the rest of the multi-disciplinary team, and the fact that the notion of 'team' was being distorted so in effect we had nursing teams and everybody else, and that is not a very good way to work.* (Dr Bartlett)

[58] Mr Mc Donald also told us that no consultants attended the meeting, which took place in April 2005: "*One of the things I constantly said* [to Ms Leveaux] *was when I see the team I need to have all the team there: the nurses, doctors, everybody who has an interest, even patients if you can arrange it. When I went there were 23 or 24 people, of whom two had never heard of the report, just under half had never seen it. I presented the report page by page and went through it in detail, including the second paper, and at the end I had a round of applause, which is very unusual when bringing bad news to people. I asked them why they were applauding and they said, 'You know what you're talking about, and… someone is seeing how things really are'. That struck me as for them a great relief. That was fine, but the problem was that many of the people who were important weren't there, and that was a real shame".*

Senior clinicians clearly have a responsibility to be listening leaders, if you like, and to be encouraging leaders of nursing and other staff. However, there needs to be a robust nursing system with role models and a cascading supervisory system which encourages quality from the other side. The answer to the apparent paradox of Jim Mc Donald saying that there is no medical leadership but that there is medical hegemony is that actually nursing quality deteriorated. The medical staff probably simply filled the gap or whatever but, if you do not have that creative tension, then it starts to appear that those who are 'stronger' are taking over. At the same time, however, senior clinicians also felt that they themselves lacked power, influence or whatever. (Professor Eastman)

I am aware of the criticisms and concerns… and that may well have been a nursing perception. It was a difficult position for the nursing staff at the time, largely because of the way that the service was organised. That served to exclude nursing staff particularly from many aspects of multi-disciplinary team work. It was probably frustrating and difficult for them. The service has now been completely reorganised very much bearing in mind these concerns and criticisms. That has been helpful in terms of moving away from the consultant being seen as slightly detached and uninvolved in multi-disciplinary teamwork, much more connected with the wards and also in bringing the nursing staff more actively into multi-disciplinary teamwork and decision-making. (Dr Mezey)

Management and governance arrangements

10. We derive our analysis of the period 2002 – 2004 from written and oral evidence to this Inquiry and from the two reports to which we have referred. We have read many internal Trust documents ranging from Board papers and minutes to memoranda on restructuring and policy implementation. From these sources we have reached our own conclusions which do not differ significantly from those of others who have considered the same matters, including members of the Trust's senior management team. We organise these under the following headings:

- Management and clinical governance
- Management of the Forensic Service
- Working practices in the Forensic Service

i) Management and clinical governance

11. Senior Trust management were ineffective with poor leadership, poor management and poor communication. The Trust had no strategic vision for, and an inadequate understanding of, the Forensic Service's activities. We heard this not only from consultant psychiatrists within the Forensic Service, notably Professor Eastman, but also from Mr Mc Donald who told us that:

> *The Trust itself and the senior people in the Trust had no real understanding of the kind of challenges these forensic services have.*

Professor Eastman told us:

> *I am nevertheless still very worried that there is disconnection between the Board and the service… There should be a clear strategy, specific to nursing and forensic services, which conforms to a ward strategy but which recognises the unique differences from other parts of the Trust.*

12. Senior management failed to act effectively on the information provided in the two external reviews and as a consequence the Forensic Service did not move forward. Senior managers were not good at taking action to address serious issues, and policy implementation lagged behind policy development. We consider that these propositions can be demonstrated with reference to management of the Forensic Service, which we consider below, but we first take the opportunity to mention two other matters affecting the wider Trust. These are the delayed implementation of MAPPA, which we consider elsewhere,[59] and the failure to carry out an internal inquiry

[59] Refer to Chapter 2.9

in accordance with Trust policy following the January 2002 index offences.[60] We deal briefly with the latter below.

13. The Trust's Critical Incident Reporting and Inquiry Procedure requires the completion and submission of a critical incident report within two weeks. In serious cases, defined such that the assaults committed by John Barrett in January 2002 undoubtedly qualified, the policy requires a critical incident inquiry. The policy also provides for a critical incident monitoring group to *"ensure that the processes for managing critical incidents are working effectively and consistently across the Trust"*, to audit critical incident reports and to *"establish a system for recording and monitoring critical incidents centrally"*.

14. Following the January 2002 assaults, a critical incident report was produced which said that there would be a joint inquiry with St George's Healthcare NHS Trust, which is where the incident occurred. That inquiry was duly established but with terms of reference which did not include the care and treatment provided to John Barrett by the mental health Trust. It completed its report in May 2002 and concerned itself only with the security arrangements at St George's Hospital. There was no inquiry touching on the mental health Trust's acts and omissions in relation to John Barrett, as a patient of the Trust for the previous five years. As Dr Fisher conceded when he gave evidence to this Inquiry:

> *I do not believe the process we followed was in accordance with the Trust's critical incident policy at the time. It was led by St George's as the acute Trust and had a focus on the issues that were relevant to them*
>
> *I cannot really give a good reason as to why* [there was no inquiry by the mental health Trust] *but it is glaringly obvious looking back. I believe our track record is reasonably good at responding to incidents and looking at them. All I can think is that it was at a time of significant change to the leadership of the Trust, and people were distracted, though that is not a good enough reason.*

[60] Refer to Chapter 1.4

15. Even if this was, as Dr Fisher asserted, a rare instance of the Trust failing to conduct an inquiry in accordance with its own critical incident policy, after an incident in which a patient almost killed a member of the public the Trust should have given the highest priority to reviewing how its responsibilities had been discharged. We would therefore have expected the incident to have attracted the attention of senior managers and to have been notified to the Trust board. The initial proposal to establish a joint inquiry may well have been sound, but when that inquiry chose to restrict itself to matters of interest only to St George's, the safeguards within the Trust's policy should have ensured that senior Trust managers were made aware, presumably by the critical incident monitoring group, that the joint inquiry had not covered the mental health aspects. That this was not recognised, and that the Trust lost sight of the January 2002 incident, demonstrates a significant failure in the management of critical incident monitoring and in implementation of the policy. It also suggests a lack of awareness and sensitivity in the organisation about the impact of its activities on the wider community.

16. Clinical governance was not effective in identifying and remedying weaknesses in the Forensic Service. There appears to have been some reluctance among senior clinicians within the Forensic Service to accept that Trust-wide clinical governance arrangements, including policies and procedures, had any relevance to the practice of forensic psychiatry. One aspect of this was the attitude of clinicians to the Trust's risk assessment documents, which were used in the Forensic Service but regarded as lacking coherence. The Trust, for its part, did not use clinical governance tools effectively. Arrangements for clinical audit were patchy and not necessarily geared to the Forensic Service. In John Barrett's case, clinical governance arrangements did not identify non-compliance with legal and good practice requirements.

17. There was no audit schedule to monitor staff compliance or effective training to ensure understanding of Trust systems and policies. We refer later in this report to a number of systems and documents that were inadequately completed or lacked authorisation at the right level - consent documentation, leave forms, ward round minutes, risk assessment documentation, Home Office reporting and compliance with terms of conditional discharge. In addition the nurse at the time John Barrett absconded on September 1st initially used the wrong documentation when she applied

the AWOL policy. In a response to a question, Ms Goddard told us that there was no schedule of audits to check whether Trust policies were being implemented by operational staff.

ii) Management of the Forensic Service

18. Judith Chegwidden, non-executive director of the Trust, described the relationship of the Forensic Service to the rest of the Trust as one of separation. We suggest co-existence may be a more apt description, with each side seeming to keep to a minimum contact with the other provided that the other's activities did not interfere with what it saw as its own priorities. On the Trust management side those priorities were running and managing the budget of a large and expanding organisation in which the Forensic Service was not seen as a problem because it balanced its books. For its part, the Forensic Service saw itself as distinctive – because it regarded forensic psychiatry as being different – and as knowing best how to run its own business, with the emphasis being on clinical management of patient care. The tragic death of Denis Finnegan forced the Trust to take responsibility for what was happening in the Forensic Service and weakened the Forensic Service's claim to be left alone to manage its own business.

19. There was a lack of basic management information. For example mechanisms were not in place for quantifying and monitoring the work of consultant psychiatrists. One consequence of this was articulated to us by Dr Fisher:

> *The issue about which we had concerns, and which were raised by Dr Oyebode, was to do with academics making sure that they fulfilled their NHS commitment as well as their academic commitments, their academic work being both of a good quality and relating to the work of the service.*

20. The Trust is relatively unusual among mental health providers in that it is linked to a medical school and a significant proportion of its consultant medical staff have part-time contracts for their NHS commitments. This arises from the decision to add to the Trust's portfolio by recruiting academic practitioners who therefore have a contract with the university and a contract with the Trust, having duties part-time in each.

Indeed, of six consultants within the Forensic Service, three had academic contracts and were thus part-time in relation to their NHS work. This was compounded by an additional part-timer, though not academic, since one of the consultant forensic psychiatrists was part-time by virtue of being the Trust's medical director. We do not seek to say that they do not pull their weight. We observe, however, that their weight is necessarily fractional.

21. For the Trust, the whole is not the sum of the parts – the addition of several fractions does not equate, in organisational efficiency terms, to the perceived numerical total. There is a need to ensure that appropriate arrangements are in place for continuity of cover on those days when the academic component apparently precludes input to the NHS. Such arrangements appeared to us to be lacking, at least in their practical effectiveness, at the Shaftesbury Clinic during the time that John Barrett was under their care.

22. We recognise that there is value in a service having an academic link, and vice versa, since it is likely to enrich both. However, in the Forensic Service the size of this link is large. We are aware that within the Trust questions have been raised as to the value to the NHS of this large academic component. We consider that any review of staffing should also explore methods of substantially improving continuity.

23. Senior Trust managers were not confident about being able to bring about change within the Forensic Service because the consultant psychiatrists obstructed their efforts to do so. Indeed, the rationale for the management reorganisation that has taken place within the Trust since 2004 was that the old management structure was medically dominated. There was a permanent state of unacknowledged conflict between Trust management and the consultant psychiatrists in the Forensic Service. The consultants considered that they were not listened to and that as a consequence poor management decisions were made, while senior managers regarded the consultant psychiatrists as presenting a challenge to be overcome. When Dr Oyebode, himself a consultant psychiatrist in the Forensic Service who earlier as clinical director had been regarded by some of his consultant colleagues as the Trust's stooge, was in 2002 appointed as the Trust's medical director he became the focal point of the conflict:

From my own perspective and that of some others, essentially the service became run by a dyad of the clinical director and the Service Manager – which would have been Deji Oyebode and Mark Clenaghan. The management team was much more a rubber-stamping operation and the driver behind that was the Trust wishing to control it much more….I had a very strong message from all sorts of decisions that Dr Oyebode had been chosen as clinical director because he would be strongly a Trust person. (Professor Eastman)

Other senior managers, including the chief executive, knew the situation and it must have been clear to them that Dr Oyebode's authority was being undermined, but no action was taken.

24. The role of Ms Leveaux as the service manager in the Forensic Service was too wide and senior Trust management did not give her enough support. Her capacity to bring about change within the Forensic Service was also constrained by the countervailing power of the consultant psychiatrists. It was, within the confines of the Shaftesbury Clinic, an unequal battle, particularly as professional groups other than medicine were insufficiently recognised within operational management. For example there was no nurse or other health professional in a senior management position to influence policy and change. Mr Mc Donald at interview commented that:

When I looked at the management structure, the team structure, I was struck by the large number of senior medics and the almost non-existent number of senior anybody elses, certainly not many senior nurses. I looked for, and didn't find, a modern matron or a nurse consultant or anybody in those sort of roles.

We had reached the same conclusion before meeting with Mr Mc Donald. Indeed, we were especially struck by the lack of such roles in an organisation which was likely to need them and which would be likely to be significantly less effective without them.

25. Those consultant psychiatrists who did not have a designated role as medical or clinical director were insufficiently engaged in management decision-making. From this vantage point they were well placed to criticise what managers were trying to

achieve but they appear not always to have considered their own obligation as leaders within the Forensic Service to support and implement management decisions.

iii) Working practices in the Forensic Service

26. We adopt Mr Mc Donald's description of the Forensic Service, which is based on his extensive experience of reviewing forensic mental health services:

> *They hadn't developed in the way other services had:* [such as] *with a strategy, consensus standards being set, and an expectation for performance management, improving outcomes and the experience of patients, and regular audit*.

We have already commented on the role of consultant psychiatrists within the Forensic Service in relation to Trust management of the service. We now look at working practices and roles in respect of patient care.

27. Effective multi-disciplinary working was hampered by the composition of in-patient teams in which all disciplines apart from nursing were members of a consultant-led team, and a nurse would join team discussions only for those patients who were on the particular ward where the nurse worked. This undoubtedly weakened the position of nursing within teams, particularly in relation to consultant psychiatrists. We consider this was more than a matter of organisation and that working practices reflected a culture in which consultant psychiatrists were both too dominant within multi-disciplinary teams and yet distanced themselves from some of the day-to-day clinical management of patients. As Mr Mc Donald explained:

> *There was a sense there was good MDT working. However, deep down I had the impression from talking to individuals that people simply didn't get on, they didn't trust each other. To have good communication and good MDT working you have to have mutual respect and integrity, and I thought those were missing.*

28. The style of teams appears to have been determined more by the personalities and working practices of individual consultant psychiatrists than by commonly agreed standards or by the expectations of other disciplines. We observed this when John Barrett transferred from Dr Bartlett's to Dr Mezey's team. Consultants who had been with the Forensic Service for many years had developed their own style and had got used to working autonomously with very little monitoring and supervision by management. The consultants collectively resisted attempts by Trust management to change established ways of working. These attempts were regarded as interferences in clinical practice which they considered the domain of clinicians.

29. There was a lack of critical self-awareness among clinicians. Mr Mc Donald made the observation in relation to nurses that they did not reflect on their practice and were isolated from comparable services. Professor Chambers, the Trust's director of nursing, made the same point to us. As a consequence, some nursing practice was poor and in Mr Mc Donald's view there was a lack of awareness of the particular demands of forensic mental health nursing in relation to risk management. We consider that the same general observation about lack of critical self-awareness can legitimately be made about consultant psychiatrists within the Forensic Service. One example of this, which we have seen in John Barrett's case, is poor compliance with legal and good practice requirements in respect of consent to treatment under Part IV of the Mental Health Act, and reporting to the Home Office. Ms Carter, interim chief executive, commented on this:

> *We have consultants who lecture nationally on the legal and medical implications of forensics, and then I have to intervene to get them to do their paperwork to fulfil the terms of the Mental Health Act. I don't expect to have to do that as a chief executive, and I have had to intervene. They are good people but it is about this attention to detail and being compliant with these things, and it is important because it puts the patient, the Trust and themselves at risk. That feels like a weakness, and how do you get people to see that without me sounding like the headmistress telling them off? It is about how you get them grounded in the importance of them paying attention to some of this local detail.*

30. We agree with these observations and are not persuaded that there has been sufficient recognition by some medical staff in the Forensic Service of the need for a substantial change in the way they perceive their role within the Trust nor appreciation by some staff of the value of challenge from other disciplines. Some appear to have believed that, if for no other reason than that they were highly qualified and experienced, they were delivering high quality patient care. This is well illustrated by the consultant psychiatrists' response to Mr Mc Donald's report, which they chose to regard as being critical only of nursing within the Forensic Service.[61] There was a gap between what they believed about their practice and the reality of what they were doing.

31. Mr Mc Donald put it this way:

> *When they take the view they are a centre of excellence, it is from the point of view of what they do nationally and internationally in terms of the contribution to research and academia, and on that point they probably do a great deal of work. How relevant it is to the delivery of service in the medium secure unit I don't know.*

32. Weaknesses within the service were reinforced by insufficient staff training. The training records for staff within the Forensic Service indicated that people attended very little training. There were particular deficits in the training of nurses, which left them disempowered in relation to other professional groups. This was especially true for those nurses who worked predominantly on night shifts. There was also an overall lack of leadership training within the Forensic Service and among nurses a system had grown up which led to people being promoted too quickly, before they had gained sufficient experience.[62]

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[61] Refer to Dr Bartlett and Dr Mezey's comments in paragraph 7 of this Chapter.

[62] Professor Chambers told us: "*I do not wish to be critical of what happened before, but there seemed to me to be a lot of people who were appointed to the position of Charge Nurse much too early on in their career. We had a system in the Trust whereby everyone who completed his or her nurse training at Kingston University was automatically given a Staff Nurse post in the Trust. They did not have to do an interview, they didn't have to do anything, they just automatically shifted, then within six months they were promised that if they completed a competency manual they would be promoted to an E-grade staff nurse. Then those same people could end up being promoted to an F-grade position inside 18 months, so that meant somebody two years out of school was then managing a very difficult ward. I did not feel that was in the best interests of the Trust, or the patients, or even the individuals concerned, so we stopped that last year* [2005]".

33. Staff appraisal systems were poorly implemented. In relation to consultant psychiatrists the Trust's requirement that all were to be appraised annually was not adhered to. Dr Mezey told us:

> *In my case I had an appraisal in December 2004, which was after the homicide. I hadn't had an appraisal for about two years before that. That isn't because I didn't want an appraisal.*

34. Supervision arrangements were loose. We heard both from Dr Fisher and Dr Bartlett that their monthly management supervision sessions with each other did not take place as scheduled. Dr Fisher told us:

> *Dr Bartlett would have reported at the time of the incident to me, and the intention was that I would see her regularly for some sort of supervision. However, I am sure that that did not happen as regularly as it should. I am sure meetings were cancelled on both sides.*

Ms Leveaux told us:

> *Mark Clenaghan, who had been the service manager some time before me, and was technically my supervisor, but I have to say I didn't feel supervised.*

35. Finally, leadership within the Forensic Service was unsatisfactory. The interface between corporate management and the management of the Forensic Service was poor. It was a theme of both the HASCAS review and Mr Mc Donald's report that consultant psychiatrists were not fulfilling their leadership responsibilities and were somewhat detached from the day-to-day demands of the Forensic Service. We formed a similar conclusion. In so far as this can be taken as a criticism of the consultant psychiatrists, we understand that they do not agree with it. As for nursing, we have already observed that the Forensic Service lacked a senior nursing post, such as a nurse consultant, to provide leadership. Nurses were promoted without first having developed their management and leadership skills. One consequence of a lack of

leadership within the Forensic Service combined with weak management was that it was difficult to effect change.

36. We would have expected to see a management structure that was facilitative through listening and leading staff. Senior clinicians who did not have a dedicated management role were insufficiently engaged in management decision-making and failed to provide leadership beyond their clinical responsibilities. Management is not purely the domain of the senior executive team within the Trust. It is also the responsibility of managers at an operational level and of senior medical staff. Consultant psychiatrists should provide clinical leadership and direction. They should be exemplary role models, empower people within their teams, listen to them and provide effective channels of communication. They should work with their team so that they share a clear vision and common purpose about what they are all trying to achieve.

37. We are left with no doubt that the arrangements in 2002 - 2004 for managing the Forensic Service were ineffectual and that the service lacked a clear sense of purpose and direction during the period that John Barrett was a patient. The nature of the problems and their persistence are demonstrated by the following extracts from oral evidence to this Inquiry in 2005 - 2006:

- *When I first came to the Trust* [in 1998], *the Forensic Service was almost like a separate unit, and although the Trust may have paid their pay packets, it didn't seem quite part of the corporate whole, and I still think there is some hang-over with that. With the role of what used to be the clinical director in the old format of the Trust before we moved to Borough Services, consultants were expected to take on that role without sufficient back-up, and the corporate role was not properly understood – and the more separate the Service, the less it was understood. I really think there was a reluctance to believe that if you have a chief executive you should do what he says! Quite difficult.* (Ms Chegwidden)

- *In the time after Dr Oyebode stopped being the forensic* [clinical] *director* [in 2002] *we had another part-time clinical director who was working at*

Broadmoor… and running in parallel with that we had an acting service manager. The Board was concerned and probably slightly less robust than it should have been about seeing the weaknesses in that particular management arrangement. I remember coming back from a completely unrelated event where I had shared a meeting with [the clinical director] *and thinking 'This is not working', and talking to the medical director and one or two other people and they said 'No, it is not working'. We were quite good at saying it wasn't working, perhaps slightly less good at doing something about it.* (Ms Chegwidden)

- *When I took over as clinical director we had had no permanent clinical director for over two years. We had had* [another doctor]*… He was still working at* [another hospital]*, he was looking after patients with us, and he was given a small amount of time to be our clinical director as well, and this I think he would admit was not a very satisfactory arrangement. The Trust never resolved his contractual arrangements, so we had had a degree of uncertainty around strategy and direction and governance. We had also had simultaneously an acting service manager who we did not appoint to the substantive post…, so Caroline* [Leveaux] *took over in July* [2003]*, I took over in October and we inherited a service that I think had slightly lost its way.* (Dr Bartlett)

- *The Forensic Service has always been somewhat resistant to being integral within the Trust, and prefers to see itself as a semi-independent service. It is part of the Trust when it suits it, but it is somewhat resistant to the Trust when it doesn't suit it. In terms of governance processes, in my time* [1996 – 2002] *it was always a bit of a struggle in effecting some governance standards and monitoring that. In my time I had to work very closely with the then clinical director Dr Oyebode to say, if we had a governance meeting, 'Deji, I need you here. There are two or three medical issues we need to discuss and I need you beside me in order to give that degree of authority that they need to be done.' It has always been a difficult issue; it has always been an issue we have struggled with and I always felt it was an issue we have had to pull the service. Left to its own devices, the service would progress things on its own agenda that suited it rather than the Trust.* (Mr Clenaghan, service director for

the Forensic Service (1996 – 2002) and now borough director for Merton in which post he briefly had responsibility for the Forensic Service until 19th June 2006. He gave evidence to this Inquiry in February 2006).

- *The* [Forensic] *Service has been medically dominated and other disciplines have found it very difficult to go against that view expressed by the medical staff because the medical staff are perceived to be that group of staff that has the power and influence within the service.* (Mr Clenaghan)

- *The culture of the place seems to be one in which consultant-led teams work quite separately from other consultant-led teams, and if you had to explain why team A, say Dr Bartlett's team, does things one way and team B, say Dr Mezey's team, does it some other way in the end the answer is going to be that is how that particular consultant does things.* (Ms Leveaux)

- *The medical director was not in control… it was his role to try and deal with it, or to pass it on to someone who could deal with it… instead of which there was generalised grumbling which was not new, but there were no solutions, so all it did was raise anxiety.* (Ms Leveaux)

- *It* [the Trust's management ethos] *was command and not control. I didn't feel I was held within any management structure particularly. For me in terms of what I could do, it was quite negotiated. I didn't feel very powerful to say 'do this' because if I did then I was accused of bullying. With some people you could set some parameters. I didn't spend the whole time negotiating but there wasn't a strong structure.* (Ms Leveaux)

- *Something which I am not sure was new, and which the Forensic Service themselves readily recognise, was that they were originally separate from the Trust, they were almost an autonomous organisation, and there is still a bit of that now. That is partly because of the history of that service but also because the client group is in some ways separate and has less contact with the rest of the organisation.* (Dr Fisher)

- *There was a forensic management team from which the doctors were then excluded because they made too much noise. Doctors made lots of noise so they were excluded, but the effect of that we are still discussing today, because it meant that suddenly the clinical service became a sort of parochial interest of the people sitting on the forensic management team instead of being a serious concern for all the senior people in the service. I think that was a great shame.* (Dr Bartlett)

- *What happened at the time we were still running a clinical service structure. What then happened is that the service managers ran everything within the service apart from the doctors. And the doctors were accountable to the clinical director and the clinical director was accountable to the Chief Executive. So what would then happen is that if you had a situation where – service managers technically were not accountable, not responsible for the doctors, but the clinical directors were – and if there was a gap in that accountability or the responsibility, it created a problem for the Trust.* (Dr Oyebode, clinical director of the Forensic Service 1998–2002 and medical director of the Trust since 2002)

- *I look at this on a broader canvas which relates to the way in which the* [Forensic] *Service operated and also the relationship between the service and the Trust as a whole. An important aspect of the response is that senior clinicians felt disempowered within the service in relation to the relationship between the service and the Trust.* (Professor Eastman)

- *There really was* [in the early years of the Forensic Service] *a common spirit and so on. It felt as though that was seriously damaged. Essentially, the management team changed in its composition, function and role after I ceased to be clinical director* [in 1998]*… The management team was much more of a rubber-stamping operation and the driver behind that was the Trust wishing to control it much more. I quite understand that a Trust needs to control that, but there was an element of throwing out the baby with the bathwater. People then felt disempowered… For a long time, people simply hunkered*

down and did their own work within their own teams and did not feel that they had an influence. (Professor Eastman)

- *Because the service was run by the clinical director* [Dr Oyebode] *and the service manager, to a Trust agenda… people rather 'gave up'. I do not mean that, exactly, but there came a time when morale became quite low. It felt as though there was both a lack of a place to discuss, but there was also a feeling that there was not a culture of discussion. There was the wish to impose Trust models across the service that was so powerful that it baulked discussion really… I suppose people felt disempowered in that way.* (Professor Eastman)

- *Another aspect was that, when the* [Forensic] *Service felt itself to have become a problem for the Trust, rather than an opportunity, it was repeatedly stated that the Forensic Service was a problem but then it was not articulated exactly what the problem was against the standard of other forensic services. That will have been overcome because there is now the London-wide forensic strategy group… That will mean that all* [forensic] *services in London are assessed against each other, rather than against CMHTs or against fantasy.* (Professor Eastman)

- *Nursing did not get any share of the research budget of the £1.7 million that came into the Trust annually for research through the Collier process. None of that had ever gone to nursing so I felt that needed to change… The other thing that struck me about nursing in the Trust was that it was quite inward-looking. People did not go out and see what was happening in the wider world, so I have tried to do that and also tried to bring the wider world into the Trust.* (Professor Chambers)

- *Sometimes the consultants are not aware of just how much power and control they have and how others perceive them, and if we don't make them aware of that then they are not likely to change, so that was one of the areas that we have begun to explore - how we might do things in a more shared and joint way… We can't ignore the fact that some people are going to find it much more difficult, but as I said earlier we must have more parity and equality*

amongst the professional groups, and I feel that nursing to some extent is a little bit responsible for it being in the position that it was and from which it is now hopefully recovering. (Professor Chambers)

- *We agreed that we needed to have a forum where we all talked together, so we now* [February 2006] *have a very inclusive forensic management team; it is all heads of disciplines, all consultants. In terms of what you would say is an effective working group… We have had one meeting like that and we have now committed to those meetings on a monthly basis. We discussed drafts of operational policies, standards within that, and it was an extremely difficult meeting. I have had reasoned comments back from one consultant; I have had very vitriolic comments back within the context of the meeting amongst the others.* (Mr Clenaghan)

- *I went over to a meeting with the entire multi-disciplinary team, with the service director* [Mr Clenaghan]. *I sat at the back, because they were having a discussion about one of the action points in the forensic action plan, and I was absolutely horrified at the way they were talking to Mark* [Clenaghan], *they being the* [Forensic Service] *consultant group, four of them, the way they dominated the discussion and the way they completely disarmed his attempts to get them to consider changing something actually quite minor… I sat there for about 20 minutes listening to this debate, and I was truly horrified.* (Ms Ness)

- *I don't feel as if he* [Professor Eastman] *has shifted at all. He was lobbying and all the consultants were nodding other than Dr Oyebode at the time. He is still trying to set up an alternative structure, he is still lobbying for this alternative structure that everyone in the room was saying no to, except the doctors, which is that there is a clinical governance structure led by the doctors which then tells all the managers and every other clinician what to do and how to be.* (Ms Ness)

- *That there is a need to bring everyone down to earth and recognise that paperwork is important. They are not working well as a team where each*

person is mutually valued although this is improving. There is a lack of insight about what needs to be done… There has been a sense of denial but now a more positive movement. There has been a poor interface between clinicians and management. There is a need for strong performance management and the feel that we are doing this in partnership. (Ms Carter)

Changes since 2004

38. The above comments from senior management within the Trust and Forensic Service demonstrate that there is still a lack of trust and confidence within the organisation and that communication problems and ineffective leadership and management still exist.

39. Ms Ness told us that an external consultant had been appointed in 2006 to work with the Forensic Service and that:

We are changing policy, changing procedure, but attitudes as you know are incredibly difficult to shift… [we] *made a point of briefing the external consultants so that they would work very differently from usual… Last week, we had a three-hour meeting, which was the feedback about what the consultants had found, and for the first time, those consultants had interviewed all the senior managers, the senior nurses, OTs, psychologists, everyone, individually…The feedback was just as you described… the service is still being described as medically dominated, the lack of visible leadership because they pop in and out, people feeling unheard, people feeling disrespected.*

40. Ms Carter, who became interim chief executive in December 2005, told us in May 2006 there had been a good deal of scrutiny of the Trust over recent years:

There were 365 recommendations that were almost impossible to monitor and manage. The management team were finding it difficult to prioritise as so much needed to be done.

She wrote a business plan for the Trust which identified the *"top ten high impact areas"*. The plan has been discussed with the Healthcare Commission and the Strategic Health Authority and has been agreed as a positive way forward. Among the ten priorities covered in the plan the following are of relevance to our analysis of the Forensic Service:

- Clinical and managerial leadership to include nursing leadership development, accountability framework for managers and middle manager development
- Ward/team development to ensure multi disciplinary working
- Record keeping to include assessment, care plans, CPA, documents to support legal requirements for detained patients, identification of 'guardian' of the patient record and maintenance of standards
- Supervision and appraisal to ensure the implementation of a Trust wide appraisal
- Individual personal development plans (PDPs) for every member of staff
- Training needs analysis for the Trust resulting from PDPs
- Implementation of clinical supervision and associated framework across all disciplines of healthcare professionals throughout the Trust
- Audit of patient records with supervisory framework

41. Although it appears that these 365 recommendations had been reduced to a 'top ten', when we asked for the Trust's services improvement action plan we were provided with a document containing the larger number. In our view no organisation can have an effective focus if it is attempting strategically to manage several hundred issues in one arena.

42. There are signs that there has been recognition that changes are needed in both clinical practice and attitudes. Although some of what needs to be done has been recognised, there has been an apparent lack of urgency in implementing the necessary changes, an example being in relation to nursing and the nurse consultant post. We were told:

We are very keen to recruit a nurse consultant…in order to give that leadership and direction… I am concerned with the broader picture and the strategic view, and we need somebody in there who is credible and who knows their 'stuff', who can engage with people and bring people with them. (Professor Chambers)

43. However, even though a nurse consultant is seen as a key improvement, we were told in May 2006 that the post had only just been approved. This surprised us. The concept[63] was introduced in 1999 and by April 2003 there were 860 nurse consultant posts approved nationally of which 528 had been filled.[64] New nurse consultant posts were subject to a central scrutiny and approval process by the Department of Health. This sometimes resulted in significant delay. However, from April 2003[65] NHS organisations wishing to establish such posts were permitted to do so with the agreement of their Strategic Health Authority.

44. Some of the apparent delay within the Trust's establishment of such a post may have been internally generated. Professor Chambers told us there were difficulties in implementing change, although she thought the situation had improved:

On the whole there has been a pincer movement, because we have a new management structure and reorganisation, we have much tighter performance management now than hitherto – and that caused a little bit of dissent and people were quite angry for a time, and there will still be pockets of that; however, that is greatly diminished compared with before, so people are gradually seeing the benefits of this. It is like in any organisation with any change, you will always have the early implementers and the laggards and we have both of those, but it is the laggards who have influence who concern me, and they tend to be the medical people.

[63] Reference: 'Making a Difference' Department of Health 1999 and HSC 1999/217 which sets out the aims for the post.
[64] Reference: 'An Evaluation of the impact of nurse, midwife and health visitor consultants'. King's Fund, September 2004
[65] The relevant notification is contained in PL CNO (2003)5: Approval of nurse, midwife and health visitor consultant posts.

Conclusion

45. We are required to review in detail the care and treatment of a single patient. In the course of this Inquiry weaknesses in management and governance have been drawn to our attention, but without a consensus about what needs to change. As far as the Forensic Service is concerned, John Barrett's case is illustrative. We conclude that during the period he was a patient of the Forensic Service deficiencies in systems, processes and governance arrangements put patients and the public at risk.

46. Our conclusions are based on written and oral evidence received up to and including May 2006. We remain concerned about the lack of management processes and clinical governance arrangements to monitor implementation and compliance. More fundamentally, while there have been limited improvements in recent months, our firm impression is that the culture of the Forensic Service has not changed. This is amply demonstrated by the oral evidence to this Inquiry from which we have quoted extensively above.

47. We doubt whether there is the managerial capacity within the Forensic Service or the wider Trust to achieve within an acceptable timescale the objectives that have been set. We conclude that this has serious implications for the safe delivery of patient care by the Forensic Service. **We recommend that a service improvement team, taking a national perspective, work with the Trust and the Forensic Service to turn around the performance of the Service, to identify failings and put in place systems and processes that are robust and effective with regular monitoring to ensure safe and effective patient care.**

48. We question whether the Shaftesbury Clinic should continue to operate as a medium secure unit until this work has been undertaken. This is for others to decide.

Chapter 2.2 - Clinical Management and Social Care
March 1997 – January 2002

Introduction

1. In this chapter we consider John Barrett's management by mental health services from his first contact in March 1997 until 8th January 2002, when he injured three people in the genito-urinary clinic at St George's Hospital. The discussion in this and subsequent chapters is based on the factual material in Part 1 of this report.

2. In reviewing John Barrett's care in this chapter we draw attention to matters that are also relevant to the later period of care, which we consider in the following chapters, as what happened before 8th January 2002 should have informed his subsequent management by the Forensic Service. We have used the following headings:

- The nature of John Barrett's mental disorder
- Difficulties in assessing John Barrett
- Violent and threatening behaviour and absconding
- Response to treatment
- John Barrett's understanding of his illness and attitude to treatment
- Overview of clinical management March 1997 - January 2002

The nature of John Barrett's mental disorder

3. In the following paragraphs we draw attention to features of John Barrett's mental disorder as recorded in the multi-disciplinary notes. Prior to 2002 John Barrett was diagnosed as suffering from persistent delusional disorder, with occasional references to other possible diagnoses. We draw attention here to features of John Barrett's illness, as recorded during this period, which appear to us to call into question the diagnosis of persistent delusional disorder. The diagnosis was later changed to paranoid schizophrenia, as we describe elsewhere. The psychiatric history before 2002 was germane to any subsequent consideration of diagnosis. For the relevant diagnostic criteria and a discussion of how psychiatric diagnoses are made, see Chapter 2.3.

4. John Barrett was assessed by a psychiatrist for the first time after his arrest on 5th March 1997 for breach of the peace. The most prominent symptoms of mental disorder were paranoid delusions which formed what was described as a well encapsulated delusional system. His core belief was that he was subject to police surveillance which was being carried out because he had in the past had sexual intercourse with young women who were under the legal age of consent. This explains why in February 1997 he had gone to Wandsworth police station to admit the offences, as if he believed that by this means he would remove the necessity for the police to keep watch on him. The account of his delusions that John Barrett gave in March 1997 was corroborated by his partner, JW, who described his paranoid beliefs as having been present for over a year before his arrest. At times when he was particularly paranoid John Barrett identified people, extending from JW to complete strangers, as being part of a conspiracy with the police to keep him under surveillance. The core delusion was elaborated at different times to include reference to the security services and their supposed power to control people. Another aspect of his delusional system was the belief that he was entitled to compensation, running to millions of pounds, because the police surveillance amounted to harassment. At times in his psychiatric history John Barrett expressed the belief that he was very rich, although it is not clear whether he believed he actually had the money or was referring only to his presumed entitlement.

5. The delusional system was disclosed to psychiatrists and other mental health professionals several times during these years. However, it is not clear to us that the content of his delusions was fixed, as implied by the description of his delusional system as well encapsulated. For example, it was recorded in May 2000 that he had spread salt around and outside his flat to stop demons. This indicates delusional beliefs not in keeping with his previous delusional system of police surveillance and conspiracy.

6. Other features of mental illness were described at different times during this period. When John Barrett was first assessed for admission to hospital on 5th March 1997 he reported having heard a voice, as if 'thrown' by a ventriloquist, telling him it would kill him and JW and he also expressed the belief that JW was capable of telekinesis. In subsequent assessments in March 1997 he was noted to be guarded and

suspicious during interview. This could be explained by his paranoid mental state or by his wish to minimise the severity of his symptoms, whether for his own sake or to mislead those who were assessing him. He was also described as circumstantial at interview. Other symptoms were elicited in May 1997, with his references to *'semantics'* and *'little meanings'*. It is difficult to know whether these were related to the core delusional system but it is possible that they were. In October 1997 it was recorded that he experienced thought blocking, which is a symptom of mental illness but not indicative of delusional disorder.[66]

7. When John Barrett was admitted to hospital in January 1998 the description was *"rather odd, perplexed manner, looked suspicious. Guarded answers"*. Perplexity as a symptom of mental illness is sometimes found in patients with schizophrenia. In January 1998 he was described as *"circumstantial and pseudophilosophical"*. This is suggestive of thought disorder which is not a symptom of delusional disorder. Thought blocking was noted again in July 1999 when he was seen at home. In August 1999 he spoke of people approaching him and walking past him and giving *"ambiguous"* statements. This suggests ideas of reference in relation to strangers,[67] but could equally have been a manifestation of his paranoid thinking. In September 1999 he was described as *"quite evasive"* and also as having *"thought blocking"*. This was interpreted as an attempt to hide his symptoms.

8. On 14th June 2000 it was noted that at times his speech was rather convoluted and verging on nonsensical. This may have been thought disorder, although it was not noted as such. On 16th June he was reported to be laughing to himself, which is suggestive of the affective incongruity which is sometimes found in patients suffering from schizophrenia.

9. No clear symptoms of mental illness were elicited during the May 2001 admission, although he was observed to be talking about religious matters, which was not normal for him, and as not being relaxed. It is possible that that this was an indication of abnormality of mental state but we cannot be confident in making this attribution.

[66] It is impossible to know whether what was seen then was thought blocking or, as recorded subsequently, by Dr Dein in August 2004, a deliberate thoughtfulness in answering questions so as to limit the disclosure of symptoms and thus minimise the appearance of active mental illness.
[67] Incorrect interpretations of casual incidents and external events as having direct reference to oneself.

10. As described below, at times John Barrett threatened or physically attacked people, including strangers, whom he believed were conspiring with the police against him. John Barrett's delusions also explain some of his violence towards JW, for example the attempted strangulation in January 1998. We know that the core delusions persisted up to 8th January 2002 because he believed then that the principal victim was in some way linked to the surveillance operation. He subsequently confirmed this belief after his admission to the Shaftesbury Clinic.

11. John Barrett's paranoid illness had interfered with his social functioning to the extent of causing him to become fearful for his safety in everyday situations, such as journeys on public transport. JW told us that at times John Barrett's paranoid thoughts prevented him from interacting normally with other people and he became socially isolated. But it is also the case during these years that there were times when he was in employment and therefore presumably either not experiencing symptoms or at least feeling less troubled by them.

Difficulties in assessing John Barrett

12. There are repeated references in the notes to John Barrett's guardedness. These are to be understood both as indicating suspiciousness but also as showing that he attempted to manage his interactions with mental health professionals by not disclosing symptoms to them.

13. The experience of the two consultant psychiatrists responsible for his treatment during this period was that even at times when reports were received from third parties, notably JW, that he was paranoid and was behaving strangely, it was difficult on mental state examination to detect symptoms of mental illness. For example, convincing reports were received both before and after Dr Zolese's assessment of 10th April 2000 but she was unable *"to ascertain if he is actually ill"*. When John Barrett was assessed for admission in May 2000 no clear symptoms were elicited, but once he was on the ward he was observed to be hostile and paranoid. By June 2000, Dr Zolese had still not been able to elicit clear symptoms. She decided on a plan which required repeated mental state examinations *"to find evidence of delusions"*. The evidence did

subsequently emerge from remarks he made to a nurse about the powers of the secret service to control people. But John Barrett denied any abnormal beliefs when Dr Yates assessed him a week later. Dr Yates found him to be guarded, circumspect, wary and untrusting.

14. Dr Bale's experience of assessing John Barrett was similar to that of Dr Zolese. In April 2001 John Barrett reported that he was having problems in his relationship with his then girlfriend and that he had been *'aggressive'*, but on assessment Dr Bale found no clear signs of mental illness. A month later, JW reported what appeared to her to be a major relapse of the illness, including *"talk of a conspiracy to ruin his life"*, and also threats made against her by John Barrett. When he was assessed by Dr Bale at home on 18th May 2001, no delusions were elicited and the only symptoms were arousal, irritability and guardedness – which could in part have been attributable to the circumstances of the assessment with a large number of police officers in attendance. Once admitted, John Barrett was observed to be guarded and suspicious. The impression given to those assessing him was *"taking a lot of time to answer questions and giving the impression of covering his signs of mental illness"*. As Dr Bale told us, during that admission there were no clear-cut symptoms of psychosis. It was thus difficult to justify continuing detention and compulsory treatment.

15. Another challenge in assessing John Barrett was that, in the absence of clear symptoms of mental illness, his demeanour and behaviour varied from day to day so that his settled presentation on one day could not reliably be used as a guide to the likelihood of a settled presentation on subsequent days. Disturbed or aggressive behaviour was thus not a reliable indicator of deterioration in his mental state nor did its absence indicate mental stability.

16. The clinical picture was further complicated, as is often the case, by John Barrett's use of drugs. From his first admission in March 1997 it was noted that he was a heavy cannabis user. He also mentioned that he had smoked cannabis the night before the assaults of 8th January 2002. It is therefore reasonable to infer that he continued to use cannabis throughout. Reports from time to time that he was using cannabis support this inference. For example, in January 2001 JW told John Barrett's social worker that he was using cannabis and that it made him paranoid.

Violent and threatening behaviour and absconding

17. From his first contact with mental health professionals a link was made between John Barrett's mental disorder and violence towards his partner, JW. This persisted, with frequent reports of actual violence and threats of violence between 1997 and 2001.

18. An even more striking aspect of his behaviour during these years was stranger confrontation. Starting with the incident which brought him to the attention of mental health services in March 1997 when he followed a man home, there are numerous reports of John Barrett coming into conflict with strangers. Given the possible relevance of this aspect of his history both to the January 2002 assaults and to the fatal attack on Denis Finnegan in September 2004, we list below all recorded incidents of actual or threatened confrontational behaviour involving members of the public, some of whom were clearly strangers to him. The list excludes assaults on JW and assaults on nurses and patients while he was in hospital:

- March 1997 – followed a man home
- April 1997 – confrontation with the proprietor of a business
- April 1997 – arrested for threatening a member of staff at an employment agency
- May 1997 – followed a man home and threatened to kill him
- May 1997 – threatening a member of staff at an employment agency
- October 1997 – three different incidents when he came into conflict with members of the public
- November 1997 – fought with the manager of a factory in Cambridge
- June 1999 – arrested for fighting
- June 1999 – reported by JW to be *"talking about getting a hostage"*
- July 1999 – accused a neighbour of having an affair with JW and reported by JW to be *"approaching members of the public accusing them of things, and trying to pick a fight with them"*

- April 2000 – knocking on doors and looking through windows late at night and harassing people
- January 2001 – JW reported that he was *"shouting a lot when out"*
- December 2001 – arrested after a confrontation with police officers

19. John Barrett's aggression and physical violence extended to hospital staff and other patients. This was first noted in May 1997, when he was described as threatening and abusive towards staff. There were serious incidents in May and June 2000, with assaults on patients and staff on two different wards. The assaults were said to have been unprovoked and the wards where they occurred refused thereafter to accept him back. It is also of note that after he was transferred to John Meyer Ward following the May 2000 assaults he was described as calm and appropriate despite provocation from other patients. This highlights variability in his presentation such that no reliance could be placed on a particular type of behaviour being sustained, especially if the context changed.

20. It is noteworthy that he expressed some regret for the assaults but only because he had suffered as a consequence by being transferred to John Meyer, a locked intensive care ward. He was described as showing a *"complete lack of responsibility"* for the assaults. This is significant in that it indicates concern about the effect of his actions upon himself, but a lack of empathy for others. Lack of empathy is an issue which would commonly form part of risk assessment and could have been the subject of specific therapeutic work. We return to this issue in the next chapter when we discuss John Barrett's period as an in-patient at the Shaftesbury Clinic.

21. There was sometimes, as in May 2000, doubt as to whether his violent behaviour was better understood as occurring in the context of a psychotic illness or as evidence of poor impulse control and an underlying tendency to react to situations of stress or frustration by resorting to violence. One way this was characterised was as indicating that he had an antisocial personality disorder, but he was never formally diagnosed as suffering from any form of personality disorder.

22. In addition to violent incidents, there are several reports of John Barrett being sarcastic and provocative towards patients in ways that were not threatening. As with

the violent outbursts, it is not possible for us to know whether such behaviour arose from abnormalities of mental state. We note that JW said she thought sarcasm in John Barrett was an indicator of active mental illness.

23. Another recurring point is sexually inappropriate behaviour towards female staff. This is first referred to in June 1997, when John Barrett was said to be *"over-familiar and inappropriate"* with Dr Zolese. In August 1999 he made sexually inappropriate comments in an occupational therapy session. In May 2000 the notes record over-familiarity with females and in May 2001 he was reported to be getting physically close to female nursing staff and wanting to deal only with them, to the exclusion of male staff. Similar behaviour was also seen in 2002 during his admission to the Shaftesbury Clinic when he was sexually inappropriate towards an OT.

24. It was recognised as early as January 1998 that there was a risk of John Barrett absconding from hospital. This was also noted when he was admitted in August 1999. It is recorded that he absconded in June 2000 when he did not return from ground leave and instead went to stay with a friend - not JW with whom he was then cohabiting. It is recorded that his absconding on this occasion was in response to frustration at being in hospital and not knowing the likely duration of his stay. We refer to this later when we consider his absconding on 1st September 2004.

Response to Treatment

25. From his first contact with mental health services, the main treatment given to John Barrett was anti-psychotic medication. His condition was noted to respond to medication. In May 1997, when an anti-psychotic was given to him by depot injection, his behaviour changed dramatically. He was better able to control himself and less intimidating, challenging, interfering and argumentative. A similar response to depot anti-psychotic medication was reported in February 1998. The same pattern was repeated again in May 2001 when within the space of ten days, during which he was treated with anti-psychotic medication, he moved from irritability, arousal and aggression to being settled and, according to JW, *"back to his old self"*.

26. As we discuss below, the pattern of treatment during these years was that medication was given under powers of compulsion when John Barrett was detained under the Mental Health Act. Following discharge he did not continue with medication and his condition would deteriorate.

John Barrett's understanding of his illness and attitude to treatment

27. A consistent theme in John Barrett's psychiatric history during these years is that he lacked insight into his illness. At its simplest this referred to the fact that he was deluded, that is to say he believed that there really was a police surveillance operation. However, even at those times when his delusions were not apparent on interview, and when he was therefore believed to be more in touch with reality, he did not accept that he suffered from a mental illness characterised by paranoid delusions. In May 1997, despite acknowledging that he was paranoid, he said that he did not value hospital treatment and he discharged himself as soon as the period of detention expired.[68] In October 1997, when he was at home and had stopped taking the prescribed anti-psychotic medication, it was recorded that he had *"no insight"*. While it is likely that there was some variability in his insight at different times, it is also clear that he learned to say what he thought professionals wanted to hear. For example, in October 1997, when he was being followed up by the CMHT, he claimed to be taking medication regularly although he said he saw no need for it. It seems more likely that he was not in fact taking it. After being admitted to hospital in August 1999 he was described as insightless and as saying *"the fastest way out of hospital is to comply"*. According to Dr Yates's forensic assessment of June 2000, his lack of insight extended to the need for treatment and the risk he posed to others. During the May 2001 admission John Barrett told an assessing doctor that he had suffered from mild paranoia about five years previously – presumably in 1997 – but not since then. By implication he saw no reason at that date for further psychiatric treatment.

28. Given that John Barrett did not consider himself to be mentally ill, it is perhaps not surprising that powers of compulsion had to be used to ensure he took the

[68] In a letter he wrote during the May 1997 admission in support of his request to be discharged from detention under section 2 of the Mental Health Act, John Barrett attributed his problems to cannabis and stress: *"drugs and stress counselling would be more appropriate"*.

prescribed medication. He first agreed to take an anti-psychotic at a low dose (Risperidone 2mg daily) in May 1997 but thereafter the pattern was that he regularly took medication only at times when he was detained in hospital under the Mental Health Act, and therefore subject to a legal regime authorising the administration of medication without the patient's consent. Even when he was detained, his compliance with medication could not be relied upon. For this reason anti-psychotic medication was given in liquid form (1999) and administered by injection (1997, 1998, 2000 and 2001). He was also regarded as unreliable when telling doctors and other professionals about his compliance with medication. For example in October 1997, when he was an out-patient, he said he was taking anti-psychotic medication even though he did not think he needed it. He was not believed. When discharged in June 1998 he soon stopped medication, saying that *"he feels fine without it"*. In 2000 he stopped medication immediately after being discharged from detention under section 3 of the Mental Health Act, having previously said he would continue with it as an out-patient. It is perhaps an indication of his attitude to medication that in July 2000 he said it gave him time to clear his head of *"unhealthy thoughts"*. This suggests that at best he saw it as having some value in reducing paranoid thoughts but he did not accept the need to continue with it on a prophylactic basis when he was not troubled by such thoughts. During the May 2001 admission he made it clear that he was not happy to take any medication and would accept it only if he had no choice. Although he did thereafter agree to accept a prescription of an oral anti-psychotic following his discharge, there is no reason to believe that he took it as prescribed.

Overview of clinical management March 1997 – January 2002

29. John Barrett's psychiatric history from March 1997 to January 2002 was characterised by episodes of hostility, suspicion and unprovoked physical violence, sometimes in settings where he asserted without evidence that there was provocation. There was potentially a particular risk to people who became a focus for his paranoid delusional ideation of which there are a number of examples.

30. He responded well to medication, militating against a diagnosis of delusional disorder which characteristically responds poorly to medication. Throughout his contact with mental health services during this period there were, in addition to

paranoid delusions, a variety of other abnormalities of mental state as well as at least one instance of bizarre behaviour spreading salt around and outside his flat. His mental state was viewed as difficult to assess with frequent guarding which was interpreted as showing that he recognised which symptoms and experiences he should not report to others. His pattern was to discontinue medication at the earliest opportunity. JW said he was a times not taking medication though he asserted he was. Both liquid and depot forms of medication were used in an effort to ensure greater compliance. In 2000 a section 25A supervised discharge order was used to try to promote engagement with the CMHT and to try to secure his compliance with medication as an out-patient.[69] His engagement remained limited during the currency of that order which was subsequently lifted. Throughout this period he continued to deny that he suffered from a serious mental illness and he chose instead to attribute his difficulties to stress and the use of cannabis. When his paranoid thinking brought him into conflict with others there is no evidence during this period that he recognised the reality of the situation.

31. As we explain more fully elsewhere, we consider that the phenomenology of his presentation more closely fitted a diagnosis of schizophrenia than of delusional disorder. If he had been diagnosed as suffering from schizophrenia, however, it is unlikely to have altered the management of his care during this period.

32. The relatively short hospital admissions were a reflection of the lack of clear symptoms and of his unwillingness to receive hospital treatment voluntarily. Weight was given, rightly in our view, to reports received from JW, who was often the only source of information about John Barrett's deteriorating mental state and behaviour. But where no symptoms were found, as happened in 2001 following assessment of his mental state in hospital under section 2 of the Mental Health Act, he was discharged.

33. We find it understandable that his care was managed in this way. We make no criticism of his management during this period. It was typical of the interventions and approaches to be expected of a CMHT.

[69] Section 25A does not include the power to compel treatment in the community but requires the patient to attend appointments and to allow access to mental health professionals in accordance with the care plan.

34. Having made those general observations, there are four specific points of potential criticism we need to address arising from this period. The first arises from Dr Yates's assessment and report of June 2000. His description of John Barrett's potential for homicidal violence may seem prescient, and it could be asked why both in 2000 and subsequently John Barrett's care was not managed more restrictively. It is relatively easy to undertake an assessment on another team's patient and to highlight issues as representing high risk. We intend no criticism of Dr Yates when we say that that is the safe way to proceed in that it is not likely to lead one into criticism. A close reading of Dr Yates's report shows that he thought the most likely victim of a homicidal attack was John Barrett's partner, not a stranger. When he was assessed by Dr Yates John Barrett had shown a propensity for serious violence towards JW but there was nothing at that time comparable to the serious assaults he was to commit in January 2002. There was also the general difficulty faced by members of the CMHT that they had no power to compel John Barrett to co-operate with them or to take medication. Section 25A, which Dr Yates recommended, was ineffective in securing John Barrett's compliance with depot anti-psychotic medication. In the absence of John Barrett's compliance with medication the more assertive style of management that the team adopted following his discharge in October 2000 risked further alienating him from mental health services and thus reducing the likelihood that future deterioration in his mental state or behaviour would be picked up. There was a difficult balance to be struck, and we have no reason to question the decision of the team to discharge him from section 25A in April 2001, notwithstanding Dr Yates's recommendation.

35. The second specific issue is the use made of Mental Health Act powers of detention and compulsory treatment in May 2001. John Barrett was detained under section 2, which allows for detention for up to 28 days. As a matter of good practice, it was correct to carry out an assessment early during the 28 day period to decide whether to extend his detention by the making of an application under section 3, which allows for an initial period of six months' detention for treatment. Dr Bale and Mark Veldemeijer carried out such an assessment and concluded that his condition did not warrant an application under section 3 – in effect that further detention under the Mental Health Act was not justified.

36. We have considered whether, in arriving at the judgement that he was not detainable, they may have placed too much emphasis on the degree of his illness, that is the presence or absence of mental state abnormalities, and not given sufficient weight to its nature. There was by May 2001 a clear history of violence and threatening behaviour associated with paranoid delusions. There was also a history of the condition responding to medication, and of John Barrett disengaging from treatment as soon as compulsory powers were lifted. We therefore consider that a case could legitimately have been made for detaining him under section 3 because his illness was of a nature to justify detention. However, had he then been detained under section 3 we think it unlikely that it would have made any difference to his management thereafter. This is because we do not consider that John Barrett would have gained sufficient insight to comply with out-patient treatment following discharge through a further period of treatment as an in-patient. That is the clear evidence from previous periods of detention, including that of 2000 which lasted over five months.

37. In our view, the only means of securing John Barrett's compliance with treatment as an out-patient would have been a community treatment order, which is not available under the Mental Health Act. We note that the Government is now proposing to amend the 1983 Act to introduce what will be known as supervised community treatment. The Department of Health's briefing sheet,[70] makes clear that the proposed measure would cover someone who has a chronic mental disorder that has stabilised following treatment in hospital. It seems likely that had such a power existed in 2000, its use would have been recommended by Dr Yates. It also seems likely that, had it been used, such a provision would have secured John Barrett's compliance with depot anti-psychotic medication for some time following his discharge.

38. The third issue relates to Dr Bale's request for a further assessment by a forensic psychiatrist. He asked for this in May 2001 while John Barrett was detained under section 2 of the Mental Health Act, but before the forensic assessment had taken place Dr Bale discharged him from detention. Later, when John Barrett had failed to keep

[70] Supervised Community Treatment, Department of Health – April 2006.

out-patient appointments with Dr Bartlett, consultant forensic psychiatrist, Dr Bale advised her that there was no need to persist in her attempts to secure John Barrett's attendance. The assessment therefore never took place. When we asked Dr Bale about this he gave the following explanation:

> *The rationale for doing it was simply because we had sectioned him; his history, the suggestion of previous reports saying, 'Call us again if you'd like to.' There was a sense of anxiety from people who had been involved previously. For instance, John Meyer Ward felt another forensic opinion might be helpful. It is difficult to know what we would expect out of such an opinion, given that we hadn't found any symptoms anyway* [and]… *they* [do not]… *have any techniques we don't have in terms of getting symptoms. Part of the reason for trying to carry on with* [a forensic assessment in] *out-patients would be starting the process of trying to see it through. Again, once we had made the decision that we couldn't find any symptoms, we had some semblance of a plan of him allegedly continuing contact with us and medication. That followed previous recommendations. I wasn't convinced they would be able to come up with anything very different to that. He hadn't done anything at that point that would suggest any more reason for them to take over his care, and if they took over his care what else would they do, see him in the community or not.*

39. We agree with Dr Bale's reasoning. We think it unlikely that a forensic assessment in the summer of 2001 would have added anything to John Barrett's management at that time.

40. The fourth potential criticism arises from John Barrett's arrest on 31st December 2001. It could be suggested that the police should have informed mental health services of his arrest and held him for a psychiatric assessment. Had such an assessment taken place it is at least possible that he would have been detained under the Mental Health Act and thus prevented from committing the assaults of 8th January 2002. We consider that this is not only to place unrealistic expectations on the police, to make themselves aware of the mental health history of everyone they arrest, but also to risk further stigmatising people with mental health problems and eroding their

right to medical confidentiality. Elsewhere in this report we consider the role of multi-agency public protection arrangements (MAPPA).[71] They apply to clearly defined categories of violent and sexual offenders and at that time had no application to John Barrett. We have also seen that in March 1997 John Barrett was psychiatrically assessed following arrest, but that was because his mental state was sufficiently disturbed that police thought it appropriate to arrange for him to be medically examined. That was not the position in December 2001. In these circumstances we make no criticism of the police for failing to notify mental health services of John Barrett's arrest.

41. Finally, we observe that the period of care before 2002 provided information of considerable potential value to those who became responsible for John Barrett's subsequent care. This information was in the notes and included detailed descriptions of symptoms, recorded incidents of behaviour giving rise to risks to others, John Barrett's response to treatment and his attitude to mental health professionals and to specific treatment interventions. In the following chapters we refer to relevant aspects of John Barrett's history when discussing his clinical management by the Forensic Service.

[71] Refer to Chapter 2.9.

Chapter 2.3 - Clinical Management
January 2002 – October 2003

Introduction

1. In this chapter we consider John Barrett's management by mental health services from his arrest on 8th January 2002 until 10th October 2003 when he was conditionally discharged by a mental health review tribunal and left hospital.

2. John Barrett was continuously detained throughout this period. He was first remanded to Wandsworth prison. On 16th April 2002 he was transferred, as a remand prisoner, under sections 48/49 of the Mental Health Act to the Shaftesbury Clinic. On 20th September 2002 he was sentenced to a restricted hospital order and thereafter remained at the Shaftesbury Clinic under sections 37/41 of the Mental Health Act.

3. Throughout John Barrett's time at the Shaftesbury Clinic his care was provided by forensic mental health services. In Chapter 1.1 we describe how the Forensic Service based at the Shaftesbury Clinic was managed and we comment on the composition of care teams, workloads and working methods. We begin this chapter by describing broadly the role and general approach of forensic mental health services. This provides the context for the analysis in this chapter and the two chapters that follow, where we refer to the balance between therapeutic benefit for John Barrett and the protection of the public. Throughout his time at the Shaftesbury Clinic John Barrett was detained under the Mental Health Act and subject to the special restrictions in section 41(3). Another important part of the context therefore is the legal framework of the Mental Health Act 1983 and more particularly the restricted patient regime which gives the Home Office powers and imposes corresponding duties on those responsible for the patient's care. In Chapter 2.8 we discuss the powers of the Home Office in relation to restricted patients, with reference to what happened in this case.

Forensic Mental Health Services and Public Protection

4. Forensic mental health services manage patients who inherently present a significant level of risk to others. One does not admit a patient to such a service

principally for their own protection. The practitioners therefore have a heightened responsibility toward the public. Indeed in some respects the patient's RMO and colleagues are guardians of public safety. They discharge this responsibility in any intervention or course of action by weighing the likely benefit to the patient against potential risk to others. It is therefore part of their duties that at times they must restrict a patient's freedoms, or deny him what he would see as progress, for the greater public good. The therapeutic alliance which professionals strive for must therefore be tempered with both realism and recognition that hard messages need to be given to patients. The patient's assertions must be challenged, his views explored, and his position as a person presenting risk to others used to explain why certain courses of action are necessary even though he might prefer otherwise.

5. This might be seen as conflicting with the primary purpose of a health professional, that is to help the individual. Central to forensic services, however, is this tension between therapy and security which permeates all aspects of their work. It is therefore not possible always to put the patient first. When the balance is misjudged, as we believe it was in this case, the patient may progress through the system but at a cost to others.

6. We now analyse the care and treatment during this period under the following headings:

- The index offences
- Diagnosis and its consequences
- Treatment and response to treatment
- Leave of absence
- Discharge planning
- Risk management
- Risk assessment documentation
- Organisation and quality of case records and organisation of care
- Leadership of the team and decision making

The index offences

7. In common with many other patients of forensic mental health services, John Barrett had committed serious offences, in his case violence against the person. Given that he was deluded at the time of the index offences, achieving a clear understanding of how the offences occurred and their seriousness for the victims was an important aim for both him and the team. The expectation would be that such an understanding would lead him to accept interventions, such as treatment for mental illness, that would tend to reduce the risk of future violence. It would also lead the team to an appreciation of the relational factors so as to influence and manage them in his later care.

8. Medical entries from John Barrett's period on remand in Wandsworth prison threw further light on his state of mind and motivation when he committed the index offences. The link was clearly made between fearing for his life and carrying a knife. When in May 2002 he reflected on this it is striking that he not only showed no remorse for the index offences but appeared unable to accept responsibility for carrying a knife. Dr Bartlett's SHO recorded:

> *He claimed to now think that the victim was an innocent bystander in which case John was 'disappointed' 1) that a verbal incident could result in this, 2) that he had been carrying a knife for ten days - a 'cruel twist of fate for me and him', and 3) that he had been involved in mental health services for seven years and for 10 days.*

The lack of remorse which characterised John Barrett's violent offending was summarised by Dr Campbell, Dr Bartlett's SpR, in his report of 9th July 2002 for the sentencing court:

> *He shows little remorse and makes no attempt at reparation following episodes of violent or aggressive behaviour.*

9. Those responsible for his treatment at the Shaftesbury Clinic took the view, we believe correctly, that the persecutory paranoid delusions John Barrett was

experiencing at the time of the index offences caused him to misinterpret the principal victim's behaviour and/or to misidentify him. Those same delusions had led him the previous week to arm himself with a knife for protection against his imagined persecutors, one of whom he believed had threatened to kill him. As late as October 2002, John Barrett's understanding of the index offences continued to be informed by his delusions at a time when his mental state and behaviour were reported to be more stable. He also continued to justify his behaviour as having been in response to the principal victim's provocation and violence, although this is contradicted by contemporaneous witness statements. Dr Campbell's entry of 14th October recorded that John Barrett:

> *Made a clear connection between his long-standing beliefs about police surveillance and the man who he claimed had threatened him and JW on the tube in 1997, saying that this was the same man who threatened him five days before the index offences of January 2002. He believed that this man was connected with the principal victim but recalled thinking at the time that it was too much of a coincidence.*

10. John Barrett told Dr Campbell that *"he would not have been placed in a medium secure unit if he had not been punched first and if he had not been carrying a knife"*. There is nothing in Dr Campbell's entry to indicate that he challenged John Barrett's version or his disavowal of his responsibility. It is also of interest that according to Dr Campbell's note of the same date:

> *John Barrett believed that the police rather than the mental health team had been responsible for deciding on the size of the substantial police escort when he attended court to be sentenced.*

This is an example of John Barrett seeming to minimise the concerns of others about the risk he presented. It is not clear from Dr Campbell's note whether it was reinforced to him that, in addition to any views from external agencies, the clinical team also believed he was a risk.

11. Similar points about the index offences emerge from the record of John Barrett's discussion with Dr Ferris on 16th October 2002 when he appeared to place the blame firmly on the principal victim: *"maybe he'd just broken up with his girlfriend or something", "he had a problem"*. Dr Ferris recorded him as being dismissive of his responsibility and the nursing record of the ward round on 29th October 2002 states that *"John seems to be greatly minimising his own index offence"*.

12. In summary, in October 2002 John Barrett appeared still to believe that some parts of his delusional interpretation of the sequence of events leading to the index offences were true. Moreover, he continued to believe – though not necessarily as part of his delusional system - that he had been provoked by the principal victim and that in consequence he had some justification for what he did. Further, we have found no record that John Barrett had shown any concern for the well-being of those he had seriously injured. In our view these were all relevant matters for forensic mental health services.

13. Our first observation about how the team dealt with the index offences is that it is not clear to us that these points were explicitly understood. There are a number of references in the notes to John Barrett's attitude to the offences, but after he was convicted there is no analysis or record of substantial discussion. Second, there is nothing in the notes to indicate that when John Barrett expressed his distorted view of the index offences he was challenged. When he gave his self-justifying account to Dr Ferris on 16th October 2002 there followed *"a discussion of projective mechanisms"*, but there appears not to have been a careful consideration of what John Barrett had actually done, perhaps with reference to the contemporaneous witness statements, as compared with John Barrett's incorrect version of events. It is striking that as late as 19th August 2003, when John Barrett was well on his way to conditional discharge, Dr Ferris reported that:

> *John Barrett continued to see being provoked as a precipitant to the event, although he acknowledged his state of paranoia and that his reaction was in excess of the provocation.*

Given that the witness statements do not support the claim of provocation but show that John Barrett himself had confronted the principal victim, this should have been of concern in a patient approaching discharge. Indeed Dr Ferris did refer to it as such in his report to the tribunal.[72]

14. Third, there remained unresolved, and apparently not discussed, the extent to which his past violence, which was not confined to the index offences, was attributable to what the entry for 21st January 2003 referred to as *"conscious choices"*, or whether a paranoid mental illness was a sufficient explanation. There were at least two components to John Barrett – the psychiatric patient and the criminal. The two were strongly interrelated but should also be considered separately. There was in our view a need to understand the criminogenic[73] aspects of his functioning. The matter is alluded to in the notes but there is an absence of analysis or discussion. Such an analysis should in our view have taken into account his history of interpersonal violence, including assaults on JW and on staff and patients during previous admissions. Fourth, we note that the view was communicated to the Home Office, in the annual statutory report dated 14th July 2003, that *"his current attitude to the offence is one of remorse"*. The same thing was said on other occasions when requests were made to the Home Office to authorise leave. We have found no record in the notes that John Barrett expressed remorse. What he told Dr Ferris on 19th August 2003 above would at the very least imply some need to qualify the statement that he was remorseful.

15. The team took the view that provided John Barrett was free of paranoid psychosis the risk of violence was low. This was stated in the annual statutory report dated 14th July 2003:

> *His index offence took place in the context of a psychotic illness during which he believed that he was under surveillance from the police and that the man he attacked had been part of this police surveillance. As it is quite clear that the attack took place in the context of a psychotic illness, namely a delusional*

[72] Dr Ferris reported that he continued *"to minimise some aspects of the offence"* and to believe that he had been provoked by the victim.
[73] Criminogenic – producing or tending to produce crime or criminality.

disorder, and that this delusional disorder is no longer present, he is therefore not considered dangerous at this stage. If he were to become unwell again then these would be the circumstances at which he would be dangerous again.

This was confirmed to us by Dr Mezey:

We felt that there was a risk, which we categorised as low, but we felt that we had carried out a careful risk assessment, we had identified the factors associated with relapse and an increase in risk and that we felt we were able to manage that risk in the community.

It would follow from this approach that John Barrett's attitude to the index offences was of secondary importance, provided that he had internalised the need to continue treatment and if mechanisms were in place to identify any deterioration in his mental state.

16. While we agree that the most significant risk factor for violence that could be effectively managed was John Barrett's paranoid psychosis, we would have expected to find more evidence of efforts to explore and change his thinking about the index offences. There were important lessons for him arising from what he had done. Foremost among these was that his mental illness made him potentially dangerous. This dangerousness arose from his tendency when he was ill to attribute malign motives to strangers. It was increased by his arming himself with a knife. He needed to understand these things as relevant to his risk to other people. Our impression is that John Barrett did not reach this level of understanding.

17. We note that in August 2002 the recommendations made by the psychologist, Ms Leicht, included undertaking an offending behaviour programme but we have seen no evidence that this work was done. John Barrett was subsequently seen by another psychologist, Ms Houston, for six sessions between November 2002 and January 2003. One of the areas covered in their sessions was *"the relevant contributory factors to the development of his illness and his index offence"*. The report of those six sessions describes discussion of his violence towards his partners. However, in relation to the index offences it is limited to the following:

> *Previous reports when he was under Dr Bartlett's team have documented the events leading up to Mr Barrett's index offence. However, I think it is significant to note that he describes himself as a person who would never normally carry a weapon, saying that he 'abhors such things'. He went on to say 'I would never in my wildest dreams see myself as that type of person'. Mr Barrett described himself* [as] *a person who is normally very easily able to brush off stares or intense eye contact from other people, readily accepting that some people are 'just lookers'.*

It is not a criticism of Ms Houston that she made no recommendations for further individual psychological treatment or for work in relation to the index offences, but we consider it a matter of more than passing interest that John Barrett, with his history of confrontational and violent behaviour, distanced himself from the index offences in this way.

18. Even if we accept the team's view that John Barrett had made a connection between his paranoia and the index offences, we consider that throughout the in-patient period he continued to minimise his personal responsibility for what he had done. We consider that there was a need to challenge his version of the index offences and to educate him in relation to matters that would tend to reduce the risk of future violence. In order to do this effectively the team would have had to carry out their own analysis. The analysis would have needed to place the index offences in the context of John Barrett's previous history of violence and to have considered the nature of his violence and its precipitants. As a minimum we would have expected any plan to have included challenge to John Barrett's version of the index offences, which substantially blamed the principal victim, and to have reinforced the seriousness of the assaults for the victims resulting from John Barrett's arming himself with a knife.[74]

19. Such work may have been done, but we have found no record of it. We consider that relevant discussion and analysis in relation to a forensic patient's offending should be explicitly recorded in the notes. It should be apparent from the notes not

[74] Refer to Chapter 1.4 for information about the injuries sustained by the victims

only what the patient says about the index offences, but the extent to which his version accords with what the team understand to be the facts. The notes should also detail any issues arising for the patient's future clinical management and any further work needed.

20. We consider that the lack of an explicit analysis of the index offences, and the absence of therapeutic interventions designed specifically to address the issues which such an analysis would have identified, were significant shortcomings in John Barrett's clinical management during the in-patient period.

Diagnosis and its consequences

21. While he was a patient of the Trust, John Barrett's condition attracted a number of different diagnostic attributions.[75] Principally these were persistent delusional disorder/delusional disorder and schizophrenia. He had from time to time a number of abnormalities of mental state, oddities of conduct, or behaviours which were seen as inappropriate. We now discuss how these were viewed and whether they could be seen as symptoms of a mental disorder which would point to a diagnosis. Whether, or to what extent, any of these differences matter in respect of his later care and treatment by the Forensic Service is an issue we will explore.

22. We first explain how mental illness is diagnosed before going on to consider how the matter was approached in this case and its implications for John Barrett's management as an in-patient.

23. The diagnosis of mental illness is fundamentally based upon pattern recognition. Except for a minority of relatively rare conditions, there are no specific diagnostic tests available, such as the blood tests and x-rays used to diagnose physical illnesses. What instead is done is what used to be undertaken with physical diseases until we had scientific tests which could offer certainty. Diagnosis rested upon the presence of

[75] We refer to these in Part 1. We also mention there that Dr Nayani in his report of 15th August 2002 gave the diagnosis as persistent delusional disorder. Dr Farnham, whose report of 19th September 2003 is mentioned in Chapter 2.7, reached the same conclusion. We have not explored the nature or detail of non-Trust reports. Reports may vary as to standard or purpose. Neither the number nor the length of reports is necessarily a guide to the relevance or correctness of the views expressed.

certain symptoms, perhaps in the absence of certain other symptoms, to form a recognisable pattern of disorder such that people with this pattern had common pathways by way of presentation, characteristics, treatment response and future progression.

24. These patterns have been refined over the years into diagnostic systems or guidelines. These are schemes which allow clinicians to use a common therapeutic language to describe what they see and what has been shown to be important for patients.

25. There are two main systems. The International Classification of Diseases, 10th Revision (ICD-10) published by the World Health Organisation, and the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) published by the American Psychiatric Association. The former is European in origin, the latter North American. Each is used most widely in the territory in which it was developed, however there is common usage of DSM –IV in Europe and both are acceptable and recognised.

26. The systems overlap – they are similar but not identical. The explanation which follows uses ICD-10.

27. The thinking and research work which underpin diagnostic attributions took place years before either of these systems arose. They codified the pre-existing work.

28. In John Barrett's case notes a variety of terminology is used, to which we refer in this report. We now explain the background to some of this terminology.

29. With regard to the diagnosis of schizophrenia, in 1959 Kurt Schneider described what he believed to be its core features and he named these symptoms of the first-rank, as opposed to those he considered less diagnostic which he called symptoms of the second-rank. Manifestation of one first-rank symptom, in the absence of altered consciousness or persistent affective disorder, was sufficient for a diagnosis of schizophrenia. However, it is now recognised that Schneider's first-rank symptoms should not be used as absolute criteria and that they yield both false positives and false negatives. It is possible, indeed not uncommon, to suffer from schizophrenia yet

have no Schneiderian first-rank symptoms, and equally to have first-rank symptoms yet not have schizophrenia.

30. The Schneiderian first-rank symptoms of schizophrenia include:

- Auditory hallucinations of one or more of the following kinds:
  Hearing thoughts spoken aloud
  Hearing self-referential voices speaking in the third person
  Auditory hallucinations external to the person, commenting on the individual who is experiencing them
- Thought withdrawal, insertion and broadcast
- The experience/belief that his feelings/thoughts or actions are being controlled or influenced by an outside force
- Somatic hallucinations/passivity – the patient believes that he is the passive recipient of bodily sensations imposed from outside himself
- A delusional perception: this is a phenomenon incorporating two stages in which there is first a normal perception, followed by its being given a delusional interpretation as having a special and highly personalised significance.

31. Second-rank symptoms, according to Schneider, include other forms of hallucinations, depressive or euphoric mood changes, emotional blunting, perplexity, and sudden delusional ideas.

32. Schizophrenia is characterised by fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect. The most intimate thoughts, feelings and acts are often felt to be known to or shared by others, and explanatory delusions may develop to the effect that natural or supernatural forces are at work to influence the afflicted individual's thoughts and actions in ways that are often bizarre. Hallucinations, especially auditory hallucinations, are common. In the characteristic schizophrenic disturbance of thinking, peripheral and irrelevant features of a total concept, which are inhibited in normal directed mental activity, are brought to the fore and utilised in place of those that are relevant and appropriate to

the situation. Perception is frequently disturbed in other ways, and irrelevant features of ordinary things may appear more important than the whole object or situation. Perplexity is also common early on and frequently leads to a belief that everyday situations possess a special, usually sinister, meaning intended uniquely for the individual. Thus thinking becomes vague, elliptical and obscure, and its expression and speech sometimes incomprehensible. Breaks and interpolations in the train of thought are frequent, and thoughts may seem to be withdrawn by some outside agency. The affect is characteristically shallow, capricious, or incongruous. The onset may be acute, with seriously disturbed behaviour, or insidious with a gradual development of odd ideas and conduct. The course of the disorder shows equally great variation.

33. For practical purposes it is useful to divide the possible symptoms into groups that have special importance for the diagnosis and often occur together, such as:

a) thought echo, thought insertion or withdrawal, thought broadcasting;
b) delusions of control, influence or passivity, are clearly referred to body or limb movements or specific thoughts, actions or sensations; delusional perception;
c) hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient amongst themselves, or other types of hallucinatory voices coming from some part of the body;
d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities;
e) persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;
f) break or interpolations in the train of thought, referred to as thought disorder, resulting in incoherence or irrelevant speech, or neologisms;
g) catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism and stupor;

h) “negative” symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and lowering of social performance;
i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

34. ICD-10 diagnostic guidelines are that the normal requirements to establish a diagnosis of schizophrenia is that a minimum of one very clear-cut symptom (and usually two or more if less clear-cut) belonging to any one of the groups listed as (a) to (d), or alternatively symptoms from at least two of the groups (e) to (i) should have been clearly present for most of the time during a period of one month or more. Conditions meeting such symptomatic requirements but lasting less than one month, whether treated or not, should in the first instance be diagnosed as an acute schizophrenia-like psychotic disorder and reclassified as schizophrenia if the symptoms persist for longer periods. It will be seen that the first and second rank symptoms are contained within these symptom groupings.

35. DSM-IV approaches the issue similarly, so that for a diagnosis of paranoid schizophrenia to be made there must have been certain symptoms present for a specific duration.

36. Paranoid schizophrenia is the most common type of schizophrenia. The clinical picture is dominated by relatively stable, often paranoid, delusions usually accompanied by hallucinations, particularly auditory, and also perceptual disturbances. Disturbances of affect, volition and speech, and catatonic symptoms, are not prominent. The course may be episodic with partial or complete remission, or chronic. In patients suffering from schizophrenia there can be a gradual decline in social functioning, with a coarsening of personality features and a deterioration in the expression of those individual attributes which make the person unique, such as volition and emotional responses. A person who has suffered this decline is sometimes referred to as ‘deteriorated’ or as having ‘negative’ symptoms. In contrast to other sub-types of schizophrenia, paranoid schizophrenia is associated with less of this deterioration and there can be good preservation of personality without decline – the

sufferer can appear to have full function although to someone who knows them well, subtle changes can be apparent.

37. Examples of the most common paranoid symptoms are:

a) delusions of persecution, reference, exalted birth, special mission, bodily change, or jealousy;
b) hallucinatory voices that threaten the patient or give commands, or auditory hallucinations without verbal form such as whistling, humming or laughing;[76]
c) hallucinations of smell or taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.

Thought disorder may be obvious in acute states. Affect is usually less blunted than in other varieties of schizophrenia, but a minor degree of incongruity is common, as are mood disturbances such as irritability, sudden anger, fearfulness and suspicion. Negative symptoms such as blunting of affect and impaired volition are often present but do not dominate the clinical picture.

38. Persistent delusional disorder is a condition in which long-standing delusions constitute the only, or most conspicuous, clinical characteristics and which cannot be classified as organic, schizophrenic, or affective. The condition is characterised by the development either of a single delusion or of a set of related delusions which are usually persistent and sometimes lifelong. The delusions are highly variable in content. Often they are persecutory, hypochondriacal or grandiose. Other psychopathology is characteristically absent. Clear and persistent auditory hallucinations, and schizophrenic symptoms such as delusions of control and marked blunting of affect are all incompatible with this diagnosis. Occasional or transitory auditory hallucinations, particularly in elderly patients, do not rule out a diagnosis of persistent delusional disorder provided they are not typically schizophrenic and form only a small part of

[76] At different times John Barrett reported auditory hallucinations. The most frequent were indistinct whispering voices, for example in May 2003. There were also, for example in May 2004, clear auditory hallucinations in the second person saying *"we will kill you"* and on 1st and 2nd September 2004 he reported command hallucinations insistently saying *"kill, kill"*.

the overall clinical picture. Apart from actions and attitudes directly related to the delusion or delusional system, the patient's affect, speech and behaviour are normal.

39. The ICD-10 diagnostic guidelines are that the delusions constitute the most conspicuous or the only clinical characteristic. They must be present for at least three months and be clearly personal. There must be no, or only occasional, auditory hallucinations and no history of schizophrenic symptoms (delusions of control, thought broadcasting etc.).

40. We now consider how a diagnosis was arrived at in John Barrett's case. In the previous chapter we summarised and commented on the information that had accumulated by January 2002 regarding John Barrett's mental disorder. His detention at the Shaftesbury Clinic provided ample opportunity to review diagnosis in the light of the known history and the team's own assessment. Even before he was transferred to the Shaftesbury Clinic, relevant clinical observations were made in prison. In particular, on 11th March 2002 he was described as *"circumstantial and over-inclusive"*. The words transcribed by the assessing doctor *("dentist/dental floss/nice tie doctor")* are suggestive of thought disorder. On 8th April 2002 he was described as regularly misusing words and using polysyllabic words inappropriately. This also suggests thought disorder.

41. During the period under Dr Bartlett's care in 2002 there were numerous instances where abnormalities of mental state were recorded. Indeed, Dr Bartlett concluded on 14th May 2002 that *"John Barrett was suffering from paranoid schizophrenia, not delusional disorder"*.[77] This was thereafter recorded as the diagnosis in ward round minutes until, following his transfer to Dr Mezey's team in October 2002, the diagnosis was changed back to persistent delusional disorder in December 2002. What follows is a list of the observed and reported psychotic phenomena between May and June 2002:

[77] Surprisingly Dr Campbell's report of 9th July 2002, which was prepared for the Crown Court, maintained the previous diagnosis of persistent delusional disorder. Dr Bartlett told us this discrepancy arose because the view was taken that the evidence disclosed by JW could not be used in a report to the court. We consider this view is mistaken as the expectation would be that all relevant information is made available to the court.

- On 7th May *"seizing every opportunity to engage in philosophical discussion, legend, Pope John Paul I… said as police not carrying briefcase therefore not looking for him. Talking to and laughing to self loudly in toilet and corridor yesterday"*. This is suggestive of the affective incongruity and possible response to auditory hallucinations which would be typical of schizophrenia and not typical of persistent delusional disorder. On this date the team under Dr Bartlett recorded that diagnosis was *"Being assessed"*, having previously been persistent delusional disorder.
- At the ward round on 14th May John Barrett was said to be "*more guarded than when seen in prison and his speech was more thought disordered. He was also reported to be deluded and he had been observed talking to himself"*. The team under Dr Bartlett changed the diagnosis from persistent delusional disorder to paranoid schizophrenia.
- On 17th May he said: *"When I leave the ward in 5 months will go to the French Riviera with his nubious beauty"*. This is a neologism and suggestive of thought disorder.
- On 23rd May circumstantial speech was recorded and further neologisms were discussed, although there was disagreement within the team as to whether they were true neologisms.
- On 27th May John Barrett reported that "*a white deposit was seen in his urine and said that he had 'a broken dick' and that he wanted a Chinese doctor to fix it"*. He was also overheard saying that "*he might have prostate cancer"*. Unusual somatic complaints or unusual explanations for somatic phenomena are compatible with schizophrenia but do not support a diagnosis of delusional disorder unless they are part of the core delusion, which was not the case here.
- On 15th June the following entry was made: *"John believes that people know what is happening to him telepathically. John confessed* [to JW] *that he has been having a battle with these telepaths (voices) because of the money they have to pay 'They have to knock it down' from 16 million to 12 million. John said when he is let out he is going to chop off somebody's finger because that's what differentiates a human from a chimpanzee… John said the telepaths had tried to help him kill himself in Wandsworth prison but he didn't. He was also going to kill a priest, probably one of the chaplains,*

because the priest was red when talking to him. John has asked his girlfriend to bring him a book so that he can write his thoughts. It is only by writing down his thoughts he can remember them. As the telepaths are always trying to erase his thoughts. John believes he is on telly a lot. Girlfriend stated that a similar thing had happened four years ago. When he believed he is on telly 24 hours a day and everything is about him". These are psychotic symptoms which include ideas of reference, thought withdrawal, and bizarre delusional beliefs which are not apparently part of the core delusional system. All are symptoms of schizophrenia but not of delusional disorder. We emphasise that this information came from JW and that John Barrett did not express these thoughts to medical or nursing staff.[78]

- On 17th June he was reported to have behaved as if responding to auditory hallucinations and also to have displayed incongruous laughter. These are symptoms typical of schizophrenia.

42. In May 2003, when John Barrett briefly stopped taking anti-psychotic medication, he experienced what he described as "'*whispering' voices in the area around his head which were not loud enough for him to hear what they were saying"*. In our view these were auditory hallucinations, which while compatible with a diagnosis of delusional disorder could also be indicative of schizophrenia. This is a matter to which we return when discussing the post-discharge period during which whispering voices were a recurrent feature of his mental state, even when he claimed to be taking medication.

43. The above refers to what was observed and recorded at the Shaftesbury Clinic. Although some of these features of John Barrett's mental state were new, others had been noted earlier in his psychiatric history.

[78] Dr Bartlett commented to us on this: *"JW told us all about the telepaths, and raised I suppose three bits of phenomenology in my mind, one being possible thought withdrawal, probable thought reading, and possible thought broadcast, all of which was not brilliantly described, it was left with question marks, and it came from this third person who we had to think about. So these qualified as bizarre delusions, useful if you want to diagnose schizophrenia, but again these were one-off reports. He never told us about these things, we didn't know how reliable the report was, but it was supportive if you like of a change of diagnosis"*. We would only observe that the information from JW about telepaths came to the team in June but the diagnosis had been changed in May before the team had this information.

44. This previous history, for example John Barrett's references to telepathy, telepathic and psychic powers in April and May 2000, together with his bizarre behaviour at that time, tended to corroborate the information received from JW in June 2002. Further, there was good reason to regard JW as a reliable informant and she had been so regarded before John Barrett's admission to the Shaftesbury Clinic. If there was any doubt about this at an earlier date, her intervention in May 2003, when she disclosed that John Barrett had stopped his medication, was surely conclusive.

45. In summary, the in-patient period of care in the Shaftesbury Clinic provided new information relevant to diagnosis. Dr Bartlett told us:

> *We did change the diagnosis, but in the sense of thinking 'There is more phenomenology than previous people have picked up', and that is the advantage of a long-term in-patient forensic assessment*.

46. We consider that Dr Bartlett was right to conclude that there was significant psychopathology apart from the elaborated non-bizarre delusions relating to police surveillance. A diagnosis of paranoid schizophrenia, albeit in the absence of Schneiderian first-rank symptoms, accommodated the additional symptomatology. It did not, according to Dr Bartlett, lead to any change in the treatment plan or the risk assessment during the period that she was responsible for John Barrett's treatment.

47. In looking at how Dr Mezey approached the diagnosis of John Barrett's mental illness, we note that on 29th October 2002 when she assessed John Barrett for the first time she recorded him as having *"partial insight into delusional disorder"*. We take this to mean that John Barrett was at that time accepting a diagnosis of delusional disorder, not that Dr Mezey was endorsing his view. In Chapter 1.6, we have described with reference to entries in the multi-disciplinary notes the process by which the diagnosis reverted to persistent delusional disorder. The best account of the thinking behind the change is in the ward round minutes of 3rd December 2002 which suggests that the absence of first-rank symptoms was used to exclude a diagnosis of paranoid schizophrenia. When we asked Dr Mezey about the change of diagnosis she explained it as follows:

The reason that we decided to revert to the diagnosis of delusional disorder, which he had had in the past, is because our experience with John Barrett when he came to us was that he was rather well when he was transferred to us. The acute psychotic symptoms had largely resolved. He was quite compliant, he was engaging well in therapy, he appeared to be quite insightful, and the presentation in terms of the historical data looking at all the reports and looking at the work that Dr Bartlett's team had been doing, seemed to us to be much closer – or it seemed to us that a diagnosis of persistent delusional disorder was more appropriate.

I suppose the reason we took that view is that because in schizophrenia, unlike delusional disorder, you tend to see much more of an apparent fragmentation in the individual's personality, a deterioration in their personality, a deterioration in their social functioning, a gradual decline. He had been ill for six or seven years, he had had numerous admissions, and it was quite surprising that when he got better on the ward he was functioning at a very high level. He came across very well. He was articulate, he was engaged, he was quite active in terms of the ward activities.

So we also checked to see whether there had been any convincing first-rank symptoms, so for a diagnosis of schizophrenia we would have expected to see records of him having experienced auditory hallucinations in the third person, there being passivity phenomena, schizophrenic thought disorder, and again looking through the documentation and also the more recent admission under Annie Bartlett, I think none of us were convinced that there really was evidence for first-rank symptoms of schizophrenia.

It seemed to us to be a rather stable, persistent, relatively encapsulated delusional system, with predominantly paranoid delusion – persecutory ideas – but which once treated did not seem to have created much damage if you like to his under-lying personality and functioning.

48. We accept that it was possible to conclude that there was no clear evidence of first-rank symptoms but, as we have explained, neither this nor a high level of

functioning excludes a diagnosis of paranoid schizophrenia. This is perhaps to say no more than that while it may have been reasonable to prefer a diagnosis of persistent delusional disorder, paranoid schizophrenia would, in our view, have been a possible diagnosis. It has the advantage of encompassing the full range of recorded symptomatology, including the paranoid delusions, while persistent delusional disorder does not account for such phenomena as thought disorder and bizarre somatic complaints.

49. Features of a person's mental state not captured by, or indeed excluded from, a particular diagnosis have to be explained. If they are not explained they may be overlooked and any significance they have might be lost.

50. We consider that an adequate analysis of John Barrett's psychiatric history during his in-patient care, while no doubt having to come down on one side or the other on the question of diagnosis, would have recognised that there were features in John Barrett's psychiatric history that were not typical of persistent delusional disorder.

51. It is not useful for us to determine whether Dr Bartlett, Dr Mezey or other doctors achieved the 'correct' diagnosis. It is more relevant to consider how they viewed the symptoms. As will have become apparent from the way we explain the diagnostic process, it is reasonable to use a diagnostic system. Dr Mezey told us she used DSM-IV. We are satisfied that this was reasonable. Dr Mezey also told us that if the diagnostic criteria in DSM-IV are used, the additional phenomenology, which led Dr Bartlett to change the diagnosis, is compatible with a diagnosis of what in DSM-IV is called delusional disorder. We accept that if approached in this way it was possible reasonably to conclude, on the basis of information then available, that John Barrett was suffering from delusional disorder. It appears to us that the approach taken by Dr Mezey was, as indicated, one whose starting point was the absence of clear evidence of first rank symptoms.

52. If there are features not explained by the chosen diagnosis, there should be a process for considering their meaning – both prognostically for the patient, as to whether current treatments remain appropriate or whether other steps should be

taken, and also in relation to risk. This clearly becomes of greater importance when discharge from hospital is being considered.

53. We did not find anything in the notes to show that there had been a process of consideration during 2003-2004 of all the features of John Barrett's mental disorder which we have previously highlighted. The team seem not to have considered, in detail, the body of knowledge derived from his previous history.

54. The understanding of John Barrett and his illness, particularly the significance of the emergence of violence when psychotic and what the harbingers of psychosis were, was something that we believe may not have been fully grasped. As we discuss below, in closing off the diagnosis of paranoid schizophrenia, a therapeutic avenue was also closed off.

55. As to the relevance of diagnosis to treatment and risk management, we accept the point Dr Bartlett made to us about her period as RMO:

> *The truth of it is that we were treating him for a psychotic illness, we were aware of his risk, and whether we called that delusional disorder or paranoid schizophrenia made zero difference in terms of that period when I was looking after him. It did not affect the risk assessment, which was at quite a preliminary stage really; this was the first time that anyone had ever taken a really good look at him, and that is the time when you can start thinking in detail about the phenomenology.*

56. We agree with Dr Bartlett that during this period, when John Barrett's condition responded well to anti-psychotic medication, the treatment of his mental illness would have been the same whether the diagnosis was paranoid schizophrenia or delusional disorder. Treatment with anti-psychotic medication appeared to have achieved a resolution of the positive psychotic symptoms, including the paranoid delusions, when Dr Mezey took over his care in October 2002. Apart from a brief period in May 2003 when the whispering voices returned, no positive psychotic symptoms were recorded between October 2002 and April 2004.

57. It does not follow, however, that distinguishing between the two diagnoses of delusional disorder and schizophrenia was irrelevant in the case of John Barrett. We conclude that the important point, to which we return in the next chapter, is how the diagnosis affected the recognition of symptoms and the treatment plan when John Barrett became unwell following his discharge. We consider that the diagnosis of persistent delusional disorder may have contributed to a different approach from what one might have expected had the diagnosis been paranoid schizophrenia. Though the starting point of treatment may be the same, that is by the use of anti-psychotic medication, the implications of the diagnosis and of the treatment interventions which flow from it are significant. Persistent delusional disorder by its nature is persistent, and it is widely accepted that treatment response is often poor. This, we consider, might establish a foundation in the minds of some health professionals that resolution of symptoms was not possible and that a residuum of symptoms was to be expected and tolerated. Furthermore, those features which fall outside the pure diagnostic requirements may be perceived as features of the individual's personality. In the case of John Barrett it seems to have been accepted that *"whispers"*, which we are satisfied were not different from auditory hallucinations but simply auditory hallucinations at lower volume and so less personally intrusive to him, would persist intermittently in response to stress. An alternative view is that these were unresolved and incompletely treated symptoms of schizophrenia. It is of note that they were treated by only one type of medication, Risperidone. It is apparent that this did not completely remit his symptoms. We consider that a reasonable approach to treatment in circumstances where symptoms persisted would have been to offer trials of other medication in an effort to gain better symptom control. This was not done. Risperidone remained the chosen anti-psychotic throughout John Barrett's treatment by Forensic Services.

58. We conclude that the persistence of symptoms equated to the continuance of active disorder. It is clear from the past pattern of John Barrett's illness that this would therefore be accompanied by a propensity to misperception and misattribution, bizarre ideation and interpersonal violence, including violence to strangers.

59. If the team had considered that schizophrenia was the correct diagnosis, this would potentially have opened up additional treatment avenues. For the treatment of

schizophrenia, a common approach is to adopt some form of treatment algorithm which targets first one category of medication then another, with psychological approaches and pharmacological augmentation as other approaches to be taken. For example, if a person's symptoms are treatment-resistant, they may be prescribed Clozapine, the specific indication for which is treatment-resistant schizophrenia. It is perhaps of interest that in Broadmoor Hospital, John Barrett has been prescribed Clozapine. His pattern of illness and attitude to treatment continues; there has been an episode of covert non-compliance with medication which was accompanied by a deterioration in mental state.

60. We next consider briefly the question of personality disorder. We have referred in Chapter 1.6 to the psychological assessments that were carried out while he was a patient at the Shaftesbury Clinic. Essentially these concluded that he was not suffering from a personality disorder that warranted any form of specialist intervention. We accept this finding. While it is clear that John Barrett has a propensity for interpersonal violence which would appear to pre-date the onset of mental illness, our view is that it was reasonable for mental health services to confine themselves to treatment of his mental illness and management of the risks associated with it.

61. We consider that in John Barrett there was an intertwining of personality issues and issues of mental illness. The two were inextricably linked. Whether or not he had a personality disorder is, we believe, a sterile debate. What was required was treatment for those aspects of his difficulties which were treatable. We do not criticise the team for not giving specific treatment for personality disorder.

62. While personality disorder as an entity did not warrant specialist intervention, there were components of John Barrett's functioning which did require attention but which were not attended to. These relate to what we have referred to as the criminogenic factors, which could have been ameliorated by work on anger management[79], interpersonal relationships and consequential thinking. We would have expected such issues to be part of the normal considerations of a treatment package for a mentally ill patient within a medium secure unit. We have commented above on

[79] John Barrett's history included many occasions when he had been angry and violent – see Part 1.

the absence of specific interventions in relation to John Barrett's attitude towards the index offences. While work was done in psychology sessions on interpersonal relationships, with particular reference to John Barrett's history of violence towards women, we have found no evidence in the multi-disciplinary notes that consideration was given to other criminogenic factors or that specific interventions, such as anger management, were used.

Treatment and response to treatment

63. We now consider the treatment of John Barrett's mental illness and the extent to which he came to accept that he suffered from a severe and enduring mental illness for which medication was of benefit.

64. Even before he arrived at the Shaftesbury Clinic it was known that John Barrett's psychotic symptoms responded well to anti-psychotic medication. This was confirmed during the Shaftesbury Clinic admission, both by the remission of symptoms between April and October 2002 and by the return of symptoms in May 2003 when he briefly stopped medication. If he was to be believed when he claimed that he had stopped for only a week or 10 days, then it is striking how quickly symptoms returned, specifically auditory hallucinations in the form of whispering voices. It is important to note that by his own account, which was accepted by Dr Mezey and her colleagues, he was free of positive psychotic symptoms continuously between May 2003 and his discharge in October 2003.

65. Throughout his time as an in-patient John Barrett was treated with Risperidone, an oral anti-psychotic medication. This did not change with the changes in diagnosis between delusional disorder and paranoid schizophrenia. Risperidone is available both as tablets and as liquid. The latter can be used for people who struggle to tolerate tablets, for example those with swallowing difficulties, but it is more commonly used for patients for whom compliance is perceived as a problem. It is not difficult for a determined person, when administered a tablet, to take it in their mouth and hold it until moments later and unsupervised, they can spit it out. When the clinical team suspect this, the liquid version may be used instead. It is much more difficult to avoid ingesting this form of the medication. John Barrett was prescribed Risperidone in

liquid form from at least 28th May 2002. This prescription continued unaltered through 2002 and into 2003. An in-patient prescription was re-written for the same medication from 16th September 2003 to run until 16th October 2003, but in fact did not run beyond 10th October 2003 because John Barrett was then discharged. We have found no evidence that John Barrett had a tablet intolerance. Indeed, he took the same medication in tablet form after his discharge. We therefore infer the use of liquid medication during the in-patient period was intended to secure compliance.

66. The discharge summary sheet for 9 October 2003 shows a 'to take out' prescription of Risperidone, at the same dose as had been current while an in-patient, but in tablet form. It is therefore clear that while John Barrett was given liquid medication for most of his in-patient care, this was changed to tablets at the point of discharge. We understand why tablets were given for community use, being easier to take, but in our view this change should not have occurred at the point of discharge. There should have been a thorough appraisal of John Barrett's compliance during the in-patient phase of his treatment. That would have helped shape a view on whether he still needed liquid or could be moved to tablets. If the latter, a period of in-patient time should have been allowed for the taking of tablets to be monitored to determine whether there was any suggestion of the previous covert non-compliance. As it was, John Barrett's approach to tablets was unknown when he was discharged from hospital.

67. Having established John Barrett on a medication regime that in the Shaftesbury Clinic effectively brought his psychotic symptoms under control, there was still the question whether he would continue with the prescribed medication after his discharge. Case law establishes that a patient with a history of serious violence who suffers from a relapsing psychotic illness which is controlled by medication will not be entitled to discharge if there is a likelihood of non-compliance and relapse.[80] A key indicator of compliance with oral medication after discharge from hospital is the

[80] *While in the controlled environment of the hospital [the patient] is taking medication and, as a result, of the medication he is in remission. So long as he continues to take the medication he will pose no danger to himself or to others. The nature of the illness is such, however, that if he ceases to take the medication he will relapse and pose a danger to himself or others. The professionals may be uncertain whether, if he is discharged into the community, he will continue to take medication. We do not believe that Article 5 requires that the patient must always be discharged in such circumstances. The appropriate response should depend on the result of weighing the interests of the patient against those*

patient's acceptance that he suffers from an illness and needs to continue with treatment. We now consider whether this was John Barrett's attitude.

68. Based on the previous history, the position before his admission in 2002 was that John Barrett did not consider himself to suffer from a mental illness. He had never complied with either oral or depot medication as an out-patient. He positively disliked medication. He had learned to be evasive and guarded in his communications with mental health professionals. He rationalised what others regarded as a serious mental illness by attributing his problems to cannabis and by maintaining that much of his delusional paranoid thinking was based in reality. This was also how he was described by Dr Campbell in his report of 9th July 2002 for the sentencing court. At that time John Barrett continued to express grandiose delusions; he denied that he had ever suffered from a psychotic illness and he did not believe he needed medication.

69. According to Dr Mezey and other members of the team, this changed during the course of John Barrett's in-patient treatment. Dr Mezey told us:

> *By the time that we came to discharge him he had accepted certain things. He had accepted that he had a serious mental illness, a psychotic illness, that he needed the medication. He had accepted the fact that medication was helpful, and in fact he had stopped the medication* [in May 2003] *because he thought that it was nothing to do with illness, he thought it was just cannabis that had made him ill and wanted to test it out, but by the time of his* [discharge in October 2003] *he was saying that he thought the medication really was helpful because it stopped him having these thoughts.*

It may be true that by October 2003 John Barrett was saying that he had a serious mental illness and believed the prescribed medication was helpful, but a number of factors lead us to question whether this really was his view.

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of the public having regard to the particular facts. Continued detention can be justified if, but only if, it is a proportionate response having regard to the risks that would be involved in discharge. Lord Phillips M.R. in R (H) v MHRT [2001] EWCA Civ. 415.

70. First, there was his tendency to be evasive and to limit the information he gave to mental health professionals, with the object of telling them what he thought they wanted to hear. This was evident in May 2003 when he spoke to JW first and to members of the team only after she had passed on what he had told her, and even then he gave equivocal accounts of the symptoms (*"he thought he might have had some 'whispers' but he wasn't sure"*). His communications with mental health professionals, if not deliberately deceitful, were permeated by his wish to minimise their interference in his life. Characteristically, he was concerned that he should not be penalised for stopping medication.

71. Second, John Barrett remained ambivalent about whether he was suffering from a chronic mental illness, as opposed to having experienced paranoia in the past as an adverse reaction from cannabis. This is found in the notes on 29th July and 19th August 2003 when it was recorded that he expressed ambivalence in the illness awareness group. John Barrett's voicing of such issues, which can often be picked up by non-medical and non-nursing staff who may be seen by patients as not connected to the clinical heart of the team, is something which we consider was indicative of a problem. The team should have been concerned about ambivalence evident at this late stage. When his insight was discussed at the ward round on 19th August 2003, it was concluded that he was likely to continue to take medication because of the threat of return to hospital and JW's supervision. This was an acknowledgment that his insight was quite limited.

72. Third, it is not clear to us that John Barrett accepted fully the medical advice that maintenance anti-psychotic medication prevented the return of psychosis. In June 2003, that is after the relapse of May 2003 which was seen by the team as a significant learning experience for him, Dr Scholtz recorded that "*in discussing medication he referred only to its calming properties and made no reference to psychosis"*. We consider that this became relevant after discharge when John Barrett appears to have come to believe that medication was not effective in treating the auditory hallucinations, in the form of whispering voices, which he started to experience again in April 2004.

73. Finally, the history showed that John Barrett was slow to recognise and report symptoms. This issue was commented on in team discussion as late as 9th September 2003 when reference was made to his *"poor recognition of any deterioration in his mental state"*. There was therefore a continuing concern that if he were to relapse he would not recognise changes in his mental state.

74. Despite his acceptance, particularly after May 2003, that he had been helped by medication, our conclusion is that John Barrett continued to believe that his mental health problems resulted from a combination of past cannabis use and stress. We have not seen any evidence that the views attributed to John Barrett by Ms Houston, based on her work with him which ended in January 2003, had changed by the time of his discharge in October 2003:

> *He was quite concrete about it in that his view was, I smoked cannabis and the cannabis made me paranoid, and the paranoia made me have irrational beliefs and I acted on those irrational beliefs. My understanding was that he did accept he had an illness, but his understanding of that illness was quite circumscribed; it was paranoia that* [was] *triggered by his cannabis use.*

75. The fact that a patient is compliant with oral medication, as John Barrett appeared to be between May and October 2003, does not preclude a change to depot medication. There are mechanisms under the Mental Health Act for the compulsory administration of medication, including depot, to a detained patient. These carry both advantages and disadvantages. The question for the team was whether to insist on depot medication, using powers of compulsion if necessary, so as to reduce the risk of non-compliance following discharge, and thus the risk of further violence.

76. Where there are doubts about compliance with oral medication, the administration of a depot injection provides certainty that the patient has received the prescribed dose. While it is right that a conditionally discharged patient in the community cannot directly be compelled to take medication, such a patient's refusal to accept depot medication may in some circumstances provide grounds for recall to hospital for further in-patient treatment. It is by this sanction that compliance with depot

medication is effectively enforced. If a patient is to be given a depot, this should be established and the dose stabilised before discharge.

77. In addition to the matters already mentioned, there were other factors which, in our view, merited consideration. The apparent speed with which he experienced psychotic symptoms after stopping medication in May 2003 reinforced the need for full compliance following discharge, but John Barrett's history was that he had never complied with anti-psychotic medication as an out-patient. That his symptoms had not been evident to clinicians until they were told about them by JW showed again the difficulty of assessing John Barrett's mental state.

78. A decision that had to be made while John Barrett remained an in-patient was whether to persist with oral medication or to change the prescription to Risperdal Consta, which is Risperidone in the form of a long-acting depot injection. The team did indeed consider the possibility of changing the prescription to a depot. This was against the background of John Barrett's known dislike of depot medication, as evidenced by previous episodes of treatment. The first recorded discussion of this issue was at the ward round on 20th May 2003 when the question was asked, following his admitted non-compliance with oral medication, whether *"a depot injection would be more beneficial"*. This was to be considered in relation to John Barrett's risk management plan.

79. Dr Ferris sought John Barrett's view on 7th June. As could have been predicted, he did not agree to a change. The ward round minutes of 17th June record that "*his refusal was accepted by the medical members of the team"*. There is no record of discussion of how his refusal was to be reconciled with the risk management plan. The overall plan remained, as before the episode of non-compliance, to recommend conditional discharge to the tribunal which was then expected to hear the case on 8th July.

80. Future compliance with medication was next raised at the ward round on 2nd September 2003 when it was said that John Barrett needed to be made aware that if he stopped his oral medication *"we will need to switch him to Risperdal Consta"*. This seems to be an acknowledgement of the risk of non-compliance but, given that the

team would be supporting conditional discharge at the tribunal hearing the following month, it was by then too late to establish him on depot medication and to note his responses and attitude over time.

81. The team returned to the issue at the following week's ward round. In team discussion it was reiterated that John Barrett:

> *was likely to have poor recognition of any deterioration in his mental state, and that intramuscular depot medication would be necessary if he was non-compliant with oral medication.*

This message was communicated to him at the section 117 meeting on 23rd September when he was told, by way of preparing him for discharge, "*that if it did not work out as planned readmission and a change to depot medication might be necessary*". This was incorporated in the CPA contingency plan*:*

> *If concerns that John is not taking his medication – encourage to do so; reinforce its importance; consider depot. If concerns re deteriorating mental health – arrange formal assessment; admit to hospital if necessary.*

82. To have told John Barrett that if he stopped oral medication, or if his mental state deteriorated, consideration would be given to the prescription of depot medication, would not in our view have increased the likelihood of his complying with oral medication after discharge. It could be argued that this was the creation of a safety net plan, but we consider rather that it risked reducing the likelihood of his reporting any difficulties.

83. Given the factors enumerated above, we consider that a case could have been made for preferring depot to oral medication. If compulsion had been used to establish John Barrett on depot medication as an in-patient, and if he had accepted that depot medication would be part of the plan on discharge, the risk of future non-compliance would have been reduced. We have not found evidence in the notes of adequate

consideration of this matter. The factors to which we have referred were not made explicit and there is little evidence of a considered decision-making process within the team.

84. In relation to the issue of compulsion, it appears to us that John Barrett was given an effective veto on depot medication when he was seen by Dr Ferris on 7th May 2003. We would have expected a different approach. In our view the decision whether to switch to depot should have been explicitly taken by the doctor in consultation with the team taking account of John Barrett's known preference to stay on oral medication. Of particular relevance were his never having complied with oral medication as an out-patient and his covert non-compliance in May. We consider too much weight was given to John Barrett's preferences and to maintaining the therapeutic relationship between him and the team, and not enough weight to protecting the public.

85. In commenting on the team's approach, we do not say that John Barrett failed to comply with oral anti-psychotic medication following discharge. We do not know. John Barrett told us that he took the medication and it remains the view of members of the multi-disciplinary team that he did so. JW also believes that he took Risperidone throughout the period of conditional discharge, although she did have concerns in July 2004 that he was not taking the full prescribed dose.[81]

Leave of absence

86. For patients of forensic mental health services who are detained in secure conditions, periods of leave from hospital are regarded as an essential part of their rehabilitation. Exposure to the wider community tests the stability of a patient's mental state and behaviour in the face of varied stressors. In John Barrett's case it was also seen as providing evidence of his ability to manage his time and to avoid behaviour, such as consumption of drugs or alcohol, which would indicate increased risk. It is important within any unit and any clinical team that leave is used for positive

[81] Refer to Chapter 1.7 paragraph 48, JW's conversation with Dr Mezey on 30th July 2004.

therapeutic benefit and testing. It should not replace sessional activities which might otherwise offer advantage.[82]

87. During the early part of his admission to the Shaftesbury Clinic John Barrett was assessed as a high absconding risk. Even in October 2002 the risk was rated as 4 *("serious and imminent")*. This remained true in early December when he was taken to see a dentist in the grounds of Springfield Hospital in a vehicle with three nurse escorts in addition to the driver. According to the nursing record of the ward round on 17th December 2002, the decision was made that day to "*allow him one hour per shift in the secure Shaftesbury Clinic garden escorted by two nurses*". By then the assessed risk of his absconding had been reduced to 3 *("serious")*.

88. On 7th January 2003 the ward round minutes record *"absconding risk considered to be low therefore give him escorted leave on the grounds – 1 hour per day"*. However, the risk was still recorded as 3 on the form and remained so until the case conference on 21st January. That was the occasion on which it was concluded that *"the team would probably agree to a conditional discharge"*. At the case conference it was reported by nurses that John Barrett had used his escorted leave in the grounds of Springfield Hospital appropriately but that he had been missing occupational therapy (OT) groups as he preferred to go on ground leave. According to the nursing note of the case conference the decisions on leave were:

> *Ground leave not to be increased this week but to be increased to 1 hour per shift next week if he attends OT programmes. Team considering applying to the Home Office for community leave but to have unescorted ground leave first.*

This contemplates a staged process, from escorted to unescorted ground leave, leading to community leave. But in the typewritten ward round minutes the plan included *"An application should go to the Home Office for escorted community leave"*, that is before there had been any unescorted ground leave. On 22nd January the team's SHO wrote on Dr Mezey's behalf to the Home Office to request

[82] Refer to Home Office guidance on leave in Chapter 2.8.

authorisation for escorted community leave with one escort, twice a week for up to three hours. The letter said *"He has done very well on escorted ground leave and there have been no untoward events"*. The accompanying form (Annex E: Format for the Submission of Requests by Responsible Medical Officers for Leave) recorded that the risk of violence and harm to others was low, that John Barrett *"regrets the index offence and the indulgence in substance abuse"*, and that he was insightful into his illness and the need for medication. The word *"None"* was written on the form in answer to the question *"Have there been any incidents of absconding and what risk do you believe the patient would present now of absconding?"* This will be covered in more detail below where we discuss the organisation and quality of the case records.

89. At the following week's ward round, on 28th January, nursing staff reported that John Barrett had been using his escorted ground leave appropriately and engaging in OT activities. The decision was that *"He is to have one hour unescorted ground leave on two separate occasions in the coming week at nurses' discretion. He is to be told that he must not set foot outside the hospital gates"*. At the following week's ward round, on 4th February, the nursing report was that he had used his unescorted ground leaves and would like more. Unescorted ground leave was increased to one hour daily and the plan was to *"initiate escorted community leaves"*.

90. On 28th February the Home Office responded to the request for escorted leave. They expressed concern about John Barrett coming into contact with the principal victim of the index offences. They asked why he was no longer considered at significant risk of absconding, and why he had not been tested on unescorted ground leave before the request was made for escorted community leave. On 4th March the question of leave was again considered at the ward round. The nursing report was that there had been no problems with his unescorted ground leave. The record of discussion was:

> *The need for escorted community leave remains paramount especially in view that he is applying for MHRT soon. Need to write to the Home Office regarding leave and to apply for unescorted community leave in view of the long delay in response*.

No reference was made to the Home Office's letter, which appears not to have been received until a copy was faxed to the Shaftesbury Clinic on 6th March. Dr Scholtz, who had recently joined the team as SHO, replied to the Home Office on 11th March and stated that the team were not aware of the principal victim's address or current whereabouts and she explained the basis for the team's belief that John Barrett's risk of absconding was low:

> *He has undergone a change in his attitude towards detention at the Shaftesbury Clinic and currently considers this an appropriate place for him to be. Also he has in fact had unescorted ground leave whilst an in-patient and during these leaves he has made no attempt to abscond.*

The Home Office replied on 20th March with the Home Secretary's consent to *"Escorted day leave in the local area at the RMO's discretion with a report back after three months"*. The letter said that the Home Office remained concerned about the whereabouts of the victims and it requested that further enquiries be made by John Barrett's social worker: *"We will need to know the results of these enquiries before any unescorted leave can be considered"*.

91. Having set out in detail the sequence of events leading to the authorisation of escorted community leave, we make the following observations. One would normally expect that an application for escorted community leave would be built upon a foundation of existing successful unescorted ground leave, but the application to the Home Office in January was made before John Barrett had been allowed any unescorted leave in the hospital grounds. In addition to this, without having yet had approval from the Home Office for escorted community leave, the team were already on 4th March considering an application for unescorted leave. The comment that the need for escorted community leave remained paramount, given that John Barrett would soon be applying to the tribunal, is peculiar.[83] The timing of a forthcoming tribunal hearing was in our opinion irrelevant to the process of testing out with leave. Normal practice is to proceed with leave on a graded and gradually increasing basis, testing at every level so as to have a firm base before proceeding to the next level.

[83] The earliest date on which John Barrett was entitled to apply to the tribunal was 20th March 2003.

The evidence from the notes does not show that sufficient thought was given to gradual testing by leave. The impression given by the notes is that process was dictating substance rather than the other way round.

92. The 1st April ward round minutes record that the team was still likely to support conditional discharge at a future tribunal.[84] It is also recorded that:

> *We continue to await occupational therapy to arrange his escorted leaves. In the meantime he is to have a one off escorted leave for two hours in Tooting. He is granted unlimited escorted ground leave to report every two hours. To consider applying for unescorted community leave in the near future*.

This continues the same approach to managing the case. One would normally expect to test the patient out with escorted community leave, which at the point of the discussion on 1st April had been granted but not yet started, before formulating views about conditional discharge. The note in relation to considering an application to the Home Office for unescorted leave in the near future again suggests haste rather than careful consideration.

93. On 8th April it was reported that John Barrett had been escorted on a one-off leave to Tooting which went well. The OT programme which would operate the schedule of planned leaves was still awaited. The record of team discussion was that:

> *His next community leave is to be arranged. He needs two community leaves a week. Dr Scholtz to apply for unescorted leave from the Home Office upon her return* [from leave].

This once again reinforces the impression that there was a momentum of process driving the team, rather than the content informing what the process should be. We consider that the way the process was managed did not allow for sufficient consideration of John Barrett's progress on escorted leave and, if appropriate, gradually increasing it before taking a decision to apply for unescorted community

[84] It appears that John Barrett first instructed solicitors on 28th March in connection with an application to the tribunal.

leave. In this regard, we consider that to go straight to twice weekly community leave in the first instance was inappropriate. Better practice would be to have one such episode, review it the following week, then one further episode before considering increasing to twice weekly providing there were specific therapeutic targets and aims within a defined programme.

94. At the ward round on 15th April it was reported that *"community leave programme has been installed"*. On 17th April Dr Scholtz duly wrote to the Home Office to request approval for unescorted community leave. She reported that John Barrett had completed five sessions of escorted community leaves, which implies he had taken four such leaves in the nine days since 8th April. She also reported that the team had not been able to obtain any further information about the victims. The accompanying Annex E form said that *"current attitude to index offence indicates remorse and regret"*, that his mental state had been stable since October 2002, that he *"has good insight into his illness and is concordant with treatment plan"* and that there had been no incidents of absconding. It said that it was unlikely he would come into contact with the principal victim of the index offences and that if he did *"it is unlikely that Mr Barrett would approach victim as the attack took place in the context of delusional beliefs no longer held"*.

95. At the 29th April ward round the plan included that the social worker (Ms Sturdy) was to contact the genito-urinary clinic manager concerning the victims of the index offences, implying that contact had not yet been made with the clinic. At the 6th May ward round it was reported that John Barrett had not been keeping to his in-patient OT programme. The decision was made *"To monitor attendance at OT groups – not to have unescorted leave until attending regularly (unescorted leave not granted yet anyway)"*.

96. The Home Office replied to Dr Scholtz on 10th June stating that they were unable to authorise unescorted leave unless they were told where John Barrett's victims were so as to minimise the chances of his coming into contact with them. This was because an encounter with him could prove distressing for them. At the case conference on 17th June Ms Sturdy reported that "*she had not managed to speak to the clinic manager but in response to the letter from the Home Office she would attempt to do*

so again". John Barrett's solicitor expressed the view that a tribunal would not be likely to discharge him without there having been a trial of unescorted community leave. On the solicitor's advice he withdrew his tribunal application immediately after the case conference, with the intention of applying again in anticipation of the grant of unescorted leave.[85] It was agreed at the case conference that Dr Ferris would contact the Home Office to renew the request for unescorted community leave.

97. The following week at the ward round on 24th June the team were concerned that John Barrett was disengaging from the OT programme and they doubted whether his engagement would improve in the next three months while waiting for a new date for a tribunal hearing. Team discussion included agreement that *"it remains of utmost importance that he is started on unescorted leave as this will give us a good opportunity to assess his ability to structure his day in the community"*. This again suggests to us that the target of securing his conditional discharge at the tribunal hearing which was expected to take place in September or October was driving the process. If it was believed that his engagement was not likely to improve in the next three months, which we consider was a fair assessment, then the question should have been asked whether he was in fact ready for discharge. As for testing John Barrett's ability to structure his day, this could have been done to a considerable extent while on escorted leave on the basis of the role of the escort being to accompany him but not to direct him about how to organise his time.

98. It was agreed that Dr Ferris would *"reiterate to the Home Office that it is impossible to gauge how he will do in the community without unescorted leave and the team are hopeful that this will be granted*". Dr Ferris wrote to the Home Office on 30th June:

> *We are of the opinion that Mr Barrett is almost ready for a conditional discharge to the community. This is currently being held up by his need for unescorted leave before this can be considered reasonable. This will be an important step in his rehabilitation and testing out the progress he has made.*

[85] Having withdrawn his first application, John Barrett applied again to the tribunal on 2nd July.

He explained that unsuccessful efforts had been made to discover the whereabouts of the victims and he asked the Home Office to reconsider the request for unescorted leave *"to avoid further unnecessary delay in his rehabilitation"*. We note in passing that the Home Office had not yet been told of John Barrett's non-compliance with medication and the short-lived deterioration in his mental health during May 2003. They learned about these matters only when they received Dr Mezey's annual statutory report in July.

99. At the ward round on 8th July the team noted that John Barrett was attending most of his OT groups and had set up a proposed structure for his days in the community following discharge. The team's discussion concluded:

> *It would be useful to increase his leave to four times weekly to encourage daily activities. However, it would have to be borne in mind that this is an artificial situation and could not be extrapolated to his behaviour once he was living in the community to the same extent that unescorted leave could be.*

100. On 12th July the Home Office authorised *"Unescorted day leave to the local area and visit to his flat… at the RMO's discretion"*. This was recorded at the ward round on 15th July when it was also noted that John Barrett had requested to go to Covent Garden with JW on 1st August to celebrate his birthday. Other information at the ward round was that his attendance at OT was unreliable and at the illness awareness group he had tested the boundaries with staring and behaving slightly inappropriately. The team discussion concluded that a trip to Covent Garden with JW on his birthday would be appropriate. However, other trips to the West End would not be authorised until he had had some unescorted leave in the local community pursuant to the OT plan. It was agreed that he should continue with escorted leave while his unescorted leave was gradually increased and it should be stressed to him that he would need to continue to engage in OT.

101. We find it surprising, given the OT report, that immediate progression to unescorted leave was seen as the way forward, and particularly of the nature that was then embarked upon. We are unconvinced that a trip to Covent Garden for his birthday with his girlfriend was appropriate as a first or early use of unescorted leave. A

birthday is commonly an emotionally charged occasion. An outing with a girlfriend, the first for some considerable time, can be emotionally charged. Both can be stressful. Exposure to crowds and high levels of social activity such as would be found in Covent Garden can be stressful. Stress can result in a relapse of psychosis. Measured testing would suggest that low stress situations and venues should be chosen for the first few leaves, before extending the range and scope. The Home Office granted unescorted community leave at the RMO's discretion to the local area and his flat only. Although at the ward round on 15th July the grant of such leave was recorded, by 22nd July the team had already decided to write to the Home Office to seek an extension of this to permit the Covent Garden trip. This was an acceleration of the process of moving towards discharge which again does not persuade us that the decision-making was thoughtful and measured, with consideration of the benefits and risks and the need for slow progression as part of the testing.

102. On 23rd July Dr Scholtz wrote to the Home Office to request authorisation for the proposed trip to Covent Garden. When Home Office officials queried how the proposed leave fitted with John Barrett's rehabilitation programme, Dr Scholtz telephoned the Home Office and, according to their file note, said that the leave would be *"a further test of his social interactions"*. The leave was then authorised.

103. The nursing report at the ward round on 5th August was that the birthday trip to central London had gone well and that John Barrett had requested an increase in the number of hours for unescorted community leave. In discussion the team noted the importance of gaining JW's view on how the trip to central London went, as she had accompanied him. The plan was that Ms Sturdy would contact her. Unescorted leave was increased to three hours three times per week with the suggestion of John Barrett visiting his flat in the increased time period. His leave was thus increased without having secured collateral information from JW as to his previous leave, despite having noted the importance of doing so.

104. On 23rd September a decision was taken to apply to the Home Office for overnight leave before the tribunal which was due to take place on 10th October. A letter was sent to the Home Office on 25th September by the team's new SHO:

Mr Barrett feels that it would support his case [for conditional discharge] *if he could show that he can spend a night at his flat without any problems, and we agree that this would be a good idea.*

Our observation on this is that one overnight leave a short time before the tribunal hearing was not capable of providing useful evidence to inform the tribunal's decision. Its value, if any, was purely cosmetic and the team should have recognised it as such.[86] The official who dealt with the matter in the Home Office noted in an internal memo that they were strongly opposed to conditional discharge, but nonetheless the request was granted because, so Home Office officials concluded, there was no reason to think that overnight leave would increase the risk.

105. Our criticisms of the way that leave was managed in this case can be briefly stated. Having decided, in our opinion too soon, at the case conference in January that the team *"would probably agree to a conditional discharge"*, decisions about leave appear to have been made with a view to achieving that outcome. There was insufficient regard for proper risk management considerations in the way leave was increased. When John Barrett's attendance at OT fell away, as reported for example on 8th May and 15th July, the sanction of withdrawing his leave was applied inconsistently and ineffectually. Moreover, the information provided to the Home Office in support of requests for leave, for example on 17th April, gave an unduly favourable picture.

106. Any medium secure forensic service should have at its heart the necessity for proper risk management. It is necessarily detaining patients who pose a risk to others. A gradual return to contact with the community, carefully graded and with appropriate testing and monitoring, is an essential component of how such a service should properly exercise its functions. Apart from nurse feedback at the ward round we found no evidence of any process of review and reflection in relation to the outcome of leave and the prospect of further leave. There is a community leave planning sheet for a period in July 2003 but the only documentary evidence that the team thought about monitoring the impact of such leave is itself blank.

[86] We note however that the tribunal referred to the successful overnight leave in its written reasons.

Discharge Planning

107. In the preceding discussion of leave we have alluded to discharge planning, of which the granting of leave was an important component. We now consider other aspects of discharge planning in this case: whether there was a coherent plan, whether it was realistic, whether clear messages were given to John Barrett about what was expected of him and whether effective steps were taken when he did not comply.

108. We have already indicated our view that January 2003 was too early for the team to have agreed, in the context of John Barrett's proposed application to the tribunal in March, that they would probably support his conditional discharge. That John Barrett had not then been tested with leave is one consideration that leads us to this conclusion. We also note that his stability of mental state and compliance with treatment were relatively recent and that there were still reports from OT, for example on 21st January 2003, that his demeanour and behaviour were inappropriate. The shallowness of his compliance was demonstrated by his stopping medication in May 2003. It is also significant that he did this without informing the team and was less than frank with them when the truth came out through JW. Leaving aside those general concerns, we now look at how he was prepared for discharge in the summer of 2003.

109. It was highlighted by the OT at the ward round on 3rd June that John Barrett appeared to believe that he would not need any extra support or structure when he left hospital. This was linked to the problems experienced in trying to engage him in structured activity whilst on the ward. The team agreed that he needed to understand that they would not support conditional discharge unless a plan for community activity was in place.

110. In team discussion at the case conference on 17th June, three weeks before the tribunal hearing fixed for 8th July, there was an acknowledgement that progress had been rather swift. A number of points were raised which suggested that John Barrett was not then ready for discharge, despite the efforts of the team. There was some concern amongst team members about this but the view was expressed that at a

tribunal there would be insufficient reason to detain him for a longer period. We cannot agree with this proposition. Had the team sought to uphold John Barrett's detention at the tribunal in July they could have argued, based on his prior pattern and the nature of his illness, together with the recent non-compliance with medication and the questions it raised about his insight and engagement, that further treatment in hospital was necessary in the interests of his health and for the protection of others. We think it highly unlikely that a tribunal would have discharged him in the face of such evidence. That the team did not see it in this way shows poor judgement.

111. We consider this is another instance where the team appeared to place the therapeutic relationship with John Barrett before considerations of public safety. They had led him to believe that he could expect to be discharged by the tribunal with the team's support. That had been his understanding since the case conference in January 2003, on the strength of which he made an application to the tribunal almost as soon as he was eligible to do so, and it had been reinforced since then, not least by the team's response to his non-compliance with medication in May and their approach to leave. We consider that the team should have recognised at the case conference on 17th June that John Barrett was not yet ready for discharge, and told him so. In the event, the team were spared having to make a decision because John Barrett's solicitor, realistically in our view, advised him to withdraw his tribunal application because he did not have a reasonable prospect of being discharged on 8th July as he had not yet been tested with unescorted community leave. As a consequence of the way this was handled John Barrett could have been left with the impression that the problem was essentially bureaucratic – the delay in getting Home Office approval for unescorted leave. It would have been better in our view had he been told that there were still doubts about whether he was ready for discharge and that more was required of him before the team could support his application to the tribunal.

112. Dr Scholtz on 20th June followed up the OT's concerns of the 3rd June by challenging John Barrett on his lack of realistic goals on discharge. When he told her that he wished to take it easy for twelve months, she pointed out that this was an unrealistic expectation and that without some imposed structure anyone in his position would be at high risk of relapse. She was correct in this. John Barrett appears to have got the message because by 8th July the reports were that he had set up a proposed

structure for his days in the community and was attending OT more reliably. However, the multi-disciplinary notes do not record any other challenging interviews after that of 20th June. When John Barrett was seen by Dr Ferris on 7th July the entry reads:

> *Fed up/angry not MHRT tomorrow. Discussed his singular, paranoid and selfish traits + tendency to project + to assume others view the world through his eyes -> Paranoid SZP* [schizophrenia] *explanation of this – magnifying glass -> Discussed his ?denigration of those who are less singular.*

Even allowing for its opacity, this entry contains nothing to suggest that John Barrett was being constructively challenged in a way that was relevant to preparing him for discharge.

113. The OT report to the ward round on 8th July was that he was attending most of his groups, had set up a proposed structure for his days in the community and had identified staying in close contact with the team as the most important factor in preventing relapse in the community. This was a remarkable change from his interview with Dr Scholtz on 20th June. It should have prompted the team to probe further to establish whether it was truly his internalised thinking or merely a response of expediency. When he was seen by Dr Mezey on 14th July she recorded in the notes:

> *Generally cheerful and relaxed. Informed that Home Office has agreed unescorted community leave which he is pleased about. Engaging more in OT programme. Denies any paranoid/delusional ideas – No problems with community leave. Claims to be taking medication. Pursuing course at South London College. No current problems/issues. No evidence of psychosis/ mood disturbance.*

This does not suggest challenge or even probing, but rather mutual reassurance that all was well.

114. The vicissitudes of John Barrett's relationship with JW were such that it was not clear to the team on what basis it would continue after discharge, and specifically whether they were intending to resume cohabitation. At the ward round on 1st July it

was reported that they would be living together in John Barrett's flat following discharge, but on 15th July it was said that their plan was to live apart. This suggests that John Barrett and JW were changing their minds. This would have merited further exploration of the implications for his discharge but no discussion is recorded in the notes.

115. The team discussion at the ward round on 19th August returned to John Barrett's attendance at OT, which was described as erratic. The note of the ward round records discussion about his unwillingness or incapacity to implement strategies to prevent a relapse in his condition, and future compliance with medication was a particular concern. As discussed above, it is apparent that at this and subsequent ward rounds, where a change to depot medication was discussed as a contingency plan, the team were not convinced that John Barrett had internalised the need for medication. This, together with his difficulty in implementing relapse prevention strategies, should have sounded a warning in relation to risk management after discharge.

116. On 9th September concern was again expressed that a lack of any kind of structure to his daily routine might render him more vulnerable to relapse. Despite repeatedly signalling this problem, the team appeared to have done nothing to resolve it, apart from satisfying themselves that he had at an earlier date successfully applied for a place on a part-time course at a local college. One obvious way of reducing the risk of disengagement from structured activity after discharge would have been to have suggested a condition to the tribunal, or the tribunal to have included a condition at their own instigation, that would have required John Barrett to attend regularly at a college or a day centre or similar.[87] This was not done. We note that shortly after discharge John Barrett stopped attending the college course, a decision over which the team appear to have had no influence.

117. By 23rd September John Barrett had completely disengaged from OT and was no longer attending any OT activities. The response of the team was one of resignation rather than active management, while John Barrett presumably believed that he had by then done enough to secure his conditional discharge at the tribunal scheduled for

[87] Tribunals commonly impose a condition to attend at such places and at such times as directed by the patient's psychiatric or social supervisor.

10th October. This belief was no doubt reinforced by the team's decision to apply to the Home Office for him to have overnight leave at his flat. It is striking that, according to the note of discussion, JW is a voice of caution, asking that John Barrett be followed up by people who knew him well and who would thus be able to detect the early signs of relapse. It was also discussed that if things did not work out, readmission might be necessary, and depot medication could be considered.

118. On 30th September it was discussed at the ward round that JW would probably be the first person to notice any change in John Barrett's mental state. The team did not know what form their relationship would take after discharge. This is because John Barrett and JW did not themselves know, as they had decided to proceed cautiously and tell the team of any changes in future. Given JW's pivotal role, we would have expected to find a record that the uncertainty arising from this situation had been considered by the team, but it is not apparent from the notes that the matter was discussed. It is clear that the team were confident that the tribunal would discharge John Barrett on 10th October. Attention was paid to practical matters such as providing him with enough medication to take home and making contact with his GP, but by this stage in the process the team seemed not to be capable of reviewing the overall plan and making adjustments to the discharge arrangements in response to concerns which had been expressed both by team members and by JW.

119. One other aspect of the discharge care plan is that John Barrett was discharged home rather than to a mental health hostel or similar supported accommodation where he could have been more closely supervised and monitored. There is no evidence in the multi-disciplinary notes during the in-patient period of this possibility even having been considered.[88] The fact that he was going to live in independent accommodation placed the onus for day-to-day supervision and monitoring on the

[88] In response to our suggestion that the possibility of placing John Barrett in a hostel should have been considered, Dr Mezey told us in correspondence: "*John Barrett had a home. It would have been stressful and less appropriate to have placed him in a hostel simply so that he could be more closely supervised. He did not need that level of social care and you have not identified such a need*" We are not suggesting that John Barrett's level of social functioning indicated a need for hostel accommodation. Rather, we have drawn attention to concerns that had been expressed about the robustness of the discharge plan, particularly in respect of monitoring his mental state and engaging him in structured activity. The uncertainty about his future relationship with JW was also a relevant consideration in this regard. We would have expected to find evidence that consideration was given to a possible hostel placement on discharge as part of the overall risk management plan, as in our experience would commonly be the case for a restricted patient

multi-disciplinary team, through the medium of regular meetings with John Barrett and contacts with people who knew him, of whom JW was the most important.

120. We conclude that in the weeks before the tribunal hearing on 10th October 2003 John Barrett was allowed to disengage from aspects of this care plan without sufficient challenge or direction being imposed. Latterly he drifted toward discharge. As the team acknowledged, his passage through the system had been swift. Such a rapid transit could be explained in an uncomplicated case where the factors in the offence were well understood and had been internalised by the patient, the patient had a good understanding of his mental illness, there had been a good response to medication into which the patient had insight and to which he was committed with good compliance, and there had been a steady progression of testing by leave. We are not satisfied that any of these factors had been demonstrated in a sustained way before the tribunal hearing on 10th October 2003. We therefore conclude that the proposition that he should be discharged was, at this point, premature.

Risk management

121. We have already referred to risk in our discussions of medication, leave and discharge planning. We now state some general principles of risk management in relation to offenders and people with mental disorders, and we comment generally on the management of risk in this case during the period of in-patient care.

122. In understanding and addressing factors in offending, a method of explaining the relevant matters can be found in work by criminologists. It is: offender + victim + circumstances = offence. There are thus three dimensions to the offence. Put simply, this describes the multifactorial composition of the offence as being an interaction between the perpetrator (offender), the target (victim), and the circumstances at the time. In managing the risks such individuals present, most of whom are not mentally ill, the principles apply both within a secure environment and also ultimately upon return to society. One may seek to alter factors in the offender (e.g. reduce his dependence upon alcohol or improve his ability to think through a situation instead of acting impulsively); alter factors with regard to victim type or availability (e.g. closely monitor personal relationships if a certain type of partner has been part of the pattern

of victims in the past); alter factors in the environment (e.g. impose a condition excluding him from certain areas, or a condition of residence at a certain location, or in supervised accommodation so as to monitor his activities and demeanour). Good risk management concentrates not upon only one of these dimensions, but upon all three. If, therefore, one cannot sufficiently alter the offender himself, then controlling aspects of the other two dimensions may still reduce risk to a manageable level.

123. The same principles apply to managing the risk presented by a mentally ill person. In this case, the formula could be represented as: patient + target + circumstances = behaviour. Influencing factors in any of the three dimensions will affect whether the problematic behaviour is manifest. Typically with a mentally ill person, the aim would be to stabilise or reduce symptoms by the giving of medication, in addition to any work on specific matters such as anger or alcohol and drug use. These are examples of interventions targeted upon the patient. It will be apparent that management of factors within the other two dimensions (target + circumstances) can be approached in a similar manner to that already described. Proper risk management therefore requires a good awareness of all three dimensions involved in the offence. In someone who is both mentally ill and an offender special care is needed to incorporate all relevant factors into the plan of care effectively to manage risk.

124. During his time in the Shaftesbury Clinic we are not satisfied that there was sufficient understanding of John Barrett's offending. As has been made clear in our foregoing discussion of the index offences and aspects of John Barrett's psychiatric history, we consider more should have been done to establish the factors in his past behaviour which were relevant to the nature of his illness and the offences. We also consider that insufficient attention was given to his behaviours and attitudes in the hospital setting which had relevance to how he would behave after discharge. Examples of these include his reluctance to engage with OT, his reticence in disclosing symptoms in May 2003 and his resistance to the idea that the purpose of medication was to treat a serious mental illness which carried risks. Our impression is that in preparing John Barrett for discharge the team's predominant concerns were stability of mental state, represented by an absence of paranoid psychosis, and compliance with medication. Other dimensions of risk management, such as the environment to

which he was to be discharged (with or without JW) and the importance of structure in his daily routine, were alluded to but were not clearly formulated. In regard to risk management, the standard of care fell short of what we would have expected to find in a medium secure forensic psychiatric service.

Risk assessment documentation

125. In discussing the risk assessment documentation, we start with the typewritten ward round minutes which invariably include a brief mention of the assessed risk levels by various categories: violence/harm to others; hostage taking; suicide; self-neglect; fire setting/arson; sexual offending; deliberate self harm; escape/absconding. These have associated with them a rating between 0 and 4: 0 = none; 1 = moderate; 2 = significant; 3 = serious; 4 = serious and imminent.

126. There were differences in attribution between Dr Bartlett's last ward round on 15th October 2002 and Dr Mezey's first ward round on 22nd October. These differences are perhaps best shown in tabulated form thus:

Nature of Risk	Bartlett rating 15/10/02	Mezey Rating 22/10/02
Violence/harm to others	3	2
Hostage taking	0	2
Suicide	2	1
Self-neglect	0	0
Fire setting/arson	1	1
Sexual offending	1	1
Deliberate self-harm	1	1
Escape/absconding	4	4

127. We have found no evidence to indicate why or how these ratings were arrived at. We are not aware of any significant changes in John Barrett's mental state or behaviour during the intervening week. We therefore conclude that the differences reflect how different teams viewed essentially the same information. It is of course entirely legitimate that teams may view the same information differently, but we

consider that where there are differences in attribution there should be some recording of explanatory detail to evidence that they were arrived at after reflection and discussion.

128. The risk assessments were next changed between the ward rounds of 10th and 17th December 2002, which coincided with the alteration of the diagnosis from paranoid schizophrenia to delusional disorder. The risk assessment ratings were altered downwards: violence/harm to others from 2 to 1, hostage taking from 2 to 1, escape/absconding from 4 to 3. We have not found a record of discussion which would explain the reasons for the reductions. The only information in the ward round minutes that would support a change in the assessments was the nursing report that John Barrett had agreed to suspend his passport application until at least after discharge.

129. The next reference to a relevant risk factor was at the ward round on 7th January 2003 when the absconding risk was considered to be low and therefore the decision was taken to give John Barrett escorted ground leave for one hour per day. Despite this, in the tabulated risk assessment appearing within the ward round minutes, escape/absconding remained at a rating of 3 and was not reduced until the case conference minutes of 21st January, a fortnight later, when it went down to 1.

130. On 15th July 2003 the risk assessment was re-evaluated when unescorted community leave was authorised by the Home Office. The rating for escape/ absconding was altered from its previous level of 1 to 0. No reason was given. The alteration to the risk rating followed the authorisation of leave rather than the other way round. We infer that the team linked the granting of unescorted leave to an automatic and necessary reduction in risk of absconding. This is illogical.

131. The conclusions we draw are that the risk assessments in the ward round minutes were used inconsistently between teams and were altered within Dr Mezey's team without evidence of team discussion or other explanation. We think it unlikely that weight was attached to the numerical ratings; rather it appears to have been seen as a bureaucratic necessity to complete the forms and to keep the ratings in line with the patient's leave status. We have heard from two of the consultant forensic psychiatrists

at the Shaftesbury Clinic, Dr Bartlett and Professor Eastman, that the risk assessment forms in use at that time were unsatisfactory. Dr Bartlett told us: *"There are numbers on that form which have no basis in anything at all and which we all knew but which was never quite tackled"*. She went on to say that the unsatisfactory numerical system was mitigated by *"quite detailed ward round minutes pointing at areas of concern"*. As we have indicated the ward round minutes in Dr Mezey's team lacked relevant detail. We find it surprising and unacceptable that the Forensic Service used a risk assessment instrument in which they had so little confidence.

Organisation and quality of case records and organisation of care

132. We have several observations on the quality and organisation of the notes. With regard to quality, during the period that John Barrett was under the care of Dr Bartlett's team the handwritten entries were full and the typewritten ward round minutes were informative with plenty of space given to team discussion. The notes during the in-patient period under Dr Mezey's care were scant by comparison and the ward round minutes were brief, with little evidence of team discussion. We do not believe this reflected the individual style of the minute-taker, who was usually the team's SHO, because there was no change in style or quality when a new person came into post. Our conclusion is that the team under Dr Mezey's leadership had become used to ward round minutes that failed to convey useful and important information arising from team discussions. The comparison between the approach of the two teams is well illustrated by the recording in relation to the changes in diagnosis which we have described above.

133. The Annex E request to the Home Office for leave, to which we have referred above in the discussion of leave, invites a signature by the RMO. However, in John Barrett's case they were all signed by an SHO. We consider that requests for leave should always be signed by the RMO. We have commented above that the information contained in the completed forms was superficial and in some respects misleading. One particular issue of concern is that within Annex E the Home Office ask the question *"Have there been any incidents of absconding and what risk do you believe the patient will present now of absconding?"* This received the answer *'No incidents of absconding'*. We consider that this misses the point. It is true there had been no

incidents of absconding during the period of detention at the Shaftesbury Clinic, but there had been previous episodes - in June 2000 when John Barrett absconded from hospital while on ground leave and in August 2000 when he did not return from leave. Furthermore, in the period immediately before his sentencing at court for the index offences, there were significant concerns about the risk of absconding such that a referral was made to Broadmoor Hospital. We believe the information given to the Home Office should have been what they needed in order to arrive at a judgement about the risk of John Barrett absconding. We consider it was insufficient to confine the information to whether John Barrett had absconded since admission to the Shaftesbury Clinic. We accept, of course, that the Home Office can always ask for further information, as they did on 28th February 2003, but they were not in a position to know that the information they were given about past absconding was incomplete.

134. Section 17 of the Mental Health Act provides that only the RMO may grant a detained patient leave of absence from hospital. In the case of a restricted patient there is the additional requirement that any such leave must first be authorised by the Home Office. As is the normal practice, in this Trust the policy is that on granting leave the RMO will complete a leave form which thus provides evidence that the leave has been properly authorised. Each episode of leave granted should either be covered by an individual specific form or by a form granting leave within parameters between specified dates. These forms must be signed by the RMO (or person acting as RMO in the event of absence of the actual RMO though illness or annual leave). This responsibility cannot be delegated to a deputy such as an SpR or an SHO.

135. In this case, we have found three leave forms from the period when Dr Bartlett was RMO. The purpose of the leave on each occasion was to enable John Barrett to attend court, although there is no form to cover the final court appearance on 20th September. Of the three forms, none was signed by Dr Bartlett. One was endorsed as having been signed after the event, the signature being that of another consultant psychiatrist which presumably was on the basis that Dr Bartlett was not available. Indeed, there is a further endorsement to the effect that the leave was not recommended by Dr Bartlett. It is of concern that the form for 26th July 2002 indicated that three nurse escorts should accompany the patient, all of whom should be control and restraint trained because of the risk that John Barrett would try to abscond. In our

view, this provided all the more reason why the nurses needed the explicit backing of the RMO, evidenced by a signed leave form, for such an undertaking. Unsigned forms represent poor practice.

136. As we have seen, during the latter phase of his admission John Barrett was granted extensive and regular leave, at times on a daily basis. There are five leave forms for the entirety of 2003. Of these, three cover one-off leaves: the outing to Covent Garden on 1st August, an escorted trip to Brighton on 28th August and the overnight leave to his flat on 4th October. Only the first of these three forms was signed by Dr Mezey as RMO. The second was signed by someone else and the third was unsigned. The remaining two forms, both signed by Dr Mezey, purported to confirm her authorisation of the remainder of the leave. The first, dated 1st April, provided for *"escorted community leave as per OT programme"*. The second, dated 15th July, authorised *"unescorted community leave as per OT care plan"*. This was to be taken between the hours of 9am and 6pm for periods of two to three hours. It appears to us that these two forms were completed in a way that provided the bare minimum of information. They lacked specificity and were not time-limited. We have not seen either the OT programme or the OT care plan which are referred to in the leave forms. We therefore do not know what information was available to nursing staff to supplement what was written on the forms. Only one of the five leave forms was in the multi-disciplinary notes by the time we saw them. The other four leave forms were made available to us by the Trust's Mental Health Act office, to which all leave forms must be copied.

137. Still on the subject of statutory documentation, we are not persuaded that the requirements under Part IV of the Mental Health Act were being applied appropriately. These provide that, for those detained under sections of the Act which carry with them powers of compulsory treatment, there can be administration of medication for mental disorder for three months without the patient's consent. Thereafter, there must be either a certificate by the RMO indicating that the patient is both capable of understanding the nature, purpose and likely effects of the medication he is prescribed and that he consents to it, or a certificate of second opinion by a registered medical practitioner appointed for the purpose by the Mental Health Act Commission. Such certificates, if provided by the RMO, should be signed by the RMO currently

responsible for the patient's care. There is a certificate of consent to treatment signed by Dr Bartlett dated 12th July 2002. Although the form states John Barrett had consented to medication, it seems to us that this was at a time when his reluctance was manifest, as is shown by Dr Campbell's report of 9th July 2002.[89] This is the only statutory form relating to John Barrett's consent to treatment during the period of detention which followed the index offence. We have already made reference to John Barrett being reluctant to take medication, or expressing the view that he did not need it, and in May 2003 he stopped it for more than a week. We might therefore have expected a regular review of his consent status, as is required by the Mental Health Act Code of Practice, which also recommends that such a review should take place at least annually and when there is a change of RMO. We have found no evidence that such reviews took place. There is no form for any date in 2003 nor any form signed by Dr Mezey. We conclude that this represents an omission in clinical practice and the apparent lack of any audit process to detect the omission.

138. With regard to the organisation of the case records, in addition to a set of papers that was prepared specially for our use, we had a facsimile of the original notes and we viewed the originals at the Shaftesbury Clinic. We found the notes to be woefully disorganised. For example, the progress notes, nursing notes evaluation and typed ward round minutes as contained within the 2003 volume which represents most of John Barrett's latter in-patient care, are all in reverse chronological sequence, with the most recent first, progressing chronologically backwards as one goes through the notes. This is counter-intuitive. It would impede the tracking of information by staff. It is even more confusing since the two latter blocks of data - the nursing records and the ward round minutes - are both contained behind the divider "Risk Assessment" which, however, does not contain risk assessments. The two blocks are conjoined but are separately chronologically reversed, the sequence therefore running: nursing latest to earliest and ward round minutes latest to earliest, with no division between the two. Other portions of the notes were in forward chronological order. We consider that the disorganised state of the notes is a barrier to recording and tracking of information. Not only should the Trust have recognised this by some form of audit procedure, it should also have been readily apparent to clinicians who could not have

[89] Dr Campbell wrote: *"He does not believe that he requires medication but would continue with cognitive behavioural therapy".*

found such notes easy to use and should have sought improvement in their organisation.

139. A separate set of nursing notes was used by nurses and OTs, at times by the social worker, and even on occasion by the last SHO. Sometimes nurses wrote in other sections of the notes, predominantly the medical portion.

140. Confusion within the notes and lack of effective information-tracking can also be seen in the formal ward round minutes at the point of handover from Dr Bartlett's team to Dr Mezey's team. We have already discussed the differing risk assessments. We now comment on the illogicality of what is recorded. There are two ward round minutes dated 22nd October 2002, one for Dr Bartlett's team and one for Dr Mezey's. The personnel attending these are different, and the attendance lists also differ from those present at the preceding and following weeks' meetings. We find it strange that not only should there be such an anomaly, but that apparently no one recognised it. If notes are to be useful in dynamically tracking a patient's progress, and the decisions which flow from this, then they must be accurate and follow chronologically.

141. The notes for the post-discharge period are as disorganised as the in-patient notes from 2003 and before. There were clearly times when the medical staff did not write their notes in the file, but on a loose piece of paper which was later inserted, not always in the correct place. It may be argued that this was because patients were not always seen where the notes were immediately to hand. That may be so, however it does not excuse those with the responsibility for filing from ensuring that the integrity of the notes is preserved. Even with the benefit of a set copied and numbered, together with reference to the originals, it is hard to track information. We are used to handling clinical case notes and experienced in marshalling large quantities of information but it was only with considerable difficulty that we could follow the sequential picture. We therefore conclude that the clinical team would have encountered similar difficulties and that the organisation, or lack of it, in the case notes impeded the transmission and overview of relevant information over the course of John Barrett's care and aftercare. The clinicians should have recognised this and taken steps to rectify the situation. We do not consider that electronic case notes

are the answer – such examples as exist in the UK are not problem-free. The solution lies in properly organising and maintaining the existing paper system.

142. We now comment on two decisions affecting John Barrett which in our opinion indicate poor planning and organisation.

143. On 14th October 2002 Dr Campbell told John Barrett that his care was being transferred to another team to facilitate access to a psychologist. This explanation is also recorded in the ward round minutes. Given that the Shaftesbury Clinic is relatively small, one might have expected that a resource, if it was scarce, would have been shared across the clinical teams. In our view it is poor organisation for it to be necessary to transfer a patient from one clinical team to another, with all the discontinuity and potential information and relational security loss that this entails, merely to gain input from a specific clinician. As this occurred before the reorganisation, when multiple teams served multiple wards, we do not understand why increased psychology input could not have been offered while responsibility remained within Dr Bartlett's team.[90]

144. The second is the decision reported at the ward round on 11th March 2003 that John Barrett had been transferred to Waterfield Ward. The decision was made without discussion with any team member. This does not represent a good approach to ward and risk management, although it was clearly not the responsibility of the team.

Leadership of the team & decision-making

145. Multi-disciplinary teams are complex. They comprise a number of individuals from different professions, with seniority and experience both variable. There is great advantage in an approach involving a multi-disciplinary team, since the different frame of reference for each professional discipline brings different dimensions to the discussion of the patient. It is the combination of views which is so important and provides the potential for an inclusive approach not possible from a bi- or uni-

[90] This is an instance where what is written in the notes may not give an accurate picture. We have been told that, contrary to what Dr Campbell said to John Barrett on 14th October 2002 and what was also noted by Dr Ferris on 16th October the reason for his transfer to Dr Mezey's team was the reorganization of caseloads by catchment area within the Forensic Service.

disciplinary perspective. This extends to the need for involvement of such other disciplines in discussion even when the individual practitioners may not themselves have had direct involvement with the patient. It can be a useful contribution to team decision-making if a practitioner makes observations on what they have heard from the particular stance which their professional training gives them.

146. Such a team requires a style of leadership which is inclusive and facilitating if it is to function properly. It should be a democratic forum, but there will sometimes be a need for a policy or legal decision to be imposed, though with explanation and, if possible, accommodation of the views of others. Typically in forensic mental health services the leader of the team is a senior member of the medical staff, commonly a consultant psychiatrist. This is not because of inherent superiority by training, but by virtue of the legal responsibility which the Mental Health Act places upon medical staff.

147. We turn now to decision-making within the team led by Dr Mezey, resting as it does on the style of leadership. Some team members thought they were functioning well as a team, and indeed they told us so when we interviewed them. However, the practical demonstration of their functioning left us with a different impression.

148. We consider that the team did not effectively analyse the range of factors, bearing on John Barrett's discharge, which we discuss in the preceding paragraphs. Where problems arose the team appeared to find it difficult, if not impossible, to change the direction and speed of travel. While information from different disciplines, notably OT, was reported to team meetings, the impression conveyed by ward round minutes is not one of dynamic working between different disciplines with different perspectives.

149. An example of how the team worked is the response in May 2003 and subsequently to John Barrett's stopping medication. That occurred after he had applied to the tribunal for his discharge. There was a case conference on 17th June at which the team considered the implications. In advance of the case conference reports were prepared by all relevant disciplines (medical, nursing, occupational therapy and social work). Of these only the social work report of Ms Sturdy identified as an issue

for discussion the recommendation that she and other members of the team would be making at the tribunal which was due to take place on 8th July. She did not make a recommendation in her report but said that when she had most recently seen John Barrett: *"I expressed my concern about his on-going openness and co-operation with the team, and said that this would need to be demonstrated more consistently for me to be able to support a conditional discharge"*. We take that to mean that she was not supportive of his application to be discharged. The OT report, while not considering the question of conditional discharge, commented discouragingly on his engagement with OT over the previous three months: *"progress has been minimal", "an unrealistic view of his abilities to adhere to day structure and to control his addictive nature", "John shows difficulties with adhering to day-structure and to initiate and maintain a well balanced weekly programme of purposeful constructive activities"*. Recommendations made in the report included: *"For John to set realistic long-term goals"* and *"For John to adhere to day-structure through attending his activities without prompting"*. The medical report did not raise conditional discharge as an issue but rather assumed that he would be discharged and asked: *"Arrangements for follow-up. Will Dr Basson's team be following him up in the community?"*. We have set out above what was decided at the case conference. The key excerpt from the case conference minutes is:

> ***Team Discussion***
>
> *Progress has been rather swift in that he has only been an in-patient for a year and a half and has now reached the point of possible conditional discharge. There was some concern amongst team members about this but it was felt that at a tribunal there would be insufficient reason to detain him for a longer period. There was also a concern that John does not see himself as a patient and although on the one hand this means he will do what he can to stay out of hospital, on the other hand he is also reluctant to engage in what he sees as patient orientated activities. The main concern however is that it is not clear what sort of structured daily activity he will be engaging in on discharge. If he were to be discharged by the tribunal the management plan would be regular medical follow-up, to remain on current medication, to have regular drug*

screens and to engage in more structured activities including attending his college course one week (sic).[91]

150. This summary failed to identify, with reference to the team's discussion, the opinions of those members of the team who had concerns about conditional discharge or the precise nature of those concerns. In so far as their doubts were acknowledged, they appear to have been dismissed because, presumably based on the medical view, it was felt there were insufficient grounds to continue John Barrett's detention. Our interpretation of this is that the medical view, which was to support conditional discharge, prevailed and that the specific concerns of those who had doubts were overridden without having been fully considered. In the event, John Barrett and his solicitor then joined the meeting and he took the decision not to proceed with the tribunal hearing on 8th July.

151. When we asked Ms Sturdy about her position, she told us: *"I had felt under a certain degree of pressure… to support* [conditional discharge] *when I had some reservations at that stage"*. She confirmed that the pressure was from the doctors, and specifically from Dr Mezey. We do not suggest there was anything improper about this but it tends confirm our impression that decision-making within the team was medically-dominated. Subsequently Ms Sturdy wrote to us:

I think that the issue of hierarchy within the Shaftesbury Clinic is an issue that needs to be reflected upon, particularly in relation to the impact of the medical dominance on the functioning of the service.

152. While a number of witnesses to this Inquiry described the Forensic Service as medically dominated, in general they did not identify this as a problem. It may be that people simply become used to working in certain ways, which they then see as being best suited to the task. Our view, on the contrary, is that in John Barrett's case we would have more confidence in the quality of the decision-making if we had found more evidence of discussion and of different points of view within the team informing the team's decisions. We note that HASCAS and Mr Mc Donald reached a similar

[91] This is how the discussion was recorded. Ms Sturdy told us that she did not agree with the view that "*there would be insufficient reason to detain him for a longer period*."

conclusion about the functioning of multi-disciplinary teams within the Shaftesbury Clinic.

Conclusion

153. It appears to us that the decision at the case conference in January that the team "*would probably agree to a conditional discharge*" shaped the views and actions of the team. Thereafter insufficient attention was paid to factors that suggested John Barrett was not in fact ready for discharge. His management, for example in relation to medication and leave, gave undue weight to his wishes and preferences, with correspondingly less emphasis on the principles of sound risk management. As regards medication, there was a need for a full and considered analysis of the clinical evidence to decide whether to continue with oral medication, rather than depot. John Barrett's own wishes were only one factor to be taken into consideration. It is important at this stage in a patient's rehabilitation to ensure that he is compliant with all aspects of a treatment programme including in-patient daily activities such as OT. Having built such a foundation, leave would then enable the establishment and demonstration of additional meaningful structured use of time.

154. We consider that more should have been done to prepare John Barrett for discharge and to establish the clinical management framework within which conditional discharge would operate. This conclusion does not depend for its validity on demonstrating that problems arose following discharge, but the fact that they did tends to support our analysis.

Chapter 2.4 - Clinical Management Post-discharge
October 2003 - 30th August 2004

Introduction

1. In this chapter we review the management of John Barrett's care from the date he was conditionally discharged until the day before the decision was made to bring him back into hospital. We consider the events of 31st August and 1st September 2004 separately in the next chapter.

2. We start this chapter with a brief overview in which we describe the position on 10th October 2003 when John Barrett was conditionally discharged by a tribunal. We then consider the post-discharge period under the following headings:

- Adequacy of care plans
- Adherence to care plans
- Adherence to tribunal conditions
- Communication with JW and others
- Monitoring John Barrett's mental health
- Monitoring care plans and care co-ordination
- Response to deterioration in John Barrett's mental state

The position on 10th October 2003

3. In the previous chapter we drew attention to issues raised within the team as John Barrett was approaching conditional discharge. These included doubts about whether he could be relied upon to comply with anti-psychotic medication in the community; concern about his limited insight and his unwillingness or inability to recognise a deterioration in his mental state; an understanding that JW would be a valuable source of information about John Barrett's mental state and social functioning, but also uncertainty about the nature of their relationship; and the difficulties experienced by the team in engaging him in structured activity which was seen as important to his stability. Arising from John Barrett's history, there were concerns

about cannabis use, which in the past may have contributed to episodes of psychosis, and about the potential risk to others should his mental state deteriorate.

4. The multi-disciplinary team had drawn up a care plan at the CPA meeting on 23rd September 2003 and conditions had been imposed by the tribunal. John Barrett's care would continue to be provided by the Forensic Service and specifically by Dr Mezey's team comprising Dr Mezey, an SpR – initially Dr Dhar until he was replaced by Dr Dein, Ms Sturdy (social worker) and a CPN – Mr Friel until January 2004 and Ms Galloway from March 2004. Dr Mezey was John Barrett's supervising psychiatrist under the conditional discharge arrangements, although the plan was that his regular out-patient appointments would be with Dr Dhar. Ms Sturdy was his social supervisor and the care co-ordinator under CPA.

Adequacy of the care plans

5. We have set out in considerable detail the content of the care plan agreed on 23rd September 2003 and the changes made on 27th January and 18th May 2004.[92] Leaving aside our reservations about the way John Barrett was prepared for discharge and the speed of that process, we now consider three issues arising from the care plan.

6. The single most important objective of the care plan was to maintain stability of mental state. John Barrett was not easy to assess, because of his guardedness and lack of insight into his own relapse indicators. Regular contact was necessary to monitor his mental state and his compliance with medication. To this end the care plan provided for him initially to be seen every week by Ms Sturdy, with CPN support for some of these meetings, and he was also to be seen every three weeks by Dr Dhar. After three months, as agreed at the CPA meeting on 27th January 2004, John Barrett was to have fortnightly meetings with Ms Sturdy, which would alternate between home visits with a CPN, and to be seen every four to six weeks by Dr Dhar.[93] We are satisfied that, provided there was sufficient flexibility to ensure that he was seen more often than this if there were concerns, the frequency of contact under the care plans was

[92] Refer to Chapter 1.7.
[93] We note in passing that this change in the care plan appears to have been made without regard to the condition imposed by the tribunal which required monthly medical appointments.

reasonable during the period up to the admission in May 2004. We consider below the position following that admission.

7. The reason Ms Sturdy was given the care co-ordinator role was because at the time of discharge she had known John Barrett for 16 months, while he had not met Mr Friel who at that time was the CPN member of the team. The Trust's CPA policy states that: *"The care co-ordinator will be chosen at a multi-disciplinary meeting and should be the member of the team who is felt to be most able to meet the patient's needs"*.[94] It is not a criticism of Ms Sturdy to say that it would have been better if a CPN rather than a social worker had been appointed care co-ordinator. We consider that the need to monitor the stability of John Barrett's mental state and his compliance with medication would have been better met by appointing a CPN as care co-ordinator. There was clearly an important role for a social worker to play in relation to other aspects of the care plan but that did not require her to be the care co-ordinator.

8. The practical consequences of Ms Sturdy acting as care co-ordinator were not only that she was the person with whom John Barrett had most frequent contact, but also that under the care plan he would never be seen alone by the CPN. If a social worker was to act as care co-ordinator it should have been recognised that the CPN needed to play an active and independent role. We interviewed the two CPNs who visited John Barrett with Ms Sturdy during the period of conditional discharge. Mr Friel described his role as *"to support Sue"*. He commented: *"This was the first time that I had taken a back seat with a community patient"*. Ms Galloway told us:

> *My role within this patient's care was very different from the role I normally have within the patient's care. It was more a back seat role – a second pair of eyes to go along every month, joint visiting with Sue at his home.*

There was in fact one occasion, on 26th May 2004, when Ms Galloway saw John Barrett on her own because Ms Sturdy was unavailable. This was also the only occasion when a CPN made an entry in the multi-disciplinary notes. In its description of John Barrett's mental state Ms Galloway's entry, from which we have quoted in Chapter 1.7, is more

[94] Policy on the Care Programme Approach, Care Management and Risk Assessment and Management, South West London and St George's Mental Health NHS Trust (July 2001).

detailed than any of the entries made by Ms Sturdy, including those following joint visits she made with a CPN.

9. Both CPNs spoke highly of Ms Sturdy and neither believed that the monitoring of John Barrett's stability of mental state and compliance with medication was compromised by having a social worker as care co-ordinator. We are not able to point to any failures, when Ms Sturdy missed something of significance, but we consider that this was a situation where the CPN was the person best qualified to take the care co-ordinator role.

10. A second weakness of the care plan, in our view, was that it did not provide for John Barrett to be seen at home by a psychiatrist. Elsewhere in this report we explain the principles of risk management.[95] In monitoring the effectiveness of a risk management package, it is important to take account of all three dimensions contributory to risk. In assessing a patient, information on their mental state, behaviour, and interactions is gathered. As will be apparent there are complex interrelationships between these aspects of function and the environment in which that functioning takes place.

11. We do not believe it is sufficient for doctors to rely on staff from other disciplines to gather such data. The viewpoint and frame of reference of doctors is distinctly different, and so enriches the multi-disciplinary discussion. It therefore behoves medical staff to familiarise themselves directly with the patient's functioning in the place where the patient resides. This can give potentially important information including aspects such as alcohol consumption, attitude to neighbours, self-care, neurological functioning, and many other facets. This is integral to an assessment of community functioning and cannot, we consider, effectively be undertaken remote from the patient's place of residence by confining meetings to an appointment in an office at a hospital. Indeed, this disadvantages both the doctor and the patient, who may for example be anxious or reserved in a clinical environment yet relaxed in their own domestic setting.

[95] Refer to Chapter 2.3.

12. We asked Ms Sturdy and Ms Galloway what was the normal practice in this regard.

Ms Sturdy:

> *Generally they would see them in an out-patient clinic at St George's. On other teams* [within the Forensic Service] *I have had SpRs come out on visits with me, but that wasn't the case with this team… it was just part of the way that team worked. I think it is easier if doctors are involved in doing joint visits sometimes. Obviously they do see people in clinic, but it is helpful to have a context of the home situation as well.*

Ms Galloway:

> *All the patients that I have with the other team* [within the Forensic Service], *bar one, is in a hostel.* [The doctors] *kept to their out-patient appointments, which the other members of the team might join them for, but it was usually more the community staff like social workers and especially CPNs who went into the community. I think it works okay. It works fine. The psychiatrist would expect the social worker and the CPN to be reporting back any issues. If there was a need to go and see them at home or in the hostel, that could be arranged.*

When we raised this issue with Dr Mezey we were told that it would be exceptional for a consultant to see a discharged patient at home. We have found no evidence that the possibility of a doctor seeing John Barrett at home was discussed, either at the point of discharge or subsequently. We consider that the practice should change and that the normal expectation should be for a conditionally discharged patient to be seen at home by a doctor, whether alone or jointly with another member of the team.

13. A third concern which arises from the care plan is that it envisaged that the regular out-patient appointments would be with the team's SpR, not with Dr Mezey. Given the difficulties associated with assessing John Barrett's mental state we consider that it would have been better if from the outset Dr Mezey, who had known him for a year, had taken personal responsibility for reviewing him monthly in the

community. Instead this fell to Dr Dhar who had joined the team only in September 2003 and was due to leave six months later. We have found no record of any discussion of this and, as far as we can tell, no particular consideration was given to the matter. As it happens, in June 2004 Dr Mezey did decide to take personal responsibility for regularly reviewing John Barrett in the community but that was only because Dr Dein, who was then the team's SpR, was shortly due to leave the Forensic Service to take up a post elsewhere.

Adherence to care plans

i) Contact between John Barrett and the team

14. According to the notes, John Barrett was seen by doctors on the following dates between 10th October 2003 and 30th August 2004 – the figures in brackets show the intervals between appointments:

Date of discharge:	10th October 2003
Out-patient appointment with Dr Dhar:	7th November 2003 (4 weeks)
CPA review with Dr Mezey:	27th January 2004 (11 weeks)
Out-patient appointment with Dr Dhar:	6th March 2004 (6 weeks)
Out-patient appointment with Dr Mezey:	23rd April 2004 (7 weeks)
Admission assessment for Jupiter Ward:	12th May 2004 (2 weeks)
CPA review with Dr Mezey:	18th May 2004 (1 week)
Out-patient appointment with Dr Mezey:	2nd August 2004 (11 weeks)
Out-patient appointment with Dr Dein:	19th August 2004 (2 weeks)
Out-patient appointment with Dr Dein:	26th August 2004 (1 week)

15. If we assume that this is a complete record, in the 10 ½ months of conditional discharge only two regular out-patient appointments were arranged as part of the care plan (7th November and 6th March). There were two further appointments which coincided with CPA meetings (27th January, 18th May) but all other appointments were either in response to a request by John Barrett or JW on his behalf (23rd April, 12th May, 2nd August) or because of the team's increased concerns about his deteriorating mental health (19th and 26th August). We accept that some notes may be missing, and

that Dr Dhar may have seen John Barrett more frequently than on the two occasions referred to above, but it is still the case that there were no routine medical reviews after Dr Dhar left the team in March. This was a serious failure.

16. Dr Dhar was replaced by Dr Dein in April 2004. It was her understanding that she was supposed to see John Barrett, because in his handover note Dr Dhar had said *"I tend to see him on a monthly basis"*. Dr Dein told us what she understood would happen:

> *I was initially under the impression that the* [team] *secretary would be sending the appointments to see patients in my forensic out-patients because that was how it was always done* [in other teams where she had worked]*, and that is how it is done even today in my current job. There was a misunderstanding there, and at some time in May it was clear that wasn't the case and I had to offer them appointments. Shortly after that, John Barrett was admitted and Sue Sturdy asked me to see him and I saw him. From what I can remember, shortly after I saw him towards the end of May, Gill Mezey agreed to take over his care.*

That agreement came about because in mid-June Dr Dein had arranged an intra-deanery transfer to another SpR post at a different hospital, although she did not leave the Shaftesbury Clinic until late September. She told us that Dr Mezey *"felt that for continuity of care, because of the needs of this particular patient, it was better that she looked after* [him]". We are satisfied that following the admission in May, Dr Mezey took personal responsibility for seeing John Barrett thereafter, although it would not have been necessary under the care plan for her to have seen him in out-patients until June.[96] In April and early May it was Dr Dein's responsibility to see John Barrett in accordance with the care plan but the only occasion on which she did so was during the informal admission in May. Thereafter it was Dr Mezey's responsibility. However, she did not see him until 2nd August. We criticise the failure to review John Barrett in accordance with the care plan. We consider the implications of this failure

[96] The amended CPA care plan, which previously had assigned responsibility solely to Dr Dhar, said that the out-patient appointments would thereafter be with *"Dr Mezey\Dr Dein"*.

when we discuss the team's response to the deterioration in John Barrett's mental state in the summer of 2004.

17. Contact between John Barrett and other team members took place in accordance with successive care plans, except that he missed some appointments in June and July 2004. We make no criticism of those involved as we are satisfied that missed appointments were followed up.

ii) Drug testing

18. The 23rd September care plan said *"Request regular drug screens"*. This was repeated in the 27th January and 18th May care plans. It was also incorporated into the conditional discharge by way of a condition requiring John Barrett *"To submit to drug screening and testing as required"*. The notes record only two drug screens during the period of conditional discharge. They were on 4th and 23rd August 2004, the first following the information received from JW in late July that John Barrett had used cannabis. Under the care plan it was the CPNs responsibility to take urine drug screens. Mr Friel told us that he did not do so during his period as John Barrett's CPN (October 2003 to January 2004). Ms Galloway told us that as well as the two tests she administered in August 2004, there was a test during the May 2004 admission and one between then and 4th August, and that both were negative. We have found no record of either test, or any written evidence that there was any plan for random testing. The test of 4th August was not part of such a programme but was carried out because on 30th July JW had told Dr Mezey that she believed John Barrett was using cannabis and he confirmed this on 2nd August. Ms Galloway told us that the test on 23rd August was random and not a follow-up to his admission of cannabis use and the positive test on 4th August, to check whether he was continuing to use cannabis. Indeed, Ms Galloway asked us to accept that throughout her period of CPN responsibility, the requirement in the care plan for random testing was implemented.

19. In response to our observations on drug testing Ms Galloway made the following points:

1. *Mr Barrett's appointments were given to him often 4 weeks in advance, i.e. at an appointment he would be given the next. If I were to urine test him at all of these appointments, then he would have had sufficient advanced warning to make the test negative, i.e. not providing a clear clinical picture. The care plan does not specify how often at its minimum a random or regular screen should be performed.*

2. *My appointments with Mr Barrett were 4 weekly only, and sometimes this regularity was not achieved due to cancelled appointments and his admissions. Indeed, during April and June 2004, I did not see him at all. It was also not deemed required by the team or myself to insist Mr Barrett attended outside of these regular appointments for testing. The focus of my interactions was about getting to know him and addressing any mental health issues which were present.*

3. *I believe that at most I saw Mr Barrett on 5 occasions in a community setting. It would not have been appropriate to test him on the first meeting. One of these appointments was purely as a standard appointment, one week following discharge. This was the responsibility of the Care Co-ordinator but I carried this out in the absence of Sue Sturdy, as she was on leave. I also relied on verbal feedback at Mr Barrett's CPA* [on 18th May] *from a ward nurse that a urine test was negative, and decided it was not necessary to repeat this 5 days later at his discharge appointment. I acknowledge that this test carried out on the ward and a test I carried out in the community was not documented, but I must stress that this documentation was not my responsibility. The extract that you provided does not reflect my position and could mistakenly be interpreted as my error.*

4. *In relation to the test of 23.08.2004… I had previously decided to urine test Mr Barrett as a random screen as reflected in the care plan. It was not as you have concluded as a follow up to 04.08.2004 test. I also believe that the*

04.08.2004 test can be seen as both a response to JW's concerns and included as a part of the programme of testing.

20. We would expect random testing to be just that. Testing should have been carried out at random, between visits and throughout the discharge period. We would have expected to see a schedule of dates and times. The difficulty we face is the absence of documentary evidence for any tests before 4th August. We cannot agree with Ms Galloway's assertion that it was not her responsibility to document the test she carried out in the community before 4th August because we understand that nurses are required to record all significant clinical activity.[97] We are not in a position to make findings about the number of urine drug screens that were taken during the conditional discharge period, but the evidence does not show that regular random drug screens were carried out in accordance with successive care plans. If, however, we accept Ms Galloway's evidence about this, it is clear both that the recording of clinical activity was defective and that the lack of any record of drug screens was not picked up by the care co-ordinator or at CPA reviews. With regard to the recording, we criticise Ms Galloway for not providing evidence in the notes that the requirement in the care plan for random drug testing was being carried out and, specifically, for her failure to record the test which she says she administered between May and August. We criticise Mr Friel for the failure to implement a programme of random urine testing for drugs in accordance with the care plan during the period that he was John Barrett's CPN.

iii) Structured Activity

21. We have seen that in the period leading up to his conditional discharge the team were concerned about how John Barrett would spend his time when he left hospital. It was thought to be important for his self-esteem that he should feel he was using his time well, and this was also considered necessary for the maintenance of mental

[97] Guidance issued by the Nursing and Midwifery Council states: *"Record keeping is an integral part of nursing and midwifery practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow."* Guidelines for Records and Record Keeping (April 2002).

stability.[98] There was also a concern that if he lacked a sense of purpose he could be tempted to use cannabis, which was known to be harmful to his mental health. The September 2003 and January 2004 care plans included as an objective: *"Encourage the development of a structured week"*. In May 2004 this became *"a structured and balanced week"*, reflecting the team's view that he had been overstretched by the demands of the work he had been doing with Mr A. There was no corresponding provision in the mental health review tribunal's conditions, such as a requirement to attend at places as directed by one or other of his supervisors for the purpose of occupation, education or training.[99]

22. When John Barrett was discharged, the only planned structured activity was to attend college for two half-days each week. But the course did not suit him and he gave up within a month of leaving hospital. We have found no record of any discussion with him about the desirability of staying on the course or finding another course or something else to do before giving up. However, Ms Sturdy has told us that structured activity was a regular item for discussion when she and John Barrett reviewed his progress:

> *My memory is that he thought about doing another course but did not proceed with this. He then began making links with other musicians on a short-term basis towards the end of the year, and subsequently began working with* [Mr A].

By November or December 2003, therefore, he was living alone at home without structured activity.

23. JW introduced John Barrett to Mr A, who is a professional musician and a former partner of hers. John Barrett started working with Mr A in January 2004, writing and recording songs. Mr A told us that between January and April they were regularly

[98] In her report dated 20th January 2003, Julia Houston included John Barrett's account of his past violence towards JW and his former wife: *"Mr Barrett was able to establish a link between the occasions on which he had been violent towards* [them*]. …he was going through times in his life when he was feeling 'impotent'* (his words) *as he was not working and described his self-esteem as 'fragile'. He acknowledged the importance of maintaining self-esteem through development of realistic goals."*

[99] These words have been adapted from section 9 of the Mental Health Act 1983, which provides such a power in Guardianship, and they commonly form part of conditions imposed by tribunals.

working eight-hour days, five days a week at John Barrett's flat. Judging from what both JW and Mr A told us, John Barrett found this work both stimulating and constructive. It also offered the prospect of financial reward as they hoped to release some of the material commercially, even going so far as to consult a specialist music industry solicitor. Before May 2004 the multi-disciplinary team also viewed their collaboration positively, as can be seen from reports sent to the Home Office:

> *Although this is not done within a structured setting, he does appear to be occupying his time appropriately through this activity.* (Ms Sturdy, 4th February 2004)

> *He has found employment working freelance in the music industry and, although the work has been stressful in recent weeks, he is extremely positive about the experience and we feel that it has benefited him in terms of his confidence and self-esteem generally.* (Dr Mezey, 29th April 2004)

24. When John Barrett started hearing voices in April 2004, and these became intrusive and distressing in May, stress was thought to be a contributory factor. The stress was attributed in part to the intensity of his work with Mr A. After he left hospital in May 2004, members of the multi-disciplinary team did not know if the work was continuing. Ms Sturdy reported to the Home Office on 18th May that it had come to an end, but in June and July she was reporting to the weekly referral meetings that the work was going on but at a reduced level. According to Mr A they continued working together after the May admission, but at Mr A's flat in Belsize Park and for only two or three days a week. We comment below on the team's contact with Mr A.

25. John Barrett was advised in May to reduce his work with Mr A. But the team were concerned that he would become bored if he did not keep himself occupied. Ms Sturdy started looking for alternative activities for him. At first it was suggested that he could work in the grounds of Springfield Hospital. When nothing came of that he was put in touch with the local Volunteer Bureau but they were unable to offer him anything of interest. The only additional activity that was found for him was attendance at a gym session organised by the Trust.

26. During the period between May and August John Barrett was travelling to Belsize Park two or three times a week to work with Mr A but he had little else to fill his days. Moreover, as Mr A reported to Ms Sturdy on 11th August, the nature of the work had changed and there was less for John Barrett to do during their time together. According to JW, by late July John Barrett was becoming disillusioned with the project. We think it likely that the combination of disillusionment and lack of purposeful activity in his life affected his self-esteem and that he became bored as he found himself with time on his hands and without friends to see or money to spend. JW noted this and contacted Ms Sturdy on 28th July when she also described what she saw as the detrimental effect on their relationship of John Barrett's loss of self-esteem. JW gave a full picture of how he was functioning when she spoke to Dr Mezey on 30th July. The changes in his behaviour Dr Mezey recorded in her note of their conversation included that he was saying he wanted to end their relationship, he had been seeing another woman, he had obtained a credit card and got himself into debt, he was smoking cannabis (as later confirmed by a urine screen), the music *"had started going wrong"*, he was up an down in his mood and he felt that nothing could be done about the auditory hallucinations he was experiencing.

27. JW's remarks to Dr Mezey on 30th July echoed concerns she had expressed when John Barrett was an in-patient. The behaviour she described was part of what for her was a familiar pattern. It was precisely to prevent such a situation arising that structured activity had been regarded as important. We comment below on the response of Dr Mezey and the rest of the team to JW's concerns on this and other occasions.

28. We conclude that the team failed to provide structured activity for John Barrett during the period of conditional discharge. Instead he was left to fill his own time. We accept that writing and recording music were appropriate activities, although as we explain below we consider that the team should have taken a greater interest in the nature of his work with Mr A. After the May admission the work with Mr A no longer sustained him. We consider that at that stage the team should have been more forceful in directing him towards activities, as had happened (admittedly with limited success) during the latter stages of the in-patient period.

29. The care plan allocated responsibility to Ms Sturdy for meeting John Barrett's need for structured activity. In September 2003 it was agreed, on the assumption that he would be undertaking a college course, that she would *"support him in planning other activities as required"*. By the next CPA meeting, on 27th January 2004, he had started on the musical collaboration. Ms Sturdy's role was *"to support him in planning\accessing other activities, e.g. voluntary work, as required"*. By 18th May, when the next CPA meeting took place, it was believed that the musical collaboration had come to an end. The care plan required Ms Sturdy to "*Offer encouragement and practical support in accessing appropriate activities*".

30. In her evidence to us JW was critical of the team's failure to direct John Barrett towards structured activity. We agree with her that the aim of the care plan was not realised, but we acknowledge that Ms Sturdy tried to find activities that would keep John Barrett occupied. When he expressed an interest in something, for example attending gym sessions, she followed it up. There is nothing in the notes to indicate that John Barrett had any other interests he wished to pursue apart from music. In our view, however, it was not sufficient merely to offer encouragement and support, and to follow up his own suggestions. The in-patient period had demonstrated that greater assertiveness was needed if John Barrett was to be motivated to undertake activities. One of the reasons for this, which was clearly documented in ward round discussions when he was an in-patient, was that John Barrett did not see himself as having a serious mental illness and he regarded himself, unrealistically, as being capable of organising his own time.

31. We criticise the way the team managed this part of the care plan. Based on the in-patient period, they should have appreciated before John Barrett's discharge that there was a strong possibility that he would not engage in structured activity when he left hospital. The care plan should have been expressed in mandatory terms: that he would be required to engage in education, employment or other activities as agreed with his social supervisor. Such a requirement should also in our view have been incorporated into the tribunal's conditions.

32. When we put this criticism to Ms Sturdy we suggested to her that in the absence of any community-based activity, John Barrett should have been required to return to

Springfield Hospital for the purpose of engaging in OT or other structured activity as an out-patient. She told us that there was no community occupational therapy service for forensic patients. We therefore accept that this was not an option open to the team. Her other observation was more general:

> *I agree that the issue of constructive activity is an important one, which I did address as far a possible, but I am not sure how this could have been achieved without his co-operation. Are you suggesting there is a mechanism by which his wishes could have been overridden? How do you suggest we could have effected this?*

33. In our view this goes to the heart of what was wrong with the team's approach to this issue. This was another area where in our judgement the team erred by concerning themselves more with John Barrett's wishes, and in trying to find ways to work with him, than with the requirements of sound risk management. We have already indicated that this could have been phrased differently in the care plan and a condition could have been sought from the tribunal. As we discuss further below where we consider adherence to the tribunal's conditions, one of the purposes of conditions and of requirements in a patient's care plan is to manage the risks associated with his mental disorder. The sanction if a conditionally discharged patient does not comply with requirements, whether or not they are framed as tribunal conditions, is recall to hospital. We think the team should have told John Barrett that structured activity was necessary to maintain stability of mental state and that if he did not participate in suitable activities consideration would be given to asking the Home Secretary to recall him. Such a recall would have been lawful if there had been sufficient concern about risk, not necessarily immediate risk. But the expectation would have been that the prospect of recall would have secured John Barrett's co-operation. This is merely to acknowledge that some coercion may be necessary in managing a conditionally discharged restricted patient.

34. We were surprised not to have found more evidence that John Barrett had been referred to appropriate community resources. If John Barrett had been given additional advice and guidance by professional agencies he might have secured training and support that would have improved his ability to find either full or part-

time employment. Within the south London area there was ample provision for adult careers guidance and job search support. Learn Direct centres could also have provided free literacy and numeracy support along with information technology training. We asked Susan Hasler-Winter, London Borough of Wandsworth mental health partnership and commissioning manager, about this. She replied:

> *This is not straightforward. Social workers in the Forensic Service cover the 5 boroughs in the Trust as well as Surrey and West Sussex, they also have the responsibility of social supervisor beyond the consortium area for a number of patients who are no longer the CPA responsibility of the Forensic Service. Social Workers therefore will not necessarily have extensive knowledge of patient's local services. Some local authorities provide staff to work jointly with the Forensic Social Workers (London Borough of Wandsworth employees) and share their knowledge of services available locally.*

It remains our view that more could have been done and that better use could have been made of available resources. It appears to us that there was insufficient awareness within the Forensic Service of what was available.

Adherence to tribunal conditions

35. In Chapter 2.7 we set out the conditions imposed on John Barrett's discharge on 10th October 2003. The one we are mainly concerned with here is the requirement *"to see a psychiatric team member as required but at least once a month"*.

36. We interpret the phrase "*a psychiatric team member"* to mean a doctor, because in context it cannot sensibly have any other meaning. This interpretation is also consistent with the note we have of the evidence given at the tribunal by Dr Dhar, that he would see John Barrett every four weeks after discharge. The requirement therefore was for John Barrett to see a doctor at least monthly. As we have noted, there was one period of 11 weeks during the summer of 2004 when he was not seen by a doctor. This was not because of any failure on his part.

37. In relation to CPN reviews the tribunal's condition was *"To see…a community psychiatric nurse…at least once per fortnight"*. During the first three months of John Barrett's conditional discharge, when the care plan provided for *"weekly social work contacts with CPN support"*, the tribunal's condition may have been complied with. We cannot be sure in the absence of any CPN entries in the notes. However, after 27th January 2004 the care plan stipulated *"CPN contact – 4 weekly"* and that became the established pattern. In changing this part of the care plan it would appear that the team overlooked the tribunal's condition.

38. The most common reason for imposing conditions on the discharge of a restricted patient is to require the patient to do something, or to refrain from doing something, with the aim of reducing, or facilitating the management of, risk after the patient leaves hospital. Another reason for imposing a condition is to ensure that when the patient leaves hospital suitable after-care, which the tribunal considers necessary to manage the risks associated with the discharge, will be available to him. For example, tribunals frequently make it a condition of discharge that the patient resides in supervised accommodation. If such accommodation were not to be made available, possibly through no fault of the patient, he would not be capable of satisfying the terms of the conditional discharge and would instead continue to be detained in hospital.[100] Conditions imposed by a tribunal are therefore components of the risk management plan. They are the tribunal's conditions, informed by the multi-disciplinary team's view, not merely the reproduction of the team's care plan in a different form. We consider the tribunal process later in this report.

39. The tribunal was told that regular monitoring of John Barrett's mental state by a psychiatrist, in accordance with the care plan, was necessary to minimise the risk of relapse which in his case was associated with a potential for serious violence. The imposition of a condition to see a doctor from the team at least once a month carries the implication, in our view, that the tribunal considered this to be necessary for the management of risk. We infer that had they been asked on the day of the hearing, the tribunal members would have said that John Barrett would not have been entitled to discharge without regular medical supervision every month, because that was an

[100] For an explanation of the relevant principles see *R v Secretary of State for the Home Department Ex p. IH* [2003] UKHL 59.

essential element of the risk management plan. We therefore consider that it imposed on the multi-disciplinary team a corresponding requirement, both to offer him monthly medical appointments and to ensure his attendance. The same observations apply to the frequency of CPN reviews.

40. Conditions imposed by tribunals are not backed by executive powers. The only sanction available under the Mental Health Act is recall to hospital by the Home Secretary. Breach of conditions by a patient does not automatically result in recall but it does increase the likelihood that he will be recalled because if the purpose of conditions is to ensure proper management of the risk associated with the patient's mental disorder, failure to adhere to conditions will tend to increase risk.

41. The Home Office told us that the conditions in this case were unusual in prescribing the frequency of meetings between John Barrett and individual members of the team, but the Home Office view is that conditions should be adhered to, not only by the patient but also by the care team. We agree with the Home Office. We note that if a condition becomes otiose or needs to be varied this can be done at any time by the Home Secretary under section 73(4) of the Mental Health Act or, following an application or reference, by the tribunal under section 75(3). The failure to arrange for John Barrett to be seen by a doctor every month and by a CPN every fortnight was not noted by the Home Office. The report received from Dr Mezey did not disclose the frequency of medical appointments. Ms Sturdy's reports did however say that John Barrett was being seen by her fortnightly and by the CPN monthly. In relation to medical appointments it appears that neither the team nor Dr Mezey, as John Barrett's psychiatric supervisor,[101] had an effective system for monitoring the frequency of his out-patient appointments.

42. When we asked members of the multi-disciplinary team about the tribunal's conditions, we were told that the team took them seriously and considered they were obliged to implement them in full. As we discuss below, when Ms Sturdy became aware in June 2004 that John Barrett had not had an out-patient appointment since the May

[101] We explain the role of psychiatric supervisor in Chapter 2.8

admission, and drew this to the attention of the team, on 15th June and again on 13th July, her intervention did not lead Dr Mezey to make timely arrangements to see him.

43. We consider that the Home Office has an important role to play in monitoring the implementation of conditions imposed on the discharge of restricted patients. We consider it a serious weakness of the current reporting arrangements for conditionally discharged patients that the patient's psychiatric and social supervisors are not required to tell the Home Office whether conditions are being adhered to both by the patient and by the team. We discuss this further in Chapter 2.8 below.

Communication with JW and others

44. Throughout John Barrett's psychiatric history and particularly since 2000, mental health professionals regarded his partner JW as an important informant. Her value to the team had most recently been demonstrated in May 2003, during the period of in-patient care at the Shaftesbury Clinic, when she had alerted them after John Barrett told her that he had stopped taking his anti-psychotic medication and had started hearing whispering voices. She had also participated actively in the discharge planning process at the Shaftesbury Clinic, both offering support to John Barrett and working with the team to identify his needs. During the conditional discharge period, she again played a constructive role when John Barrett experienced auditory hallucinations in April and May 2004. She was both very supportive of John Barrett and yet consistently responsible in encouraging him to be open with mental health professionals and to seek help when he was experiencing symptoms. When we met JW she impressed us as having a good understanding of John Barrett's illness and considerable insight into his wider social and psychological needs. Their relationship was also significant in another way. Although they had been together since 1997, there had been several separations during this time at least some of which were associated with a deterioration in John Barrett's mental state. It was therefore relevant for the team to know if there were difficulties in the relationship and whether these were linked to such a deterioration. JW was open with the team about such matters, as she had been in the past with other teams.

45. Two of John Barrett's family members were also known to the team. His mother, to whom he spoke regularly on the telephone, and his brother whom he saw quite often in London. It should not be taken as a criticism of either of them that they did not communicate with the team apart from when they were worried about him in July and August 2004. We also note in passing that there were occasions when contact between John Barrett's mother and the team was initiated by Ms Sturdy, for example when she was compiling his social history, shortly before the tribunal hearing in 2003 and when concerns were being expressed about him in the summer of 2004.

46. When discharge was being planned it was recognised that JW was likely to be the best external source of information about John Barrett's mental health and functioning. She was generally regarded by the team as a reliable informant. The team also understood the need to keep in mind when considering what she said about John Barrett that their relationship was not always settled. To a lesser extent, John Barrett's mother and brother were also regarded as useful contacts. The point was made explicitly in the medical report for the tribunal which discharged him: *"Early relapse indicators would be best observed by those close to Mr Barrett, and close liaison with Mr Barrett's friends and family will therefore be paramount."* In the September 2003 CPA care plan this was expressed as: *"Team to maintain regular contact with girlfriend and family."* The note on this in Ms Sturdy's contemporaneous record of the CPA meeting was: *"mother might be useful contact – regular meetings with John and JW would be helpful to them"*. This part of the care plan did not change in substance throughout the period of conditional discharge.

47. It is true that contact was established and maintained with JW, but this was not achieved through regular meetings. Apart from her attendance at CPA reviews, and her chance meeting with Ms Sturdy and Ms Galloway on 23rd August, contact was by telephone. JW's perception is that she initiated almost all her telephone contact with Ms Sturdy. It appears to us that JW is mistaken about this because, as Ms Sturdy has pointed out to us, she telephoned JW on at least half a dozen occasions during the period of conditional discharge.

48. We consider the lack of regular face-to-face meetings between JW and members of the team was unfortunate for a number of reasons. First, it put JW in the position

of always having to contact the team when she had concerns or criticisms rather than her being given a regular opportunity to meet and talk. This became increasingly uncomfortable for her, as their relationship and John Barrett's mental health deteriorated in the summer of 2004.

49. Second, as JW told us, she found her contact with the team disempowering because she felt they listened to her on sufferance rather than because they valued her contribution:

> *My whole experience of the mental health Trust is one of massive disempowerment; I've always felt disempowered by them. I'm a fairly bossy, assertive, strong, articulate woman but I always felt like I was banging my head on a brick wall. They made me feel as though I had no right making a fuss about John's care, or rather lack of it. Mr C,* [John Barrett's brother] *and I were all made to feel we didn't have anything of value to offer – in our own way we felt dismissed and disempowered.*

We consider that the team should have been sensitive to this feeling, even if they did not believe it to be justified. Regular scheduled meetings would have gone some way to mitigate JW's sense of disempowerment.

50. Third, we consider the failure of the team to respond effectively when JW expressed concern that John Barrett had not been seen by a doctor left her with the impression that she was not being listened to. We consider there was a lack of openness and accountability in the way the team dealt with this matter. John Barrett was not seen by a doctor for 11 weeks and yet we have found no record of any explanation having been offered to JW after she had raised the matter.

51. We can well understand, and we sympathise with, JW's feeling of disempowerment. As the failure to arrange regular medical appointments shows, action did not always follow when she pointed out the team's shortcomings. It was unfortunate that she was not generally given an explanation when her view differed from the team's and they acted according to their own assessment of what was needed. This became a matter of concern to JW when in July she provided information

which she saw as evidence that John Barrett was deteriorating, but a different view was taken by the team, and specifically by Dr Mezey. We consider this further when we discuss below how the team responded to John Barrett's deterioration. Such differences of view were to some extent rationalised by the team, as JW using concerns about John Barrett's mental health as a proxy for difficulties in their relationship.

52. It was also frustrating for JW that she was communicating information which was of clinical significance but almost all her conversations were with a social worker, in circumstances where John Barrett was not being seen regularly by a doctor. Ms Sturdy commented on this: *"I think there was a reluctance on Gill* [Mezey's] *part sometimes to speak to her, and I did feel a bit stuck in the middle of that sometimes"*. We got a flavour of the quality of her communication with JW from our interview with Ms Sturdy:

> *It was very difficult to separate out what was to do with what was going on between them and what was his mental illness, because yes, she was a good barometer in some respects in that she would report back what was going on, but also in some senses it is quite an easy way out* [for JW] *to say 'These relationship issues are just because he is not well at the moment'. There is an element of that and it was difficult to distinguish – but I am not saying that I did not take her seriously because as I say she did provide a lot of good information about what was going on.*

53. We consider the team failed to manage the relationship with JW effectively and to mutual advantage. Ms Sturdy undoubtedly listened carefully to what she had to say and passed on her concerns to Dr Mezey and the team. On at least one occasion, on 30th July, Dr Mezey spoke at length to JW on the telephone before she assessed John Barrett. But we think they should have set up regular meetings with her as part of the care plan and actively sought her views. This would not only have improved her experience of dealing with the team but would have put the team in a better position to assess the information she was providing.

54. We do not make any criticism of the way the team communicated with members of John Barrett's family. It was clear from our interview with him that John Barrett's brother was not interested in meeting or communicating regularly with mental health professionals. Neither, however, should this be taken as a criticism of him. We do not know whether John Barrett's mother had particular expectations in this regard. It is clear that when each of them expressed concerns they were listened to and what they said was noted. Our view is that in the summer of 2004 information from John Barrett's relatives and from JW was not given the weight it deserved. This was due more to the team's view about the extent of John Barrett's deterioration than to any deliberate disregard for their contribution.

55. Successive care plans said nothing about contact between Mr A and the team. It was known by the time of the CPA meeting on 27th January 2004 that John Barrett was working with him, as reference was made to this in the care plan: *"John is mainly concentrating on developing contacts and working on music projects"*. This is vague. A more precise description would have been that he was spending five days a week working at home with Mr A, writing and recording music. This was an important change from the position in October 2002. We consider it merited discussion and a decision about whether or not to speak to Mr A. We have found no record of any such discussion or decision.

56. When we asked Mr A about his contact with the team, he told us:

> *I had certainly met Sue Sturdy once, I knew she was his social worker. I didn't know for one minute until after the homicide that she worked at Springfield as part of the care team. I thought she was part of social services and looking after that, and the psychiatric team were a totally separate unit working at Springfield. I assumed there was some kind of communication between them, I didn't actually think they were part of the same unit.*

57. The meeting to which he referred took place because one of Ms Sturdy's visits coincided with a time when he was at John Barrett's flat. Mr A was getting out of his car as Ms Sturdy was getting into hers, and John Barrett introduced her as his social worker. Mr A knew that John Barrett suffered from a mental illness and that he had

been detained under a restricted hospital order because of the offences of January 2002. Indeed, he commented to us that he *"was a little surprised that no one had reached out and actually contacted me, which I thought was a little unusual… given that he was out on licence for a violent offence"*.

58. As we have recorded in Part 1 of this report Ms Sturdy spoke to Mr A on 11th August 2004 to find out why he was concerned about John Barrett's mental health. Mr A told us that he first noticed a change on 2nd August,[102] the day after he had joined John Barrett and JW to celebrate John Barrett's birthday:

> *I think we met for one of our normal meetings for coffee, and his attitude to the material we had been working on had changed completely, where he suddenly decided that everything we had done so far was complete and utter rubbish and we needed to discard it all and start again from scratch.*

It is unfortunate that from his one conversation with Ms Sturdy, Mr A was left with the impression, as he told us, that she *"seemed to be fairly dismissive of the comments I was making, and basically interpreting it as a difficult creative relationship"*. We do not believe that this was the message Ms Sturdy intended to convey. We are satisfied that she made a full and accurate note of the conversation and took Mr A's concerns seriously. The problem for Ms Sturdy was that she did not have a framework in which to assess what he was telling her because she had not spoken to him before. We are in no doubt that if the team had established contact with Mr A as soon as he became an important person in John Barrett's daily life, his communication with the team on 11th August and subsequently would have been of considerable value. In the weeks after 11th August Mr A's concerns about John Barrett grew. He told us:

> *There were all sorts of incidents; we often used to meet, he would come to Belsize Park tube station, there are a number of cafés around there. We would often meet up initially for a coffee and a quick croissant or something at Starbucks, so I met him on a number of occasions. He would ring when he got out of the station, I would say 'I'll see you in five minutes' and then we would*

[102] Coincidentally this was also the date on which John Barrett was assessed by Dr Mezey.

chat a bit and go to work. On a couple of occasions there were a few incidents at the Starbucks at Belsize Park, one where I arrived to find him standing in the doorway at Starbucks. He didn't see me, I was looking at him from the other side of the road before I crossed. He hadn't seen me, and he was standing in the doorway so people had to go by him. He wasn't actually accosting anyone or intimidating them in any way, he was actually pretty oblivious to everyone who was around him, but he was – I don't know if I can do the expression but he was a bit like those old Victorian images you see of shots of people in Bedlam. It was quite literally this very harrowed into-the-distance super-furrowed brow, and people were going by him and were actually quite alarmed by him. I remember stopping dead and thinking 'Oh… John, you look as mad as a hatter'. I do remember thinking that to myself, that he really looked not very well. As soon as I crossed the road and he saw me he [Snaps fingers] *snapped out of it.*

On another occasion – this was probably the final week – when I arrived he was inside and he had his feet up on one of the chairs, waiting. He hadn't got any drink because he was waiting for me, but it was totally inappropriate behaviour for Starbucks, and looking rather surly, and that was a bit off. On another of the days in the final week, there is another Starbucks very nearby in England's Lane, which is part of Belsize Park. It must have been the final week because I was buying a card for my brother's birthday which is on the 29th so it must have been a few days before. I was down that way and said 'Can we meet there for a change, see you in five minutes'. I remember heading towards Starbucks then and suddenly hearing him calling me from up the street, and he was going into another café, which I frequent a lot. I just went up there and followed him in. He was in an incredibly surly mood, cocky, strutting kind of manner, quite aggressive, walking into the place at the back, turning round, deciding he didn't like it and then going out. I wouldn't say we are necessarily close friends but I know a lot of people because I go into these places all the time, I have lived there for 10 years, so I was a bit concerned because it was almost embarrassing. I noticed that all the girls who were standing behind the counter were actually looking away. I don't know what he'd been doing in there before I got there. Then we turned out of there, we

were walking down the street, and he is pretty much walking along the street by my side, walking like this [whistling tunelessly, rubbing his hands]*, with this strange loud inane whistling, and rubbing his hands as he walks along – really loud. It was quite peculiar – well, quite peculiar full stop, and bizarre, but John's obviously got quite a good sense of melody and this was particularly irritating and tuneless and I wondered why he was doing it. Then we got to Starbucks, went into Starbucks and again if you were doing something like that once you enter a building you tend to change your demeanour, for all sorts of reasons – or most people do. But it seemed to be he just rolled in there and nothing changed. Even while we were inside about to go in and sit down and order coffees or whatever he was doing the same thing, continuing with this whistling and rubbing his hands, and the people in the café were kind of looking at him agog. I quickly thought 'Let's change this, we're not going to be staying here, I'll get takeaways and let's just go home shall we to my place?'. He was displaying some pretty strange behaviour.*

59. We consider this to be cogent evidence of John Barrett's deterioration from someone who knew him well and was able describe clearly the changes he had observed. Through no fault of Mr A's this was not available to the team.[103]

60. Between January and April 2004 John Barrett was spending as much as 40 hours a week with Mr A. The team knew this, or they should have known. As soon as the team had this information, which was certainly by the date of the January CPA meeting, John Barrett should have been asked if Mr A knew that he had been detained under the Mental Health Act and was subject to conditional discharge. The answer, as we learned from Mr A, is that he did know. John Barrett should then have been told that someone in the team, presumably Ms Sturdy, would need to speak to Mr A, not for the purpose of disclosing confidential information but to make contact with the person with whom John Barrett was spending so much time. She should then have spoken to

[103] Mr A also talked to us about his first meeting with John Barrett some years previously when John Barrett and JW were living together: *"I began a conversation with him, which was perfectly bland 'How are you, John?' kind of chatting about…* [who] *knows what, football, just bits and pieces, just small talk. But mid-way in that conversation, in talking about how he was, he drifted sideways and I almost began laughing at him because I thought it was a joke when he began talking about the men in the TV, you know 'I'm having the usual trouble with the men in the TV' gesturing over <u>there</u>, and this whole little delusional structure came out about two-way communication with the television, basically the idea of mind-reading to a degree, that he was sort of being monitored".*

Mr A to explain her role as care co-ordinator and to find out a bit more about the work he was doing with John Barrett. She should at that time have invited him to get in touch with her if he had any concerns in future. After the admission in May 2004, during which Mr A visited John Barrett while he was on Jupiter Ward, she should have contacted him again to explain the team's view that the work had been too stressful, and again invited him to let her know if he had concerns. The same would apply when JW told Dr Mezey in July that John Barrett was saying the work *"had started going wrong"*. Instead of seeking Mr A's view, Dr Mezey appears to have relied on what John Barrett told her - that the music was going well.

61. The team's failure to establish a relationship with Mr A is an example of a lack of thoroughness. There is no evidence in the notes that the team even discussed whether to speak to Mr A. It disadvantaged the team by denying them valuable information about John Barrett's mental health and social functioning which was relevant to the management of risk. We have identified Ms Sturdy as the person we would have expected to speak to Mr A, but we consider that responsibility lay with the team as a whole rather than with her personally.

Monitoring John Barrett's mental health

62. John Barrett was a difficult patient to assess and he was known to relapse quickly. The index offences demonstrated that he was capable of life-threatening violence when he was unwell. Yet during the period of conditional discharge he was not seen regularly by a psychiatrist. His care co-ordinator was a social worker, with successive CPNs taking what they described to us as a back-seat role. We conclude that the monitoring of his mental health not only fell short of what was provided for in the care plan and directed by the tribunal but it was inadequate.

63. Dr Mezey was entitled to delegate the task of seeing John Barrett to her SpR, but we consider it was her responsibility to ensure that medical appointments took place as provided in the care plan, and more frequently if required. While we accept Dr Dhar's account, in the absence of supporting documentation, that he saw John Barrett monthly until he left his post at the end of March, thereafter there was never a regular pattern of out-patient appointments as envisaged by the care plan. We

consider that more frequent review was merited after the admission in May 2004, but that admission was followed by a gap of eleven weeks before he was next seen by a psychiatrist.[104] Even when, according to the weekly referral meeting minutes of 15th June, Dr Mezey said she would make an out-patient appointment, she did not do so. We think it likely that this being raised at the referral meeting followed from JW contacting Ms Sturdy on 10th June. Dr Mezey was reminded again by Ms Sturdy at the referral meeting on 13th July but an appointment was not made until 2nd August. From June 2004, when we are satisfied Dr Mezey decided that in future she would see John Barrett herself, it was her personal responsibility to review him at least every four weeks. It cannot be an acceptable excuse for someone in her position to say that the matter was overlooked. It was her responsibility to organise her work properly and to ensure that the small number of patients for whom she was RMO or psychiatric supervisor were regularly reviewed by a doctor.

Monitoring care plans and care co-ordination

64. In considering the management of John Barrett's care as an out-patient, we have tried to understand how it was that he was not seen regularly by a doctor and, at least for the first six months of the conditional discharge before Ms Galloway joined the team - and arguably for longer - random drug testing did not take place as provided for in the care plan. We have already said that there was individual professional responsibility in respect of both medical appointments and drug testing. We now look at how implementation of the care plan was monitored and care was co-ordinated. The purpose of the team's weekly referral meetings, the minutes of which are fully set out in Part 1, was to keep track of the progress of community patients. Individual members of the team reported back on recent contacts and on developments since the previous week's meeting. The care co-ordinator, as the person who had most frequent contact with the patient, would give a brief presentation to the team and others would contribute if they had anything to report.

[104] This was what Ms Sturdy told the Home Office would happen when she reported to them on 18th May: *"Given Mr Barrett's recent admission, he will have increased contact with the team over the next few weeks"*.

65. Under the Trust's CPA policy, the care co-ordinator's responsibilities include *"monitoring the implementation of all parts of the health and social care plan"* and *"taking action when the health and social care plan is not being implemented"*. These responsibilities are discharged in the context of working with other professionals in a multi-disciplinary team in which individual responsibilities are clearly identified.

66. We asked Ms Sturdy what she did, as care co-ordinator, about the failure of doctors within the team to see John Barrett every month, as required by the care plan. Her response had three parts. First, that as far as she was aware John Barrett was seen regularly by a doctor before the admission in May 2004. This was also what Dr Dhar told us. Second, that as the practice was for doctors to send out their own out-patient appointments, she realised this had not been happening only when JW pointed out to her in June that John Barrett had not been seen by a doctor since being discharged in May. Third, she told us that when JW drew the matter to her attention, she raised it with Dr Mezey at the weekly referral meetings on 15th June and 13th July, as is recorded in the minutes of those meetings.

67. There was in our view a failure to monitor implementation of the care plan and to take effective action when it was known to Ms Sturdy that it was not being implemented. While it was the individual responsibility of the doctors to see John Barrett, and the CPNs were responsible for carrying out random drug tests, we consider that the care co-ordinator should have been alert to all aspects of the care plan, not just those parts that were her personal responsibility. Ms Sturdy did not monitor key parts of the care plan but assumed that her colleagues were carrying out their responsibilities under the plan. It was only because JW pointed it out that she knew John Barrett was not being seen regularly by a doctor from the team. When she did find this out, she drew it to Dr Mezey's attention but she did not follow through when Dr Mezey still failed to do what the care plan required. We have some sympathy for Ms Sturdy because we accept that one would normally expect a doctor to make routine out-patient appointments without prompting. We also accept that the Forensic Service is hierarchical, with consultant psychiatrists at the top. For Ms Sturdy, telling Dr Mezey to do her job was not a comfortable position in which to find herself. We consider nonetheless that it was Ms Sturdy's responsibility to ensure that the care plan was implemented. We consider that having reminded Dr Mezey she should have

followed this up by checking to see if an appointment had been made. If this did not achieve the desired result, and if she did not feel able to challenge Dr Mezey directly, we consider that she should have raised the matter with her own supervisor or the service manager. She did not do so. We therefore criticise her for failing fully to discharge her responsibilities as care co-ordinator.

68. When we put these points to Ms Sturdy she said it was reasonable for her first to raise the issue on 15th June, about a month after the CPA meeting on 18th May, because there had been no occasion until then to know that an out-patient appointment had not been arranged. We accept this. She went on:

> *I was also on leave in late June/early July 2004… The issue of an appointment still not having been made was therefore not raised until the week after my return in the referrals meeting. Following this an appointment was made by Dr Mezey for 2nd August.*

We cannot accept this, as the records show that she attended the referral meeting on 6th July, when the matter was not raised. She spoke to JW on 9th July who once again pointed out that Dr Mezey had not seen John Barrett. Ms Sturdy raised the matter at the next referral meeting on 13th July. More generally, Ms Sturdy says that *"the expectation that I should have done more than I did within this timeframe is unreasonable"*. She pointed out that she did not have a regular supervisor at the time, to whom she could have reported the matter; and that it would not have been reasonable to have raised it with the service manager, who in any case would not in her opinion have had *"any influence over consultant behaviour"*. She said that to:

> *Report to a senior manager in a critical manner at an early stage of problems being identified… would be likely to undermine trust between colleagues and make it very difficult for teams to function.*

69. There is considerable force in what Ms Sturdy says but it is also symptomatic of an underlying problem with the functioning of the team. We consider it was a serious matter that by 15th June no out-patient appointment had been made for John Barrett. We would have expected an appointment to have been made at the CPA meeting on

18th May or soon after. If Ms Sturdy had made enquiries of Dr Mezey and Dr Dein she would have been aware that there had not been any routine out-patient appointments since Dr Dhar left the team at the end of March. Further, the matter had been raised by JW and Ms Sturdy had told her on 10th June that she would deal with it. We are not sure on what date Ms Sturdy went on annual leave but from her entries in the notes we believe this was after 24th June, 14 days after JW had raised the matter. We consider that Ms Sturdy should have seen it as part of her responsibility to report back to JW. If the team had been functioning properly, and if Ms Sturdy had discharged her responsibilities as care co-ordinator in the way we would have expected, an out-patient appointment would have been made by then and JW would have been told.

Response to deterioration in John Barrett's mental state

70. John Barrett's stability of mental state was, we consider, in doubt from the outset as was his future compliance with the prescribed anti-psychotic medication. Team members believed that John Barrett did take the oral Risperidone throughout the period of conditional discharge. While we do not say they were mistaken about this, we note that they relied on his self-report, corroborated by JW. In a case such as this where there is a history of non-compliance, and a risk of serious violence associated with relapse, we would have expected there to have been some consideration of other ways of monitoring compliance. Compliance with medication could have been checked by laboratory testing for Risperidone levels, but this was not considered.[105] This was another example where in our view the team was too ready to place reliance on their relationship of trust with John Barrett, which in this instance was reinforced, as we have seen,[106] by the suggestion of changing the prescription to depot medication if he did not take the oral Risperidone.

[105] It was suggested to us by Dr Mezey that testing for Risperidone was neither available nor useful. On the contrary, we are aware that one of the UK's leading testing & toxicology laboratories (Guy's & St. Thomas' Hospital, London) has routinely offered testing for Risperidone from early 2003. The purpose of testing, of course, would not be to establish precisely what dose a patient is taking – though there is an approximate correlation between dose and level – but rather to determine whether he is taking it at all. We do not suggest that such testing should be routine. What we conclude is that where a patient's mental health is prone to relapse associated with substantial risk, there should be consideration of all the available tools to determine whether he is compliant with medication which he could easily fail to take.
[106] Refer to Chapter 2.3 paragraphs 80 - 82

71. Before considering the team's response during the period 16th April to 30th August 2004, it is necessary to set out how we view the symptomatology that John Barrett experienced.

72. In May 2003 when he stopped taking medication John Barrett reported hearing what he described as "whispers". According to Ms Sturdy's entry on 20th May, he said they were "*not loud enough to hear what they were saying. Was able to refer to these as voices during the discussion".* When Dr Scholtz reported to the Home Office on Dr Mezey's behalf in July 2003, she wrote with reference to what had happened in May:

> *There was one incident of non-compliance with medication in hospital which came to light as a result of him confiding in his girlfriend that he had stopped taking the medication. During this period he became unwell and started to experience auditory hallucinations. The team felt that in some ways it was a positive experience as it allowed him to make the connection between non compliance and the recurrence of psychotic symptoms, something which he was later able to talk through with the professionals on the team.*

We note that Dr Scholtz called the whispering voices auditory hallucinations and described them as psychotic symptoms.

73. When the whispering voices next recurred in April 2004, Dr Mezey included the following analysis in her letter of 29th April to the Home Office:

> *The 'whispering' was indistinct, he was unable to make out what the voices were saying, how many voices were speaking or who they were. However, he noted at the time that they were reminiscent of the auditory hallucinations which he had experienced when he was ill. After having discussed this with him and his girlfriend, I advised him that I thought that it was probably stress related as he had been under some considerable pressure the previous week to complete a music album, which he was working on with a friend. The 'whispers' had only lasted for 48 hours and, indeed as soon as the pressure of work had lifted the symptoms had disappeared.*

It appears to us that what Dr Mezey is describing here is the same phenomenon as that described by Dr Scholtz the year before.

74. The next development was in May 2004 when, John Barrett experienced intrusive auditory hallucinations in the second person. These were recorded as such in the medical notes at the time. By the date of his discharge, on 18th May, he was still hearing voices. According to Ms Sturdy's note of the CPA meeting: *"still some 'whispering' but not all the time"*. It appears thereafter that he continued intermittently to experience whispering voices. From the notes it is not possible to know how frequently these occurred, but we think it likely that they were present intermittently throughout most of the period between his discharge on 18th May and his readmission on 1st September. We note, for example, that on 26th May Ms Galloway recorded: *"No evidence of any symptoms other than 'whispers'. Experiences these every day, 1-2 minutes duration, twice daily. Feels he is coping with these"*. On 10th June JW told Ms Sturdy "*still small whispers couple of times per day*". There is then a gap in the recording but on 29th July JW reported to Ms Sturdy that John Barrett "*acknowledged he was hearing voices again – says he has been for a couple of weeks (?longer)"*. When John Barrett saw Dr Mezey on 2nd August he told her that the voices were *"a problem"* and that they had been present for *"last few days just in the background"*. When he was seen by Dr Dein on two occasions in August she found him to be guarded. He did not tell her that he was hearing whispering voices. When he was assessed for admission by Ms Sturdy on 1st September he told her that *"his voices remained at the level of indistinct whispers"*. The same day he also told Dr Anakwue that he was hearing *"whispering voices"*. When Professor Eastman assessed him on 6th September John Barrett told him that in the period up to the killing of Denis Finnegan: *"Usually he heard whispering voices that he could get by with"*. Dr Petch, who assessed John Barrett on 14th September,[107] recorded his description of the voices in May as *"coming from an area 6 inches outside his head all the way around, almost like a helmet. He said that the voices followed his thoughts and then influenced his behaviour"*. He reported to Dr Petch that between May and September *"he had a number of minor attacks of the voices of a similar kind to that described above… he said that the delusions had gone but the voices had been bothering him"*.

[107] Dr Petch assessed John Barrett for admission to Broadmoor Hospital – Refer to Chapter 1.8.

75. Dr Petch, in his report, described the voices as intermittent auditory hallucinations. We agree with him. We consider that the only difference between the voices John Barrett experienced in April 2004 *("whispers")* and the voices in May 2004 was that the latter were louder and more intense. Thereafter, he continued to experience auditory hallucinations intermittently and they were present when he was admitted to the Shaftesbury Clinic on 1st September. Dr Mezey's view that stress was a factor in the recurrence of whispering voices in 2004 is compatible with our conclusion that the voices were auditory hallucinations and symptoms of a psychotic illness.

76. We now look at particular episodes in that period.

i) 16th – 28th April

77. On 16th April John Barrett reported the first occurrence since his discharge the previous October of what he referred to as *"whispers"*. When JW sought advice on his behalf from the Shaftesbury Clinic she was initially referred to Crisis Line, a mental health telephone helpline. We consider this to have been wholly inappropriate. As part of the after-care support for a recently discharged patient such as John Barrett, telephone advice should have been available from the Shaftesbury Clinic. At the very least it should be possible for a discharged patient to obtain general advice from a member of the nursing team on the ward where he stayed last. If medical advice is needed it should also be available to out-patients of the Forensic Service, if necessary out of hours. We comment on this further at paragraphs 95-97 below.

78. Arrangements were made for John Barrett to see Dr Mezey in out-patients on 23rd April. By then the whispering voices had gone after only 48 hours. Dr Mezey's entry in the notes was brief but, as we have seen, she described his symptoms and set out in her report of 29th April to the Home Office her opinion that the voices were stress related. This was a reasonable view. It was also reasonable not to increase the dose of Risperidone, because the voices had gone by then. When Ms Sturdy saw John Barrett on 28th April the voices had not returned and he had apparently accepted, and been reassured by, Dr Mezey's advice.

ii) 11th – 18th May

79. On 12th May 2004 John Barrett was admitted to Jupiter Ward at a time when he had for several days been hearing voices saying *"We're going to kill you"* and *"You're going to die"*. These were auditory hallucinations in the second person, which were clearly audible and caused him distress. There were also other features in the history given by JW which suggested he was relapsing, such as his feeling that he had no future and his wanting her to leave him as he felt he had nothing to offer her.

80. We consider it was appropriate to admit John Barrett informally, at his own request, on 12th May. It was also appropriate to record in the notes on admission that if he wished to leave the ward he was to be held under section 5(2) of the Mental Health Act for an assessment to decide whether formally to detain him, either by the use of a civil section or by recall. From the evidence we have read and heard from witnesses we accept that at this stage John Barrett was still engaging with the team.

81. We do, however, have a number of observations. First, that Dr Mezey granted John Barrett unescorted ground leave on 13th May without having seen him. We consider this to be poor practice because the re-admission of a restricted patient, with the attendant need to focus on risk, requires a proper assessment before granting leave. This practice occurred again as will be seen when we consider what happened on 1st September 2004, the day before Denis Finnegan was killed.

82. Second, we consider that the recurrence of voices, and at an intensity that to the knowledge of the team John Barrett had not previously experienced, was highly significant. It should have been a matter of concern that the voices had recurred so soon after the previous episode in April and at a time when, according to John Barrett's account, which was accepted by the team, he had been taking Risperidone as prescribed. We consider that the opportunity should have been taken while he was an in-patient to review his medication with the object of eliminating psychotic symptoms altogether. We conclude that between May and September, while he continued intermittently to experience the auditory hallucinations which he described as *"whispers"*, John Barrett's psychotic illness was inadequately treated. One would normally expect that an adequate dose of anti-psychotic medication would control

psychotic symptoms, such as auditory hallucinations, and that would normally be an aim of treatment. We have found no evidence that that his medication was reviewed after the admission. Indeed, he did not see a doctor again until 2nd August. It appears that the dose of Risperidone was increased to 10mg while he was an in-patient but reverted to the previous dose of 8mg when he returned home, presumably because that was the regular prescription he was collecting from his GP.[108]

83. Apart from the desirability of controlling symptoms, it concerns us that John Barrett came to believe that medication was not effective in dealing with the whispering voices and that he would have to learn to live with them.[109] Our impression is that during the period between May and September his attitude to the team changed. It is impossible to know whether it changed because he was becoming ill and paranoid or if it changed because he lost confidence in the team's ability to manage his mental illness. We consider that the latter is at least a possibility. We acknowledge that if, as we believe, John Barrett was becoming dispirited during this time he could have done more to alert the team to how he was feeling. But that was not his way. On the contrary, his tendency was to play down both his symptoms and any psycho-social problems.

84. Third, we consider that the CPA meeting on 18th May failed fully to review the care plan. In addition to medication, there was a clear need to engage John Barrett in structured activity. The deterioration in his mental state in April and May should have led to closer monitoring. We have already commented on these issues. We think the CPA meeting on 18th May was a lost opportunity to review and change the care plan. In so far as changes were agreed, such as John Barrett going to the Volunteer Bureau to look for work, they made little or no practical difference to his circumstances. Similarly, while the team apparently recognised there was a need for more frequent contact after the May admission, and Ms Sturdy reported to the Home Office on 18th May that this would take place, there was a reduction in the frequency of medical appointments – none for 11 weeks - and one appointment with Ms Sturdy was also

[108] When she saw John Barrett on 2nd August Dr Mezey recorded his medication as *"taking 8mg daily from GP"*.
[109] When we met John Barrett in October 2005 he told us that he had felt in 2004 that he could cope with the whispering voices and that he would have to cope with them. He had got the impression that the team wanted him to learn to live with the voices.

missed.[110] It appears to us that for John Barrett this must have contributed to what we believe was his growing sense that the team were not able to provide effective help.

iii) 27th July – 2nd August

85. John Barrett was not seen by a doctor from the team in either June or July. He continued to hear whispering voices intermittently. As is clear from Dr Mezey's entry of 2nd August, there was now acquiescence on the part of the team such that, as long as the voices did not make him anxious and paranoid, he was expected to live with them. By his own account, John Barrett did not increase the dose of Risperidone to suppress the voices, as he had done before the May admission, but continued to take 8mg daily. According to JW, when she spoke to Dr Mezey on 30th July, he was not taking the full prescribed dose of 8 mg daily. The evidence of JW, given to us but also communicated forcefully to the team in late July, was that there had since the May admission been an insidious deterioration in John Barrett's mental health. In Part 1 of this report we quote extensively from her evidence to us and entries in the notes. JW was sufficiently concerned that she asked John Barrett's brother and mother to contact Ms Sturdy, which they did. Based on this evidence, and also on Dr Mezey's examination of John Barrett on 2nd August, the entry for which is reproduced in Part 1, we conclude that by late July there had been a relapse in his mental state, as changes in his demeanour and behaviour indicated, since his discharge in May. This deterioration was reported by JW and family members but not acknowledged by John Barrett himself. The deterioration may have been more serious by then than Dr Mezey realised, although the evidence (his demeanour when seen by Dr Dein and the third party information that came in) tends to suggest that he was worse by the end of August than he had been on the 2nd.

86. We accept that not only Dr Mezey but others involved considered that he was not relapsing. We think they were wrong. A number of factors contributed to their mistaken view:

- Inadequate monitoring of his mental state

[110] This is what we were told by Ms Sturdy. From our reading of the notes it appears that John Barrett was not seen at all between 16th June and 21st July.

- Possibly because of the diagnosis of delusional disorder they attached too much importance to the absence of expressed paranoid delusions.
- Too little weight was given to the presence of auditory hallucinations which did not fit with the diagnosis of delusional disorder and were not explicitly recognised as auditory hallucinations and symptoms of a psychotic mental illness.

87. It is clear that before 27th July neither Ms Sturdy nor Ms Galloway had elicited any symptoms apart from whispering voices or heard anything from John Barrett himself that caused them concern. We note that Ms Sturdy acted appropriately in recording and passing on to the rest of the team, and Dr Mezey in particular, information received from JW and from John Barrett's brother and mother. However, we are surprised by how little impact this information had on the team. When we saw members of the team they still maintained that the deterioration by the beginning of August was not significant and that John Barrett was being adequately managed. We infer that this was because they did not consider the whispering voices to be significant, despite the addition in May to the relapse indicators in the care plan of *"Hearing derogatory voices, which start as indistinct whispers"*.

88. Given that John Barrett continued to experience symptoms – the whispering voices - intermittently throughout June and July, we consider that the team should have been alert to other indicators of deterioration. Given also John Barrett's reticence and his poor recognition of symptoms, there was a need to obtain information from other sources and to be alert to other relapse indicators. It appears to us, however, that insufficient weight was given to information received from JW. We consider this was a misjudgement and that it was contrary to what the team had agreed when discharge was being planned in 2002.

89. The clearest example of this was how Dr Mezey dealt with the information received from JW on 30th July, as against her examination of John Barrett on 2nd August. We consider that Dr Mezey was simply wrong to conclude on 2nd August that John Barrett was not unwell or, as she told us, that he was *"extremely well"*. Even on the basis of the history she took on 2nd August it is apparent that the voices had made him unhappy, that he had smoked cannabis which had made him frightened to leave

the flat, and that the voices continued to be a problem for him even if he reported that his mood and appetite were normal. There were several matters, arising from what JW had said on 30th July, which required further exploration:

- Why had John Barrett not told Ms Sturdy that JW had moved out of the flat?
- Did he believe that his previous delusions about police surveillance, being followed etc. had a factual basis? If so what was it?
- Was it true that he was sometimes taking only 4mg of Risperidone rather than the prescribed dose of 8mg? If so, why?

The work he was doing with Mr A was another area to be explored. According to JW, John Barrett had told her it was going badly but he told Dr Mezey it was going well. According to JW, Mr A had noticed John Barrett's decreased mood, while John Barrett said his mood was good. It would have been a relatively simple matter to speak to Mr A about this but Dr Mezey did not do so.

90. We are not in a position to say how unwell John Barrett was on 2nd August. Our point is that there were by then a number of indicators that he was deteriorating such that Dr Mezey should have been less ready to accept what John Barrett told her. In our opinion there was a need to intervene, with the aim of arresting and reversing the deterioration. It was a matter for Dr Mezey and the rest of the team to judge what form such an intervention should take. John Barrett's urine was tested for cannabis and he was referred to see a psychologist in September, but that was not, in our view, adequate given the evident deterioration in his condition.

iv) <u>19th – 30th August</u>

91. When Dr Dein saw John Barrett on 19th and 26th August his presentation was strikingly different from the one previous occasion when she had assessed him, during the May admission:

> *When I saw him on 19 August I had a very different picture. I was struck by the fact that he seemed extremely guarded and I was very worried by that. Again, Sue* [Sturdy] *was there and she didn't seem too concerned about his*

guardedness, but I was very concerned that he was guarded. He almost seemed a bit arrogant when I asked him questions, and in a sense he was trying to evade my questions and prevent any further questioning. There were very long pauses in his thinking. I would ask him a question and there would be long pauses, and I wondered why they were. I wondered if he was hearing voices, if he was extremely thoughtful or if he was thought disordered, so there was a possibility that this was normal, that he was just thinking deeply, but this was not the same feeling I had about him a few months earlier. There was the possibility that either he was hearing voices or there was a disorder in his thought and he was trying to communicate between these other inputs into his thinking. I was very uncomfortable with him because I didn't feel I had the same engagement. Yes, he was there and he was speaking to me, but I felt he wasn't engaging quite as well, and I increased the dose of his Risperidone because I suspected it was because he was deteriorating in his mental state.

The following week I had some more input from the CPN and Sue and also the girlfriend and conversations Sue had with his girlfriend. When I saw him I had very much the same picture and he seemed as guarded. The reason I saw him twice was that if you see some of these patients on another day you might get a different picture, and it might just have been a one-off, a bad day. However, a week later I had the same feeling, that he was still very guarded, there were still long pauses in his thinking, which made me think he was ill, but again he seemed to be compliant. He had been tested for cannabis and he was negative, and for all practical purposes he was attending all his appointments. There was also the issue that from the CPN, from the social worker, from his girlfriend, and I found out through his girlfriend about a friend, they all felt that in this week he was a bit better. That was the impression, although I didn't feel he was better in the interview, but I was getting a broader picture that maybe he had improved.

92. When asked if she considered John Barrett had relapsed, Dr Dein told us:

I thought it was more a sign of deterioration in his mental state. The problem was that it wasn't very hard symptoms. I was basing my assessment on what he

was not saying rather than on what he was saying or what he was doing. I was basing my assessment on the quality of our own relationship in that interview. It wasn't based on him actively talking and responding to voices or admitting to anything, which is what made the assessment difficult, and I wrote that even in the second. He was very difficult to assess because he was not giving anything away, and I was more concerned as to why he was not giving anything away rather than what he was telling me. I was sure he was deteriorating in his mental state, but I also had the impression in the second week that the introduction of [an increased dose of] *Risperidone had done something. I wouldn't say I was convinced at that point he had a full-blown relapse.*

93. We asked Dr Dein how she interpreted John Barrett's reticence:

I was concerned that he was not talking because I felt in the worst case scenario he has incorporated me into a persecutory delusion and he thinks I am part of it. The next possibility was he was very concerned that I would admit him and he wanted to avoid that. The impression I had was that he was trying to avoid an admission and he was very concerned that seeing me might lead to an admission of some form. On the third level that he was, as some patients are, very suspicious and uncomfortable with psychiatrists, who have a certain amount of power to take away their liberty. Those were the three possibilities I considered, and I more or less thought it was the second, that he was getting very concerned that I might admit him.

94. We have quoted Dr Dein at length because her description of John Barrett in August 2004 includes features, such as the long pauses and his guardedness, which were noted in his previous psychiatric history during episodes when he was unwell. We consider that, based on the information available to her, Dr Dein's assessment was essentially accurate. What she said also serves to remind us of the complexity of psychiatric assessment and the difficult judgements that have to be made. Dr Dein did not take steps to arrange for John Barrett's admission. She assured us that this was because her assessment when she saw him was that he did not need to be in hospital, and clearly he was not asking for admission. With hindsight and with the information quoted above from Mr A, which was not available to Dr Dein, we consider that by 26th

August, if not before, the better course would have been to admit John Barrett in the interests of his own health and for the protection of others. But we do not criticise Dr Dein for coming to a different view because we accept that she formed her opinion on the basis of two thorough assessments of John Barrett and that she also took account of information from other sources, notably JW. We also accept that on 26th August Dr Dein was entitled to give weight to information from those who knew John Barrett well that he had been somewhat better in the intervening week than in the week preceding her first assessment.

95. We have commented above on JW being referred to Crisis Line when she contacted the Shaftesbury Clinic in April. We make the same observation about the referral over the August Bank Holiday weekend. We understand JW's reaction:

> *Dr Dein must have spoken to her* [Ms Sturdy] – *Dr Mezey was apparently away – and she rang me to say she'd rung the Crisis Line to inform them what was happening, and that if John or I needed to ring them they'd know what was going on and be able to help. That made me want to laugh out loud, but not in a funny way, because of course John wouldn't ring them. I'd passed on what was going on with regard to John's behaviour and there was no way would John ring them. I can't believe she didn't understand that.*
>
> *Also, I thought it was really offensive that for the first time they were concerned enough to do something, and that they thought John might hurt me and all they bothered to do about it was to make some pathetic call to the Crisis Line. I was very angry about it because I thought it was so inadequate.*

96. Ms Sturdy has pointed out to us that she did not expect John Barrett to telephone Crisis Line. Had JW, or anyone else, done so on John Barrett's behalf, Ms Sturdy had done what she could to ensure that the out-of-hours service would have contacted Halswell Ward and that John Barrett's notes were available to nursing staff on the ward. In our view, however, the Forensic Service should be so organised that it can offer out-of-hours advice to its community patients, and a point of contact for their family members and carers. There are likely to be complex factors in the care of a patient of the Forensic Service, with risk management plans and legal requirements less commonly seen among patients of the general adult psychiatry service. Not only

would the possibility of contact with the hospital team enhance follow-up, it would also benefit patients because such advice is likely to be more accurately informed than any more general alternative. It would also offer continuity. It is inappropriate in our view for the Forensic Service to rely upon Crisis Line or other generic provision to provide an out-of-hours service.

97. Contact with a ward is likely to be the first line of such an enquiry. Indeed, for patients only recently discharged it is probable that one or more of the nurses on duty at the Shaftesbury Clinic at any one time would have direct knowledge of the patient. They in turn should have access to specialist staff for additional advice. The concept of on-call consultant or senior medical cover being provided on a rota which includes general psychiatrists without direct knowledge of the Forensic Service is a matter which we consider requires further examination by the Trust. The relevance of direct knowledge is that the management of patients of the Forensic Service frequently raises complex legal issues and gives rise to risks to the public that are not routinely encountered in general psychiatry. If, as we recommend,[111] a service improvement team is brought in to work with the Trust, we would expect that out-of-hours communication with doctors in the Forensic Service is one of the matters they would consider.

Conclusion

98. Against a background of John Barrett's previously limited engagement, the team embarked upon his conditional discharge with a package of measures which was ineffectively implemented. John Barrett was allowed to involve himself in work which was essentially unmonitored by feedback from the workplace. The work itself was in a setting where the dynamics were complex, involving as it did working with a former partner of JW. When that work effectively came to an end John Barrett was left to his own devices even though it was recognised that he needed structure in his life. Information was not actively sought from those well placed to provide it and when they contacted the team their perception was that the response was inadequate.

[111] Refer Chapter 2.1 paragraph 45.

99. We conclude that John Barrett's discharge was precipitate, the monitoring by out-patient contact was sparse, and conclusions about risk were not well-founded. Reporting was erratic. His mental health was fragile with breakthrough symptoms being chronically evident in 2004, as was adverse reaction to stress. These symptoms arose, we consider, from a condition which occurred in an individual reluctant to engage with services, actively seeking to minimise the experience of symptoms and with a clear pattern of dislike for and non-compliance with medication except on a compulsory basis. When he experienced auditory hallucinations they were attributed to stress and were not effectively treated. They persisted intermittently which was dispiriting for John Barrett and eroded his confidence in the team. Following the return of symptoms in 2004, the conclusion that the treatment of John Barrett's condition, and reduction of the risks associated with it, would be achieved by continuing with oral medication which was only partially effective was not supported by a full and considered analysis of the clinical evidence.

100. It might be suggested that in the fatal assault on Denis Finnegan a new pathological phenomenon was seen. This was the appearance of command hallucinations, which John Barrett described as having begun only the day before he killed Denis Finnegan. It is right to say that command hallucinations are recognised as carrying additional risk in relation to violence and that he had not previously reported experiencing them. But John Barrett had already demonstrated a substantial risk of violence to others arising from his paranoid psychotic illness. The command hallucinations, like the whispering voices, were symptoms of the illness. We do not say it was predictable that John Barrett would experience command hallucinations telling him to kill, but the risk of serious violence associated with deterioration in his mental state was known. We conclude that one of the factors that contributed to the killing of Denis Finnegan was that John Barrett's illness was inadequately treated.

101. With hindsight it is not difficult to identify clinical interventions that would have reduced the risk of John Barrett committing further acts of violence. To do so would be to focus on particular decisions and judgements which were made in circumstances quite different from those in which we now review his care and treatment. Whatever view we may take of the actions and omissions of individuals, in important respects the care delivered by the team fell short of what the care plan and the tribunal

required. In the case of a restricted patient like John Barrett the primary purpose of tribunal conditions and requirements in care plans is to reduce and manage the risk of serious acts of violence. Where the care delivered falls short of such conditions and requirements the inference must be that the risk is not being properly managed.

102. The responsibility for the delivery of care does not attach only to the professionals directly involved. There is also an expectation that the organisation for which they work, in this case an NHS Trust, should have effective means for monitoring performance. In John Barrett's case there appears to have been an absence of effective mechanisms, either within the team or in the organisation as a whole, to ensure that care was provided in accordance with care plans and tribunal conditions.

Chapter 2.5 Decision-making and Process
31st August - 1st September 2004

Introduction

1. On 31st August the decision was made to admit John Barrett to hospital. The most recent assessment had been on 26th August by Dr Dein. She had concluded that he was deteriorating but she did not recommend admission on that date. Ms Sturdy and Ms Galloway also had concerns, which had been increasing throughout August. A difficulty for all of them was that they had not detected any symptoms, apart from the whispering voices which had been present for much of the time since he was discharged from hospital in May. But they had received worrying reports from JW and family members which suggested John Barrett was becoming paranoid. In her evidence to this inquiry Dr Mezey summarised the position:

> *It was a very difficult balance between hearing what was coming in from them and then our clinical assessment of John Barrett, and working out what weight to put on the relative – and often contradictory – findings from the two.*

Decisions and process

2. We now consider the following aspects of the admission:

- Why on 31st August was it decided to admit John Barrett
- How the decision was made
- What was agreed on 31st August
- The decision to admit informally
- The execution of the plan.
- What happened when he came into hospital.
- The decision to grant him leave

Why on 31st August was it decided to admit John Barrett

3. When Dr Mezey returned from annual leave the decision was made on 31st August to admit John Barrett to hospital. The reason for admission was a concern that his mental health was deteriorating. Before then, the view had been that his deterioration could be safely managed in the community. As Dr Dein explained to us:

> *As much as his original offence was related to his illness, and we had no doubts about that, they had little doubt he was psychotically unwell and that is why he had offended. In that he was now deteriorating, I was concerned there was an increase in his risk because of the link between the two and because of the persecutory nature. I thought the risk was increased but I was under the impression that it was being managed… He was still in the community but we had not allowed him to languish there. I saw him on the 19th and in the course of eight days I had seen him twice. He was seen by his CPN, his social worker, and there were numerous phone calls between him and the social worker and also with his girlfriend, all of which was communicated all the time. Sue* [Sturdy] *called me all the time to tell me what was happening, who was saying what, so although he was in the community I thought he was being monitored fairly well. To answer the question, I think his risk was increased but I thought we were managing it at that particular point in time by all the increased input we were giving him.*

4. Dr Mezey told us that when she heard the reports about John Barrett on her return from annual leave, there was one incident that particularly concerned her. It was the one reported to Ms Sturdy on 19th August when JW described how, when they were out together, John Barrett had made a comment and pointed at a man who was using a mobile phone, and had then said to JW by way of explanation *"Well, he obviously knows me"*. Dr Mezey told us how this reported incident struck her when she heard about it on 31st August:

> *We knew that he had done this sort of thing before and he shouted at a man in the street, accused someone of following him, so it was behaviour that had been noted before in the context of illness. The difficulty of course was that*

he denied any significance, that it was important, but when I came back and heard about it, as a team we thought it was worrying. It was one of the aspects of the behaviour that made us think 'Hold on, we need to bring him in and find out what is going on'.

5. The team were concerned that his mental state might have deteriorated, but they considered it was significantly different from his condition immediately before the January 2002 offences. Specifically, no one had seen any evidence that he was experiencing paranoid delusions of the kind which led him to attack the principal victim on that occasion. If he was relapsing, they believed they had intervened in good time. Admission was appropriate, they felt, because it would facilitate the thorough assessment of a patient who, as Dr Dein recorded following her examination on 26th August, was difficult to assess. With reference to the decision made to admit John Barrett on 31st August, Dr Mezey told us:

We did not change the risk at the time. We were worried about him, we thought he was not as well as he had been, but I don't think any of us felt that he represented a significant risk. If we had done we would have acted differently.

6. We agree with Dr Dein's analysis, that there was reason to be concerned about a deterioration in John Barrett's mental state, and specifically that it was possible he was experiencing persecutory ideas. Given his history, such a deterioration and the reported behaviours represented an increased risk of violence. Whether the risk had increased from *"low apparent"* to *"significant"* or even *"serious"* (using the terminology in the Trust's CPA risk assessment form) was perhaps not something that could be determined on the information then available. We therefore conclude that admission was necessary because of deteriorating mental health which had as its consequence an increased risk of violence.

How the decision was made

7. We were told by Dr Mezey, Ms Sturdy and Ms Galloway that the decision to admit was made at the referral meeting on 31st August which they all attended, as did Dr

Dein and other members of the team. We accept this evidence, although the minutes of that meeting record only:

> *More guarded recently. Possibly relapsing. Increased Risperidone recently, distractibility. Due to be seen by Sue Sturdy on 1.9.04.*

We also accept the evidence that there was a detailed discussion of John Barrett at that meeting and that both Dr Dein and Ms Sturdy expressed their concerns about his deterioration.

What was agreed on 31st August

8. In summary, this is what was agreed on 31st August (and confirmed by Dr Mezey and Ms Sturdy when they spoke on the morning of 1st September):

- John Barrett would be offered admission to hospital by Ms Sturdy when he came to see her at the Shaftesbury Clinic the following day.
- If he accepted, he would be admitted to hospital informally.
- If he refused, the Home Office would be asked to recall him.

9. There was therefore an acknowledgement that he might need some persuasion to come into hospital, as compared with the admission in May 2004 which was arranged at his request. The difference was that in May he had said he was distressed by voices which he found intrusive and worrying. In August he was saying that he was not troubled by any symptoms, referring only to occasional whispering voices, and he considered that he was functioning well, albeit that he was upset by the breakdown of his relationship with JW. We consider the choice of informal admission below.

10. We emphasise that it was not, in the minds of those responsible, an emergency admission in response to increased risk. Rather, it was arranged so as to take advantage of the opportunity presented by John Barrett's regular fortnightly visit to the Shaftesbury Clinic on 1st September.

11. Apart from whether, if John Barrett was to be admitted, it should have been informal or by the use of powers under the Mental Health Act, we consider that had the team discussed the proposed admission thoroughly, they would have identified some disadvantages in their plan. The most obvious was that an admission for medical reasons, which John Barrett might not accept, was to be explained to him by a social worker. Neither Dr Mezey, for whom 1st September was an academic day, nor Dr Dein, who had another professional engagement, nor Ms Galloway, who had an appointment to assess another patient in prison, was going to be at the Shaftesbury Clinic when John Barrett came for his appointment with Ms Sturdy. Not surprisingly, given that John Barrett was being cared for by Dr Mezey's team, arrangements were not made for a doctor from another team to be present. Ms Sturdy had planned to see John Barrett with a nurse (although this had been agreed with Gaskell Ward rather than Halswell) but he was two hours late for the appointment and no nurse was available when she saw him.

12. The team having decided to admit him on a day when Dr Mezey was not working at the Shaftesbury Clinic, it is not clear from the notes made on 31st August when she would see him. We are satisfied, however, that what was agreed between Dr Mezey and Ms Sturdy, either on 31st August or on the morning of 1st September, was that once John Barrett had been admitted informally, Dr Mezey would come to the Shaftesbury Clinic in the late afternoon to assess him.

13. John Barrett had not been prepared for the admission. There had been no discussion of the possibility of admission in his recent contacts with the team and he had not been told in advance that it would be considered when he attended on 1st September. The inference we draw from Ms Sturdy's request to JW on the afternoon of 31st August not to inform him is that the decision was made not to forewarn him. We can only assume that this was because the team were not confident of his cooperation and had in their minds the possibility that he might absent himself. A consequence of not preparing him was that he was taken by surprise.

14. A third problem was that because he was due to see Ms Sturdy at 10 o'clock the next morning a bed had to be found at short notice. This meant that he had to be admitted to the Shaftesbury Clinic, which was the only place where the team had

ready access to beds at that time. We consider the implications should have been discussed because, as became apparent after admission, there was a considerable difference for him between being admitted to the Shaftesbury Clinic and being admitted to an open non-forensic ward as had happened in May 2004.The consequence was that he felt he had been tricked into agreeing to the admission. We consider this would heighten the likelihood of absconding, especially given what was recorded about his previous absconding. In relation to this aspect of the admission Ms Sturdy told us:

> *It was my expectation that John Barrett would have a medical assessment that day and that, depending on the outcome of this, he would either be recalled or transferred to an open ward as an informal patient*.
>
> .

This tends only to confirm our view that this had not been properly thought through and agreed by the team, because Dr Mezey proceeded on the basis that, there being no bed available on an open ward, he could remain as an informal patient in the Shaftesbury Clinic.

15. Another problem was that the nurses on the ward had not been told to expect him and he was not known to most of them. His unannounced arrival on the ward coincided with a nursing handover, a particularly busy time of day. In practical terms this meant, among other things, that nurses were faced with the highly unusual situation of an informal patient whom they did not know and who was making it clear that he thought it wrong that, having agreed to admission, he was not being allowed to go to an open ward as he had expected. The nurses were uncomfortable with what they saw as the de facto detention of an informal patient on a medium secure unit and they raised this with both Ms Sturdy and Dr Mezey.

16. There was also the question of leave. If he was going to be admitted to the Shaftesbury Clinic informally, was it appropriate to grant him leave? This was a matter which could have been discussed by the team while planning the admission. Indeed, it was a relevant matter when seeking John Barrett's agreement to informal admission.

17. These points come out clearly in the evidence of Mr Sankoh who was nurse team leader on the day of the admission:

It was an unusual admission because we do not admit unplanned admissions.[112] *We always have at least two/three days in advance, or we have the opportunity of going to see the patient before they are admitted, but on that day in question I actually came out, because usually I come in to introduce myself to the patient, not to bombard him with a lot of interviews/discussions because the doctors have to do an assessment and clerk him in, and then the nurses have to do assessments, so I just came in quickly to introduce myself and then let him know that I am the ward manager in case issues arise and then they can come back to me.*

So on the day… I came out from the office and the staff said he would be staying here informally, so I asked Sue [Sturdy] *why should he stay informally as that would create a problem if he decided to leave. Then she said, it was just a quick admission because there is no open bed so they would look for an open bed, and Dr Gill Mezey, the consultant, would see him in due course.*[113] *I said I hoped she would see him because it will create confusion as to how we would deal with him, and that was why the* [section] *5 (2) came in, giving us the power to stop him and… the doctor to put him on 5(2) to stay until he is assessed.*

There was no indication of him being high risk. My only concern was that he may not have been taking his medication, but in the end he said he was taking his medication, but my impression was he was sort of tricked into admission… because he asked me, "Why am I being admitted here? I thought I was going to an open ward so that I could go in and come out." I said, "I do not know the full circumstances of you coming back here but all I will say is I will get in touch with Gill", and whatever happens I would come back to him, but in the meantime if there were any issues he wanted to talk about with me then that's fine.

18. In our view these are all matters that, had thought been given to them on 31st August, could have been foreseen. Had they been foreseen they could, and in our view

[112] We do not think this can be correct, unless it was intended to refer to Halswell Ward specifically. It does, however, highlight the problem of arranging acute admissions to the Forensic Service which, we are told, runs at 100% bed occupancy.

[113] Ms Sturdy's recollection is that she also told Mr Sankoh that Dr Mezey would telephone him about the admission.

should, have been mitigated in planning an admission which was not, according to Dr Mezey and other members of the team, a matter of urgent necessity. In our view, the most important consideration that was overlooked was that Dr Mezey should have assessed John Barrett at the point of admission. She had not seen him for four weeks. The admission was for medical reasons. The changes in his mental state in the intervening period were described to us as subtle and John Barrett did not recognise them. If the admission was not urgent, in response to heightened concerns about risk, John Barrett was entitled to expect that the consultant with ultimate responsibility for his treatment would assess him, so as to be able to form her own opinion and to give him an explanation of why she thought admission was necessary. We say this was a matter for Dr Mezey rather than something that could properly have been delegated to Dr Dein both because of its significance and sensitivity so far as John Barrett was concerned and because Dr Dein was shortly due to leave the Forensic Service. Dr Mezey had said in June that she would personally take responsibility for John Barrett's medical supervision and care thereafter.

19. We consider it a failure of the team as a whole not to have planned the admission as thoroughly as the circumstances demanded and not to have decided that Dr Mezey should assess at the point of admission. The recording of discussion leading to the decision was characteristically poor and did not even say what decision had been reached. There was then poor coordination between Dr Mezey and Ms Sturdy, which we accept was attributable to the former's change of mind about seeing John Barrett on the afternoon of 1st September. The views of the nursing team on Halswell Ward were not taken into consideration in the decision to admit informally. When those views were communicated to Dr Mezey by Mr Sankoh she responded by making, without reference to her colleagues in the team and without having assessed John Barrett, the decision to grant him unescorted leave. We consider this further below.

20. As Ms Sturdy pointed out to us, this was contrary to what had been agreed. The expectation was that Dr Mezey would assess John Barrett before any further decisions were made. Ms Sturdy's observation was that: *"In terms of team performance and functioning, I would refer you back to the issue of power differentials within the team, and the fact that power does effectively lie with consultants"*. We accept Ms

Sturdy's analysis that Dr Mezey acted without apparent regard for what had been agreed between them, but it remains our view that the admission was poorly planned.

The decision to admit informally

21. Under section 42(3) of the Mental Health Act:

> *The* [Home Secretary] *may at any time during the continuance in force of a restriction order in respect of a patient who is conditionally discharged… by warrant recall the patient to such hospital as may be specified in the warrant.*

This unfettered discretion to recall a patient must be exercised compatibly with Article 5 of the European Convention on Human Rights. Except in an emergency, this requires current evidence that the patient is suffering from a true mental disorder.[114] Recall is not the only option if a conditionally discharged patient requires in-patient psychiatric treatment. Informal admission and admission under a civil section of the Mental Health Act are also legally possible.

22. We consider two separate questions here. First, what conditions must obtain, whether as a matter of law or good practice, for the informal admission of a conditionally discharged patient to be valid. Second, whether the practice in admitting John Barrett informally on 1st September 2004 was consistent with Home Office guidance. We conclude with our observations about the clinical thinking on which the informal admission was based.

23. With regard to the first question, it could be argued that admitting him informally was consistent with good practice, as explained in the Mental Health Act Code of Practice, paragraph 2.7 of which reads:

> *Where admission to hospital is considered necessary and the patient is willing to be admitted informally this should in general be arranged. Compulsory admission powers should only be exercised in the last resort. Informal*

[114] K v United Kingdom (1998) 40 B.M.L.R. 20.

admission is usually appropriate when a mentally capable patient consents to admission…

In accordance with this guidance, many mentally ill patients are admitted to hospital informally in circumstances where they would prefer not to be admitted at all but where informal admission is for them preferable to detention. The patient's remedy in such a case, if he should have a change of mind after agreeing to informal admission, is to assert the qualified right of an informal patient to leave hospital. It is a qualified right because a hospital may lawfully hold an informal patient for up to 72 hours, under section 5 of the Mental Health Act, for the purpose of an assessment whether to use formal powers of detention. The practice, which is reflected in the guidance we have quoted, is to admit the willing patient informally, even where professionals involved believe that the patient does not agree with their view that he needs to be in hospital. This approach is sometimes characterised as the least restrictive alternative and is based on the principle that powers of compulsion should be used only as a last resort. It appears to us that this is the model of decision-making that Ms Sturdy and her ASW colleague had in mind on 1st September 2004 when they saw John Barrett to discuss admission to hospital.

24. The position of a conditionally discharged restricted patient can be distinguished in several ways from that of a person who is not subject to a restriction order but who is being considered for admission to psychiatric hospital. There is first the fact that the restricted patient has in the past been made subject to special restrictions because this was deemed *"necessary for the protection of the public from serious harm"*.[115] As a conditionally discharged patient he remains subject to a restriction order and *"liable to be recalled to hospital for further treatment"*.[116] It is also often the case because of the patient's forensic history and assessed risk that the admission of a conditionally discharged patient will be to a secure hospital which necessarily entails significant restrictions. There is then the consideration that the difference between informal admission and recall is greater than the difference between informal admission and detention under a civil section because the recalled restricted patient is subject to the special restrictions set out in section 41 of the Act, relating to

[115] Section 41(1) of the Mental Health Act 1983.
[116] These words are taken from section 73(1)(b) of the Mental Health Act 1983.

leave and transfer.[117] More importantly, only the Home Secretary or the mental health review tribunal can discharge him from detention. For this reason and because of the nature of forensic psychiatric care, it is likely that the period of detention will be longer for a recalled patient than for someone not subject to a restriction order. The conditionally discharged patient faced with the prospect of recall thus has more to lose by refusing informal admission and the pressure to accept is correspondingly greater.

25. For these reasons we consider that the guidance in paragraph 2.7 of the Code of Practice has no relevance to a conditionally discharged restricted patient. The guidance in paragraph 29.2 of the Code of Practice on the use of informal admission for conditionally discharged patients has a different emphasis:

> *The patient may be willing to accept treatment informally. In these circumstances, however, care should be taken to ensure that the patient's consent is freely given.*

Our view is that if the patient's consent is given only because the alternative is recall, it is not *"freely given"* but is attributable to the coercive power of the restriction order.

26. We now turn to the Home Office guidance on recall and its alternatives, when a conditionally discharged patient may require re-admission to hospital. The following is taken – with our emphasis added - from Mental Health Act 1983, Supervision and After-Care of Conditionally Discharged Restricted Patients. Notes for the Guidance of Supervising Psychiatrists:[118]

> *53. It is not possible to specify all the circumstances in which the Home Secretary may decide to exercise his power under section 42(3) of the Mental Health Act to recall to hospital a conditionally discharged patient, but in considering the recall of a patient he will always have regard to the safety of the public. An immediate report to the Home*

[117] Refer to Chapter 2.8 where the special restrictions are described.
[118] Home Office, Revised 2003.

Office must always be made in a case in which:
a) there appears to be an actual or potential risk to the public;
b) contact with the patient is lost or the patient is unwilling to co-operate with supervision;
c) the patient's behaviour or condition suggest a need for further in-patient treatment in hospital;
d) the patient is charged with or convicted of an offence.

54. Consideration of a case for recall will take into account any steps taken locally to remove the patient from the situation in which he presents a danger. [The Home Office Mental Health Unit] *must be notified at once of the need to readmit a conditionally discharged patient to hospital. The Home Secretary welcomes prompt admission to hospital, either informally or under civil powers, for a short period of observation or treatment. Where admission is voluntary and the patient remains co-operative with treatment in hospital, the Home Office will not normally recall if medical advice is that only a brief period of in- patient treatment is necessary for observation or stabilisation. The patient will again be subject to the formal conditions of his earlier discharge when he leaves hospital. However, it is generally inappropriate for a conditionally discharged patient to remain in hospital for more than a few weeks time informally. If the use of civil powers is necessary to detain a patient or enable compulsory treatment to be given, immediate recall will almost invariably be appropriate to regularise the restricted patient's status under the Act.*

55. In cases where it seems that admission is necessary to protect the public from possible harm the supervising psychiatrist may recommend that the patient be formally recalled to a hospital. The Home Secretary would normally be prepared to act on such a recommendation.

56. Whether the Home Secretary decides to recall a patient depends largely on the degree of danger which the particular patient might present. Where the patient has in the past shown himself capable of serious violence, comparatively minor irregularities in behaviour or failure to co-operate with

supervisors would be sufficient to raise the question of recall. The Home Secretary does not require evidence of deterioration in the patient's condition, but except in an emergency, he will seek medical evidence that the patient is currently mentally disordered. If the patient's history does not suggest that he is likely to present a serious risk, the Home Secretary may be slower to take the initiative unless there are indications of danger to other persons. There are cases in which recall to hospital for a period of observation can be seen as a necessary step in continuing psychiatric treatment. There are other cases in which antisocial behaviour may be unconnected with mental disorder. Recall to hospital will not be used purely in response to offending behaviour. Each case is assessed on its merits in the Home Office and a decision is reached after consultation with the doctor(s) concerned and with the social supervisor. However, the decision will always give precedence to public safety considerations.

57. There has been confusion over the effects of Human Rights law on the use of the recall power. In sum, the position is that a patient may not be recalled to hospital, except in an emergency, in the absence of current objective medical evidence that the patient is mentally disordered. This does not mean that the patient's condition has to have deteriorated; nor that he has to be suffering from disorder to a degree which would justify fresh compulsory admission to hospital. The Home Secretary will consider the recall of a restricted patient where it appears to him that it is necessary for the protection of others from serious harm because the combination of the patient's mental disorder and his behaviour makes it necessary. In emergency he will recall for assessment in the absence of fresh medical evidence of disorder. In such circumstances immediate discharge would follow if the medical assessment found no mental disorder.

27. The Home Office commented further in written evidence to this Inquiry on the use of means other than recall to admit a conditionally discharged patient.

Appropriateness of use of voluntary admissions and use of civil sections

The Home Office accepts that the use of voluntary admissions can have a role to play in the management of restricted patients in the community, provided such admissions are for brief periods, the Home Office is notified immediately, there are no indications of increased risk and no significant deterioration in a patient's mental state.
Use of a civil section will very rarely be appropriate. If a conditionally discharged restricted patient requires compulsory detention under the Mental Health Act it will almost always be appropriate for that patient to be recalled.

28. We now consider whether what was done in this case conformed to the guidance. The evidence is that on 1st September 2004 John Barrett was offered the choice of informal admission or recall. He did not consider that there was any clinical need for him to be in hospital. Our analysis is that he agreed to admission because he knew that the alternative was recall. We therefore conclude that the informal admission was not voluntary, because his consent was not freely given, and it was therefore contrary to good practice. We accept, however, that those involved believed that they were acting in accordance with good practice. Far from wishing to trick John Barrett into admission, as he appeared to believe, they acted as they did because they thought it was in his interests.

29. It is clear that once it was decided on 31st August to admit John Barrett to hospital there was an obligation under paragraph 53(c) of the guidance to notify the Home Office immediately. It would in our view have been lawful for the Home Secretary to have recalled John Barrett that day because he was suffering from a mental illness which warranted in-patient treatment. However, the power of recall is discretionary and before exercising it officials in the Mental Health Unit of the Home Office would, as they told us, have wished to discuss the circumstances with John Barrett's supervisors:

If we had been informed about the admission of 1st September immediately, then the casework manager would have considered whether to recall Mr Barrett. In doing so, he or she would have discussed the case with Mr Barrett's

supervisors before reaching a final decision. It is a matter of speculation as to whether Mr Barrett would, in fact, have been recalled to hospital on the information available at the time. This is due to the fact that any decision whether to recall would have turned, to a large extent, on the discussions with Mr Barrett's supervisors.

30. We consider the Home Office guidance identifies the relevant factors in deciding whether to recall a patient. The purpose of the guidance is not simply to inform practitioners of the Home Secretary's practice, but to direct them on the relevant principles which apply to the exercise of the Home Secretary's discretion. The guidance acknowledges the possibility of a conflict between considerations of public safety, which are the Home Secretary's primary concern, and matters of *"purely clinical practice"*.[119] It seeks to ensure that due weight is given to the former. The guidance expressly encourages the supervising psychiatrist to contact the Home Office in cases where consideration is being given to the admission of a conditionally discharged patient.[120] It thus envisages a dialogue, but the scheme of the Act places on the Home Secretary the ultimate responsibility to decide whether to recall a patient, not on the supervising psychiatrist or the team.

31. The team had a number of clinical considerations in mind when they decided to offer John Barrett informal admission. These were articulated by Dr Mezey in her evidence to us:

We did not think that there were grounds to recall him to hospital, but one of the reasons that we felt that we could work with him and it was appropriate to admit him informally was that he had been entirely co-operative with the team up to that point, so in spite of the other things that we had been hearing, when he had come along he had engaged, he had been working with us.

[119] Paragraph 1 of the Guidance Notes includes the following sentence: *"[The Notes] are intended to cover those aspects of the work which differ from purely clinical practice by virtue of the restriction order, which affords certain priorities to the need for public safety"*.
[120] Paragraph 51 of the Guidance Notes says: *"Telephone discussion in such circumstances is welcomed by staff in the Mental Health Unit"*. Paragraph 70 of the Guidance for social supervisors is in identical terms.

Now, if having heard from us that we felt he needed to be in hospital he then refused to go along with that, that would indicate a withdrawal of co-operation, and that I would have taken very seriously. Going back to the risk assessment plan I would have thought that would suggest he had moved into a different gear, and we would have re-assessed him. We may not at that point then have been able to put a civil section on him, we may or may not, but if he had refused to co-operate and had not been compliant we certainly would have contacted the Home Office and talked to them about possible grounds for recall.

…and we did not change the risk at the time. We were worried about him, we thought he was not as well as he had been, but I don't think any of us felt that he represented a significant risk. If we had done we would have acted differently.

The other thing that influenced us was the May admission, where because of the stresses and pressures outside just bringing him into hospital for 24 hours in May had made a huge difference. We had worked out what was going on, he had felt a lot better and looked after really, and that had been quite a successful admission, so we really hoped that we would be able to do a similar thing again.

32. We do not agree with this analysis which in our view does not, for example in emphasising John Barrett's continuing engagement with the team, accurately represent the quality of his interactions with Dr Dein.[121] Those involved may have had these considerations in mind, but it was still their responsibility to inform the Home Office as it was for the Home Secretary, not the team, to decide whether to recall John Barrett. We think the team made a mistake in treating this like the admission of a patient not subject to a restriction order where it falls to the professionals directly involved to weigh the various considerations and to make the decision whether to admit informally. We therefore conclude that the informal admission on 1st September was contrary to Home Office guidance as it effectively deprived the Home Secretary of the opportunity to recall John Barrett.

[121] On 26th August she had recorded her impression as: "*Sat arms and legs crossed, seemed v. guarded, appeared to be telling me what he thought I would like to hear … V. difficult to assess as he is so guarded*".

33. With regard to the clinical thinking behind the decision to admit informally, there was in our view significant clinical information which, looked at against the background of John Barrett's psychiatric history, indicated increased risk:

- The incident reported on 19th August, referred to above, when he had made a comment to and pointed at a man in the street with a mobile phone and said to JW *"Well he obviously knows me"*.
- The report from John Barrett's brother on 26th August that John Barrett had spoken to his mother in a way that implied he thought his previously held delusional beliefs had been justified.
- The breakdown of his relationship with JW, which had been regarded as a stabilising factor in his life and also as providing the team with information about his mental state and functioning.
- His guardedness when assessed by Dr Dein on 26th August.
- The matters reported by JW on 26th August, including that he had been verbally abusive towards her causing her to feel so frightened that she went to stay with a friend, and that he appeared at times to distracted and to be responding to voices.
- The report received from JW on 31st August, conveyed to other members of the team in Dr Dein's email, that John Barrett was behaving strangely in public, such that strangers tried to avoid him.[122]

34. In our view, these matters indicated deterioration, and increased risk, since Dr Mezey's assessment on 2nd August. That was why he needed to be admitted. If the concern had merely been to establish the extent, if any, of his deterioration then we do not see why this could not have been done, as on 2nd August, by arranging an out-patient appointment with Dr Mezey.

35. It follows, in our view, that the Home Office should have been asked to recall John Barrett on 31st August. If he had been recalled, the team would have had to explain to him the clinical grounds for admitting him to hospital and also why recall was

[122] This corresponds to what Mr A told us about John Barrett's demeanour in August.

necessary in terms of the legal framework for restricted patients and Home Office policy. At the same time it could have been made clear to him that if, following assessment, the team's concerns were allayed they would be able to recommend that he be conditionally discharged again either by the Home Secretary or by the tribunal to which the cases of all recalled patients are automatically referred.[123]

36. We find it surprising that the team did not see it this way. We consider that this was for a combination of reasons. First, that informal admission was seen as preferable, or even as the only legally acceptable option, where a patient could be persuaded to agree to come into hospital, particularly where there was no clear current evidence of psychosis or risky behaviour. Second, that there was a tendency not to attend sufficiently to relevant past and current clinical information. Third, the team's approach to working with John Barrett put a high value on respecting his wishes and securing his co-operation.

37. We put to Ms Sturdy the point that this seemed to us to be another instance where too much weight was given to concerns about jeopardising the therapeutic relationship with John Barrett, as against considerations of public safety. She disagreed:

> *There is nothing in the notes or in verbal evidence that I have given that indicates that this was my concern. It was as a result of my lengthy therapeutic relationship with John Barrett that I was able to insist that he saw me that day and that he complied with that. It was as a result of third party objective evidence about his behaviour that the plan was put in place, which should have addressed the public safety issue.*

We accept, of course, that there was not a conscious weighing up of therapeutic and public safety considerations but we would consider that her response demonstrates that her approach was based on an instinctive preference for getting John Barrett to do what was required without the use of formal legal powers. We consider that the

[123] Where a patient is recalled the Home Secretary must, under section 75(1)(a), refer the case to the Mental Health Review Tribunal within a month of the patient being returned to hospital. Rule 29(cc) of the Mental Health Review Tribunal Rules 1983 requires the tribunal to fix a date for the hearing *"being not later than eight weeks, nor earlier than five weeks, from the date on which the reference was received"*.

proper approach in the case of a restricted patient is to ask whether there is an increased risk. If there is, the presumption must be in favour of the use of formal legal powers.

38. In relation to our conclusion that insufficient attention was paid to relevant clinical information, we start by pointing to the inadequate and inaccurate recording of this key decision and the discussion of John Barrett on 31st August. Of course, we cannot know precisely what was said that day but we accept that the team had grasped the essential point: that worrying information was coming in about John Barrett and they needed to intervene. This is clear from Dr Mezey's evidence:

> *I came back and heard about it, as a team we thought it was worrying. It was one of the aspects of the behaviour that made us think 'Hold on, we need to bring him in and find out what is going on'.*

Admitting him to hospital was a pragmatic response and, as Ms Sturdy rightly says, it could have contained the risk of violence. We would suggest, however, that something more was required. The implication of much of the evidence we have received from those involved is that had they believed the risk was significant they would have asked the Home Office to recall John Barrett. They have failed to demonstrate that the issue of risk was properly considered at the time. We have set out above our view that risk had increased as a necessary consequence of the deterioration in John Barrett's mental state and the other factors to which we have referred.

The execution of the plan

39. We have a number of observations about how the admission was managed. First, as already discussed, we consider that what was intended as a voluntary admission based on professional opinions with which John Barrett did not agree became a coerced admission. Second, he was not told clearly what was expected of him when he agreed to come in informally and he believed he had been misled. Third, that he was inadvertently misled about when he would be seen by Dr Mezey.

40. In the chronological account in Part 1 of this report we have shown how the admission was managed when Ms Sturdy saw John Barrett on 1st September. When we asked her about this she told us:

> *I think there was a clear plan that we had agreed as a team, informal admission, and if that was not going to happen then we would recall him so that he would come in either way. I think that is in accordance with the spirit of the Mental Health Act. You engage with people, and engage them in the process as far as possible, and if it reaches the point where that is not possible then you have to consider the formal.*

41. We have already commented that what Ms Sturdy did, although consistent with what she had agreed with Dr Mezey, amounted to coercion because John Barrett was effectively offered a choice of informal admission or recall.

42. The consequence was that John Barrett thought he had been tricked into accepting informal admission to the Shaftesbury Clinic, even though there was no intention to mislead him. The misunderstanding arose because he believed that informal status entitled him to be on an open ward, a view apparently shared by some of the nursing staff at the Shaftesbury Clinic. We have already said that it should have been made clear to him when his consent to admission was being sought that the only available bed was on the Shaftesbury Clinic. It appears, however, that he did not realise this until after he had accepted informal admission.

43. Ms Sturdy did inadvertently mislead John Barrett in telling him that Dr Mezey would assess him later that day. This is what she had agreed with Dr Mezey when they spoke on the morning of 1st September but Dr Mezey later changed the plan and instead decided she would see John Barrett at the Shaftesbury Clinic the following day.

The decision to grant leave

44. We are satisfied that Dr Mezey alone made the decision to grant John Barrett unescorted ground leave. She did not seek anyone else's opinion. When she made the decision John Barrett had not been assessed by a doctor. We accept that Dr Mezey did take into account the nurses' impression that John Barrett's mental state was stable when he was admitted, in that she would not have granted leave if she had been told that his mental state was disturbed.

45. The context in which Dr Mezey made her decision was that John Barrett had been admitted informally. This is what Mr Sankoh told us:

> *As soon as I got into the office after I left John, Gill Mezey phoned me straight after and said "Sue told me about your concern about admitting John Barrett informally on the ward." I said, "Yes, because of the implication of leave if he wants to go." She said, "No, I will see him later because there isn't any open ward where he could go at this time, but I'm going to give you a plan that we can give him one unescorted leave just to alleviate his anxiety of being admitted on a locked ward. So you give him one hour unescorted leave. However, if he fails to return, could you make sure the staff know to let me know, and Sue also should know. Then if he wants to leave any time out of those hours you put him on* [section] *5(2).*

46. Dr Mezey explained her decision with reference both to John Barrett's status as an informal patient and to his stability of mental state:

> *His legal position was that as an informal patient he was entitled to go. That was my understanding, he was entitled to have some leave.*
> *Given he was an informal patient I think I felt, and the rest of the team agreed, that an hour in the grounds would not be unreasonable.*
> *In terms of a therapeutic alliance, his relationship with us and what we were saying to him was the purpose of the admission, I thought that it would be a short admission and that we just wanted to get a handle on what was going on, it would make him feel more confident if we gave him some leave. If we tried*

to stop that there was a risk that we would make him feel extremely unhappy, alienated, possibly feed into paranoia.

Given the fact that he had been out in the community and living an independent life until five minutes before, and nobody had picked up any new symptoms or anything that was different from what had been happening for the last three weeks, I felt that it would be reasonable for him to be given leave on that basis – but it was based on the assessments of people who knew him well. Dr Dein was concerned that she did not know him as well, but all she picked up was the evasiveness and the fact that he seemed slightly distracted, but certainly Sue Sturdy is very experienced and knew him well, he had been seen by Ken Anakwue, and Alpha had said he was pretty relaxed, he had asked for his clothes to be brought in by his girlfriend. It suggested that he had accepted the admission and therefore leave was reasonable.

47. The suggestion that as an informal patient John Barrett was *"entitled to go"* and *"entitled to have some leave"* is incorrect. Indeed, there is a contradiction between this proposition and Dr Mezey's decision that section 5(2) should be used if he were to attempt to exercise his 'right' as an informal patient to leave (or to attempt to leave) the Shaftesbury Clinic. It is yet further evidence that there was not a clear understanding of the implications of informal admission. If it was legally possible for John Barrett to agree to informal admission to a medium secure unit there is no reason why he could not at the same time have agreed not to have any leave outside the Shaftesbury Clinic, certainly until he had been seen by Dr Mezey. The fact is that he did not agree to either and therefore should not have been admitted informally.

48. As we understand Dr Mezey's position, she considered that John Barrett had agreed to come into hospital and there was reason to believe, based on the good relationship he had with the team and his demeanour as described by nursing staff, that his agreement was sincere. This was despite his unhappiness at finding himself on a ward at the Shaftesbury Clinic rather than an open ward elsewhere in the hospital. As such she considered that he was entitled to have his trust rewarded by some limited leave and she felt this was also therapeutically desirable. Given what she believed to be the stability of his mental state on the day of admission, and the fact that she had no particular concerns about an increased risk to others arising from what had been

reported to the referral meeting on 31st August, Dr Mezey considered it was reasonably prudent to allow him an hour's unescorted leave in the hospital grounds.

49. In reaching her decision we consider that Dr Mezey had an inadequate understanding of John Barrett's deterioration over preceding weeks. She failed to have sufficient regard to the coercive nature of the admission and John Barrett's dislike of confinement, which was known from his history. She therefore did not sufficiently consider the impact of the admission on John Barrett's state of mind. She also appears to have been influenced by the wish to make a concession to John Barrett because of his unhappiness at having been admitted to a secure ward, given also that she was no longer going to see him that day, and by her own mistaken idea that as an informal patient he was entitled to have some leave.

50. John Barrett had told Ms Sturdy and the nurses that he was unhappy about being on a secure ward. This had been communicated to Dr Mezey. What John Barrett did not tell anyone that day was that within a short time of being admitted to the Shaftesbury Clinic he had decided to leave.The best account we have of John Barrett's reasons for absconding on 1st September is in what he told Professor Eastman, who assessed him on 6th September 2004:

> *That when he saw* [Ms Sturdy] *on the Wednesday* [1st September]*, she was concerned about him, particularly because in the past he had been guarded in what he had said about the way he felt. He went on "I said 'if you see anything might be wrong, it is no more than stress about JW'… she said she thought I was unwell and would I come into hospital as a voluntary patient… and said if I didn't then she could have me recalled… I didn't want to go in (but) I agreed because I didn't want to be recalled… I decided I would abscond when I found I would be on a closed ward, but I was going to leave of my own free will, because I was a voluntary patient… I didn't go in intending to abscond; I decided when I was on the ward, after one or two hours… I didn't <u>care</u> I would be recalled, I just had to get out of there because I felt trapped… and I thought it was unfair. I saw a junior doctor, I went on leave and absconded.*

51. Dr Mezey did not know how John Barrett was thinking and it is unlikely he would have told her if she had assessed him on 1st September. But she should have recognised that it was not appropriate to make any decision about leave without having personally assessed him. The criticism we make of her is that she did not put herself in the best position to make the decision.

52 We turn now to the merits of the decision to grant leave. As we understand Dr Mezey's view, she thought it was harsh that John Barrett was on a medium secure unit, having agreed to come into hospital, when there was no clear evidence of increased risk to others. There was a risk of alienating him if he was not granted leave. Her response was to grant him leave. This was clearly a misjudgement, because we now know that he already felt alienated and unhappy enough to decide to abscond.

53. In the decision to grant leave on 1st September there was a failure to take account of John Barrett's previous pattern of behaviour. When he had absconded from hospital 4th June 2000 there had been a clear explanation of why he had done so. The notes for that period show that he was frustrated at not knowing how long he would be in hospital. This should have been a factor in the decision whether to grant leave.

54. For any conditionally discharged patient, being readmitted to hospital otherwise than voluntarily must surely be stressful and disheartening. John Barrett was known to be particularly motivated to avoid readmission. A theme of his in-patient treatment had been that he did not see himself as a patient: hospital was not where he belonged. Dr Dein had noted his concern to avoid readmission when she saw him in August. It was also apparent from his reluctance to agree to informal admission on 1st September and from the unhappiness he expressed to nurses. We believe it should have been in Dr Mezey's mind as a real possibility that John Barrett would abscond if he was granted leave. Indeed, she did consider it to be a possibility because she told Mr Sankoh that if that happened she was to be contacted. This also implies that she was concerned about the implications if he did so. We think this possibility was reason enough to preclude the grant of leave until Dr Mezey had assessed John Barrett. At the very least she had to assess the risk that he would abscond and the possible consequences if he did.

55. We consider that Dr Mezey's judgement in this matter was seriously flawed. If by the time she spoke to Mr Sankoh, Dr Mezey knew that it was not going to be possible for her to see John Barrett that day, we consider that she should have deferred any decision about leave until she had done so, and also had the opportunity to discuss him with colleagues in the team.

Conclusion

56. JW and others expressed concerns about John Barrett's mental state and behaviour in late August. It was clear from Dr Dein's assessments that there had been a deterioration. Self-evidently the risk had increased because John Barrett's risk to others was linked to instability in his mental health. That is surely why the decision was taken to re-admit him to hospital rather than for Dr Mezey to review him in out-patients. The proposition we were invited to accept, that risk had not increased, is illogical and wrong.

57. The admission decision was poorly communicated and executed. Its impact and consequences were ill-planned. The process excluded the Home Office yet the circumstances warranted recall. The decision to grant leave was fundamentally flawed and took place without adequate assessment or discussion.

58. The cumulative effect of these errors was a critical weakening of what should otherwise have been the safety of a readmission to hospital.

Chapter 2.6 - Events Following John Barrett's Abscond on 1st September 2004

Introduction

1. At 3.05pm on 1st September John Barrett was allowed out of the Shaftesbury Clinic for one hour's unescorted leave in the grounds of Springfield Hospital. He did not return. In this chapter we consider the following:

- The communication of information between nursing staff relevant to the risk that John Barrett would abscond while out on leave.
- The actions taken by nursing staff under the Absent Without Leave (AWOL) policy.
- The police response.
- The actions taken on the morning of 2nd September.

The communication of information between nursing staff

2. In paragraph 79 of Chapter 1.7 we have reproduced the entry in the notes made by Mr Sankoh of his conversation with Dr Mezey. Here we are interested in the first and second numbered paragraphs:

> *1. To be granted 1 hour unescorted* [leave] *to the grounds per shift.*
> *2. If he fails to return to contact Dr Gill Mezey and Sue* [Sturdy] *immediately, she will initiate and contact Home Office for a formal recall.*

3. We are satisfied that the second point was not communicated during the nursing handover between Mr Boyce and Ms Hassan. Mr Sankoh's telephone conversation with Dr Mezey took place at 1.45 pm while the nursing handover, which started at about 1.30pm, was still going on. It is accepted by both Mr Sankoh and Mr Boyce that following his conversation with Dr Mezey, Mr Sankoh spoke to Mr Boyce to pass on what Dr Mezey had said. Mr Boyce then spoke to Ms Hassan, who wrote the handover note which reads:

John Barrett Admitted today – Due to break-down. Informal. Dr Mezey to see him. Not to leave until seen. Dr Ken [Anakwue] *saw pt. S/N Mike Boyce handed. Pt can leave ward on 1 hour unescorted.*

4. This note combined elements of the original plan communicated by Ms Sturdy, that John Barrett was not to leave the ward until seen by Dr Mezey, and of Dr Mezey's supervening decision that he was to be allowed one hour's unescorted ground leave that day, even though she had not yet seen him. This tends to confirm what the timings show, that Mr Sankoh communicated the contents of his conversation with Dr Mezey to Mr Boyce while the handover was going on.

5. There is a conflict of evidence between Mr Sankoh and Mr Boyce about how much of the detail of the conversation was communicated to Mr Boyce. Mr Sankoh believes he told Mr Boyce what he recorded as item 2 in his entry in the notes (above), but Mr Boyce says that this was not communicated to him. We accept there is a possibility that in the confusion of the competing demands on nurses' attention, with Dr Mezey's telephone call coinciding with the nursing handover immediately before a staff support meeting, the information was communicated to Mr Boyce but in such circumstances that he did not grasp its significance and therefore did not pass it on to Ms Hassan. On balance, however, we conclude that Mr Boyce's recollection is probably correct. Based on our impression of him, we think it likely that he would have passed this on to Ms Hassan if Mr Sankoh had told him because it was of immediate relevance to John Barrett's management.

6. We do not, however, criticise Mr Sankoh. It is clear that the ward was particularly busy at the time of John Barrett's admission and we think it likely that this affected the way in which information about him was communicated. Mr Sankoh made a full and accurate record in the notes of his conversation with Dr Mezey.

7. Our conclusion is that the system for communication between nurses of important current management information about individual patients was defective. In our view a system which depends on nursing handover and on nurses reading a patient's notes is inadequate to convey such information.

8. We consider that there should be a board, prominently displayed in the nursing office, where current important management information in relation to an individual patient would be written, such as special instructions about leave and action to be taken in the event of a patient not returning from leave**.**

9. If such a system had been in place in September 2004, the expectation would have been that, as well as making an entry in the notes, Mr Sankoh would have written the instruction from Dr Mezey on the board.

Actions taken by nursing staff under the AWOL policy

10. The chronological account in paragraphs 88 – 93 Chapter 1.7 sets out our attempt to reconstruct what Ms Hassan did when John Barrett failed to return from leave. We cannot be confident that it is accurate because Ms Hassan's recording of the times at which she contacted people was inconsistent and unreliable. We consider that she took longer than necessary over the process, even allowing for the time taken to get through to the police because their number was engaged. She did not approach the task in a sufficiently systematic way. This is shown not just by the time she spent but also by her erratic recording. We consider that the task should have been completed more quickly and there should have been a record on the AWOL form showing precisely what she did and when. This is only to state the obvious and to reiterate the requirements of the Trust's AWOL policy.

11. However, we hold back from criticising Ms Hassan personally because we consider that her performance in this instance reflected poor practice that was endemic to the Shaftesbury Clinic with regard to patients going absent without leave. We base this view in part on what we were told by Mr Obamakin, the senior duty nurse who came to Halswell Ward while Ms Hassan was going through the AWOL procedure. When we asked for his observations on the time Ms Hassan had taken he told us:

> *As a practitioner it concerned me, but it is not unusual, and because he is informal, sometimes there is a leeway. So it concerned me as a nurse… but in practice it is not unusual for nurses in that environment or any other part of the Trust to act in such a particular way. On previous occasions, the patient*

might have come back or been caught or whatever… It could be a culture that wasn't good and needs to be improved in that particular environment.

12. We also take into account the report, dated 2nd August 2004, on absconds from the Shaftesbury Clinic which identified poor practice and made recommendations.[124] We are not satisfied that the recommendations had been acted on by the time John Barrett absconded. Those recommendations included:

- *The follow up to an abscond or an escape needs to be standardised, including that the abscond procedure is implemented immediately on abscond.*
- *Risk assessment needs to be owned by the whole team, including nurses, so that when a patient absconds the actual risk is understood and communicated effectively when the abscond policy is implemented.*

There was an acknowledgement by the Trust that at the time of John Barrett's abscond there continued to be a *"training gap"* in respect of the first of these recommendations; and that there was *"ongoing poor understanding of risk and process"* for which training would be provided.

13. We also consider that the inadequacy of staff training in policies and procedures, and particularly of staff like Ms Hassan who worked predominantly at night, was a significant contributory factor to her poor performance on this occasion. More generally, as is acknowledged by senior Trust managers, the management of nurses in the Forensic Service was inadequate and many aspects of nursing performance were poor. We comment further on such matters in Chapter 2.1.

14. In reviewing Ms Hassan's performance in relation to this matter, we have also taken into consideration the review of nursing carried out by Mr Mc Donald,[125] and his evidence to us. When we asked him whether it would have surprised him if a nurse had

[124] Internal Inquiry into five absconsions and escapes from the Shaftesbury Clinic, January – March 2004. South West London and St George's Mental Health Trust.
[125] Refer to Chapter 2.1 for excerpts from Mr Mc Donald's report

taken a long time to implement the abscond procedure and in so doing had not kept an accurate record, he replied:

> *I wouldn't have been surprised by it. In some units that don't function very well you find the threshold changes. In other words, what to you and I may be a real problem that needs to be dealt with straightaway and involve lots of people to come to a decision,* [to them] *it is no big deal, it's not a problem, and they don't know how to do it… I am not sure the nurses at the time were capable of… thinking rationally or applying risk assessment or risk management methods to these kind of things… these things were happening every day; this was not an unusual occurrence. People escaping and absconding, violence and aggression were routine and they had become routine, and nothing was* happening to make [the Trust realise] *it* [was] *a worry or a problem or an issue that needed to be dealt with. It was simply routine… the threshold had changed completely. You go to some units where the management would be much firmer, much more together, more robust on such matters; people would know exactly what to do and who to go to. That was not the case here; this was routine.*

15. We have considered one other area of potential criticism of Ms Hassan, that she did not read the entry Mr Sankoh made in John Barrett's notes that day (paragraph 2 above) which contained Dr Mezey's instruction that she and Ms Sturdy were to be contacted in the event that John Barrett did not return from leave. We have concluded that to criticise Ms Hassan for not reading the entry in the notes would be unfair because it was not a requirement of the AWOL policy that nursing staff should read recent entries in the notes. We are also satisfied that it would not generally have been expected that a nurse in the Shaftesbury Clinic would read the notes in such circumstances. In coming to this view, we have taken into account that, as required by the AWOL policy, Ms Hassan did extract information from the current risk assessment form which was in John Barrett's notes. In our view this shows that she did that which she understood was required of her by the policy. Against the background of the nursing culture Mr Mc Donald described to us, it would be harsh to criticise Ms Hassan for not having read recent entries in the notes.

The police response

16. We consider that the police acted appropriately in going to John Barrett's home in the early hours of 2nd September and reporting their findings to Halswell Ward. This showed, in our view, that the police took seriously the information received from Ms Hassan about John Barrett's history of violence. The police understood that if they had found John Barrett at home they did not have power to require him, as an informal patient, to return to the Shaftesbury Clinic. We do not consider that, having learned that John Barrett was not at home, the police had a responsibility to try to make contact with JW in the early hours of the morning. Indeed, the officers who attended Halswell Ward at 3.30am would presumably have been reassured to learn that JW had reported that John Barrett was staying with a friend and was intending to return to the Shaftesbury Clinic later that morning.

17. As regards the police response to the information received from the Shaftesbury Clinic after John Barrett had left Mr A's flat on the morning of 2nd September, we are satisfied that the police officer who took Ms Hassan's call did contact the mini-cab company to find out where John Barrett was going. The information he was given - that the mini-cab was booked to go to Richmond - did not enable the police to trace John Barrett to Richmond Park. We do not know what efforts were made either by the mini-cab company or by the police, following the police telephone call, to speak to the driver of the car in which John Barrett had travelled to Richmond Park. When the police went to Richmond Park later that morning it was in response to a 999 call made after the attack on Denis Finnegan.

18. We are not in a position to say whether more should have been done by the police that morning to contact the mini-cab driver who had taken John Barrett to Richmond Park. We do not consider ourselves competent to comment on what is a question of police operational practice. We make no criticism of the police.

The actions taken on the morning of 2nd September

19. John Barrett left Mr A's flat at about 8.30am and attacked Denis Finnegan at about 10.00am. There can be no doubt that all those involved on the morning of 2nd

September, including Mr A and JW, were worried that John Barrett might commit a serious violent offence involving the use of a knife. The context in which they acted was that they believed that John Barrett had in his possession a knife and duct tape.[126] They also knew that in January 2002 he had seriously injured three people with a knife, offences for which he was sentenced to a restricted hospital order. The previous day he had absconded from the Shaftesbury Clinic, within three hours of being admitted because of concerns about his deteriorating mental state. The question arises whether those who were in a position to assist the police to prevent what occurred did what could reasonably be expected of them.

20. The key timings, which we believe are accurate to within ten minutes, are as follows:

- 8.30 John Barrett leaves Mr A's flat. Mr A telephones JW but gets no reply.
- 9.00 JW telephones Mr A. He told her that John Barrett had left his flat in a mini-cab and that he had a knife and duct tape with him.
- 9.00 – 9.15 JW phones the Shaftesbury Clinic and speaks to Dr Mezey's secretary who told her that there was no need for her to contact the police as the Shaftesbury Clinic would do so.[127]
- 9.15 Dr Mezey's secretary telephones Dr Mezey who is not at the Shaftesbury Clinic. Dr Mezey asks her to get a nurse to telephone the police.
- 9.30 John Barrett arrives at Richmond Park.
- 9.30 staff nurse Hassan telephones the police. The police telephone the mini-cab company.
- 10.00 Ms Sturdy telephones the Public Protection Unit at Wandsworth police station.
- 10.00 John Barrett fatally attacks Denis Finnegan.

[126] Although John Barrett told police that he had purchased a pack of 3 knives, Mr A saw only one knife in the carrier bag on the morning of 2nd September and that was the information he passed on to JW.
[127] JW told us that she telephoned 3 times in the space of 15 minutes because she was concerned that staff at the Shaftesbury Clinic might delay calling the police. She says that on the third occasion she was told that the police had been contacted.

- 10.15 A 999 call is made from the scene. (Alternatively this may be the time the police arrived in response to the 999 call.)
- 11.00 The police arrest John Barrett in Richmond Park.

21. In looking at the sequence of events our first observation is that JW made a misjudgement in not informing the Shaftesbury Clinic of John Barrett's whereabouts on the night of 1st September. She had been trying to get him admitted, rightly in our view, but when he absconded and she was in a position to help secure his safe return she failed to provide information as to his whereabouts. She gave us the following explanation:

JW *I rang the ward to tell them I'd just spoken to John, he was staying at a friend's in Belsize Park – I might have said where, I'm not sure, probably not – and that he said he was going to go back tomorrow. I categorically didn't tell them where he was, and I know why I didn't tell them, because I didn't want them sending the police round because then I did think John and Mr A would be at risk, rightly or wrongly.*

Q. *Why did you think that?*

JW *Because I thought the police would go storming in.*

Q. *Why would that put John and Mr A at risk, in your opinion as it was then?*

JW *Because John was very paranoid and delusional, as we'd all known for weeks and weeks, and he'd just absconded because of what he was thinking. As I'm sure often happens in those cases, I thought they'd go storming in and they could shoot John.*

22. We do not find this convincing. It may well have been that JW was understandably relieved to know John Barrett was in a safe place, spending the night with Mr A, and she believed him when he told her that he would return to the Shaftesbury Clinic in the morning.

23. We think it would have been better on the morning of 2nd September if Mr A and JW had telephoned the police themselves, as well as contacting the Shaftesbury Clinic. In saying this we do not suggest that it would have affected the outcome, though the police might then have been able to obtain more precise information from the mini-cab company about where they had taken John Barrett.

24. Regarding the response of others who were directly involved that morning, we make no criticism of them. We accept that it was entirely appropriate for Dr Mezey's secretary to speak to Dr Mezey before acting on JW's telephone call; and that Dr Mezey, who was not at the Shaftesbury Clinic when contacted by her secretary, was right to ask her secretary to get nursing staff to telephone the police. They had John Barrett's file and were therefore in the best position to provide the information the police would need. Staff nurse Hassan acted promptly in telephoning the police and gave them the relevant information.

25. It has been suggested to us that staff at the Shaftesbury Clinic took longer than necessary to telephone the police on 2nd September. If JW first spoke to Dr Mezey's secretary just after 9am and if the telephone call to the police was not made until 9.30, there would appear to have been significant delay. However, we cannot be confident that the timings are sufficiently accurate to enable us to reach a conclusion on this issue. Those involved on the day did not record when telephone calls were made or received, and we would not have expected them to have done so. We attempted to obtain a log of the exact times when telephone calls were made from the Shaftesbury Clinic to the police but this information was not available because the telephone system had been changed since 2004. That is why we have said that the times in paragraph 20 above are accurate only to within ten minutes. In the absence of more precise information we are not in a position to comment further, save that our impression is that those involved appear to have understood immediately the significance of what JW told Dr Mezey's secretary and they acted accordingly.

Chapter 2.7 - Mental Health Review Tribunal

Introduction

1. In this chapter we consider the extent to which the procedures of the tribunal ensured that there was an adequate inquiry into John Barrett's case before conditional discharge was ordered on 10th October 2003.

2. We start with a description of the tribunal process in John Barrett's case. We then consider the following issues which arise from our consideration of the case: who should have given the medical evidence at the tribunal hearing, the thoroughness of the hearing, the tribunal's written reasons and the role of the Home Secretary in the proceedings. We make a number of recommendations.

3. Tribunal hearings almost always take place in private and are therefore not subject to the public scrutiny that attends open court hearings. Their private nature reflects their subject matter, concerning medical and personal matters affecting the detained patient. It is only by means of an inquiry such as this that the public finds out how such proceedings are conducted.

The tribunal process

4. John Barrett applied to the tribunal in July 2003. Written evidence was filed in the proceedings as follows: a medical report dated 19th September 2003 by Dr Ferris, SpR; social circumstances reports by Ms Sturdy, dated 20th May 2003 (originally prepared in connection with a previous tribunal application which John Barrett had withdrawn in June 2003) and 4th August 2003; and a medical report dated 19th September 2003 by Dr Frank Farnham, consultant forensic psychiatrist, which was filed by John Barrett's solicitors. All these reports recommended conditional discharge, except that the recommendation in the first social circumstances report was qualified by the proviso that John Barrett should be tested with a period of regular unescorted community leave before discharge. Copies of all reports were sent to the Home Office.

5. The Home Secretary filed statements dated 5th September 2003 (with a list of previous convictions attached) and 6th October 2003. The 5th September statement included an account of the January 2002 offences. It also conveyed the Home Secretary's observations on the reports and on John Barrett's suitability for discharge:

> *The Home Secretary is strongly opposed to discharge at this time and believes it is premature. The Home Secretary notes that Mr Barrett tends to minimise the extent and severity of his illness, and the risk of relapse. He is also aware that Mr Barrett does not respect the need for medication and is further aware that as recently as May he ceased taking his medication and had experienced a recrudescence of his symptoms. The Home Secretary believes that Mr Barrett needs to develop further insight in these areas before conditional discharge.*
>
> *The Home Secretary also notes that Mr Barrett has only recently undertaken unescorted leave in the local area and believes that, again before discharge, he should be further tested in this area.*

6. The first Home Office statement in relation to the October hearing, although it was prepared more than a month beforehand, appears not to have been seen by any member of the care team until the day of the hearing. This meant that there was no opportunity for the team to discuss the Home Secretary's objections to John Barrett's discharge. When we raised this with Dr Dhar and Dr Mezey, they told us that it is common practice for the Home Office statement to be seen for the first time immediately before the hearing. We deprecate this practice, which risks not giving the Home Office statement the consideration it merits.

7. The tribunal rules require the Home Office to file its statement in good time before the hearing. We would expect members of the multi-disciplinary team to obtain a copy of the Home Office statement in advance of the hearing through the Trust's Mental Health Act administrator. This would require the team to have a system for diarising tribunals and chasing the Home Office statement if they have not received it within a reasonable time before the hearing date. The team would then be in a position to consider the statement and take the Home Secretary's views into account in preparing for the hearing.

8. The application was heard on 10th October 2003. Under section 73 of the Mental Health Act, as amended in 2001, a tribunal must discharge a restricted patient unless it is satisfied that:

> *(i) He is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; and*
> *(ii) It is necessary for the health and safety of the patient or for the protection of other persons that he should receive such treatment.*

If the tribunal is not satisfied as to those matters, the patient's discharge will be conditional, rather than absolute, unless the tribunal is satisfied that it is not appropriate for him *"to remain liable to be recalled to hospital for further treatment."*

9. Oral evidence was given by Dr Dhar, Ms Sturdy, a nurse, John Barrett himself and his partner JW. No one attended from the Home Office. John Barrett was represented by a solicitor. No one else had legal representation. The decision form records that the hearing finished at 3.15pm, having been listed to start at 2.30pm, suggesting it lasted for 45 minutes. According to John Barrett's solicitor's attendance note the hearing was 54 minutes. Whichever figure is accurate, this includes the time spent on introductions, the president's outline of the procedure, the entirety of the evidence and John Barrett's solicitor's closing submissions as well as the announcement of the tribunal's decision by the president.

10. John Barrett was conditionally discharged. The conditions as they appeared on the typed decision form were:

1. *To reside at* [his home address in Putney].
2. *To see a psychiatric team member as required but at least once a month and a community psychiatric nurse and social supervisor as required but at least once per fortnight.*

3. *To submit to long (sic) screening and testing as required.*
4. *To continue to comply with prescribed medication.*
5. *To refrain from the use of illicit drugs.*

11. These are the tribunal's reasons for its decision, exactly as they were typed on the decision form, including all the errors:

> *The patient suffers from mental illness, delusional disorder, but it is no longer of a nature or degree to warrant his continual detention, not is he perceived as a risk to himself and to others. This condition has stabilised owing to compliance with medication and he has developed insight with his offending, his mental illness, and the dangers to his mental state of illicit drug use, and non-compliance with medication. Both written psychiatric reports and his oral evidence of a trained psychiatrist all supported a conditional discharge as did all members of the multi-disciplinary team. He has been symptom fee for several months.*
>
> *We are satisfied that he now has appropriate insight into the issues raided by the Home Secretary in his statements. Moreover, he has been allowed greater liberty, not only with ground leave, but also a developing number of unescorted visits to his flat, including an overnight stay. A S117 meeting has put in place a package of community support which addresses the patients' needs and with which he is prepared to comply. These elements are incorporated with the conditions set out above.*

12. The decision form was not signed personally by the judge who presided but by someone *per pro*.

13. In the discussion which follows it is not our intention to question the merits of the tribunal's decision. We confine ourselves, as required by our terms of reference, to the process by which the tribunal arrived at its decision. We have the following concerns:

- The medical evidence at the hearing was given by a doctor who was neither the RMO nor the author of the medical report and who had only recently joined the team with responsibility for John Barrett's care.
- The length and thoroughness of the hearing, with particular reference to the approach taken to the Home Secretary's reasons for opposing discharge.
- The quality of the written reasons and the fact that the decision form was not signed by the tribunal president.
- The Home Secretary's role in the proceedings.

The medical evidence

14. At the time of the hearing John Barrett had been at the Shaftesbury Clinic for 18 months, for the last 12 months as a patient of Dr Mezey. The recommendation was for a conditional discharge under which Dr Mezey would be the supervising psychiatrist. The report for the tribunal had been written by an SpR, Dr Ferris, under Dr Mezey's supervision. The Home Office had expressed strong opposition to conditional discharge. Dr Ferris had left the Shaftesbury Clinic and been replaced by Dr Dhar who had known John Barrett only since September.

15. We note that the date of the tribunal hearing was fixed on 31st July, more than two months in advance. We assume, as is normal practice, that the date would have been agreed with the hospital in advance, so there would have been no difficulty, had she so wished, for Dr Mezey to attend the hearing or to have influenced the date to avoid any period of planned leave. We asked both Dr Mezey and Dr Dhar whether they were satisfied that Dr Dhar's knowledge of Mr Barrett was sufficient to enable him to give oral evidence at the hearing. Dr Mezey told us:

> *I knew he* [Dr Dhar] *was rather good because he had a reputation as being quite good. I am the training programme director for the service, and so I inherited Dr Dhar from at least two other consultants who had all passed on reports about Dr Dhar's performance, and I had seen Dr Dhar in court giving evidence. He was a very senior and experienced SpR and we talked about the case, he understood what the issues were with John Barrett, he had read the report by Dr Ferris, I had seen the report by Dr Ferris and supervised the*

report. I think we felt when we came to the tribunal that it was going to be relatively uncontroversial. We were supporting conditional discharge and we felt that John Barrett would come across quite well in the Tribunal, he would do quite well. So I was confident that Dr Dhar would be able to represent the psychiatric view extremely competently.

Dr Dhar commented as follows:

As regards being put in that position, there was quite a thorough report that was written by my predecessor. All of the decision-making that involved his discharge was done prior to my entering the team, and the team I thought had made a careful decision at that point. There was also an independent report by a senior consultant psychiatrist for the purposes of the Tribunal so my recollection of the Tribunal itself was that I was just speaking to the report and the evidence that was already there.

16. In response to our questions to her, Dr Mezey pointed out that the training handbook from the Royal College of Psychiatrists:

Requires SpRs to gain experience in their training in the full range of activities and experiences that they would be expected to encounter as a consultant. Without the opportunity to manage patients in all levels of security, give evidence at tribunals and managers' hearings, prepare reports etc., they would qualify as consultants without being equipped to manage those tasks and responsibilities. Clearly SpRs should only be asked to take tasks that are appropriate for their level of training and seniority and only with the support and under the supervision of their educational supervisor (the consultant).

Dr Mezey advised us that:

In Dr Dhar's case he was three months away from completing his three year training to be a consultant when he gave evidence at John Barrett's tribunal and was therefore extremely senior and competent to do this and in line with the Royal College guidance on training SpRs so that by the end of three years

they have the knowledge and skills to be able to function as consultant forensic psychiatrists.

17. We also acknowledge that the tribunal was satisfied by Dr Dhar's evidence, and if it had not been the hearing could have adjourned with a direction for Dr Mezey to attend.[128] Nonetheless we are not persuaded that it was appropriate for Dr Mezey to ask Dr Dhar to attend the tribunal in her place.

18. In general adult psychiatry detained patients are principally held under sections of the Mental Health Act 1983 which are relatively short in their duration – section 2 for 28 days and section 3 for up to 6 months in the first instance. Some patients having commenced treatment under section 2 are then later detained under section 3. Patients have a right of appeal to the tribunal during every period of detention, and in some circumstances they also have a separate right of appeal to the hospital managers. It is therefore possible for a patient to have two appeal hearings after perhaps 14 days (under section 2) and then a further two hearings under section 3 after perhaps an additional six weeks. In such a case there would thus be four appeals within a period of perhaps eight weeks, a frequency of one fortnightly. Each appeal is likely to occupy staff for between two and four hours attendance at the meeting. This can have a significant impact upon RMO workload, and divert them from direct patient care, in an arena such as a busy acute ward. In such circumstances, perhaps where no member of the clinical team has more than a few weeks knowledge of the patient, it is entirely appropriate that a junior member of the medical team should both prepare the tribunal report and attend the hearing to give oral evidence, always providing that an appropriate supervisory system is in place. Indeed, it may be the junior medical member of the team whose daily contact with the patient is greater than that of the consultant and who therefore is better placed to give up-to-date evidence. Ultimately, the consultant should be in the optimum position to give an overall view of the totality of the team's opinion. Reports for the tribunal are only statutorily required to be provided from the disciplines of medicine and social work. Provision of extra material, for example from psychology, occupational therapy, any specialist therapies, and nursing, is on a voluntary basis and in cases where no such reports are provided it is

[128] For a case where a tribunal adjourned and directed the attendance of the RMO, see R (X) v MHRT EWHC [2003] 299.

the responsibility of the RMO to speak to the overview provided by contributions from their colleagues of other disciplines.

19. The situation in a medium secure unit is frequently different from that described above. It differs in that the duration of patient stay is longer, measured in months or years rather than weeks, and there is therefore an impact on the selection of medical staff who can provide in-depth knowledge. This arises because trainee staff at some levels are usually employed on short contracts, rotating between various placements so as to gain rounded experience. Thus an SHO will normally only spend six months with any one team and group of patients, and an SpR up to one year before moving on. In addition, it is almost invariable that the stakes are higher in respect of public protection in a medium secure unit since that is why the patient is detained in such a setting. These factors combine so as to skew towards a presumption that the evidence should be provided by the RMO. This presumption must however be examined in the light of needing to ensure that a consultant, when appointed, has had adequate experience during their training of presenting such evidence. This can be done only by the trainee giving evidence under supervision. We conclude, however, that there are key factors which should influence the decision as to whether the RMO, or a deputy by way of a trainee, should attend the tribunal to give oral evidence. In formulating these conclusions, it is pre-supposed that the written evidence, whichever member of the medical team compiled it, was prepared under the direct supervision of the consultant such that the consultant is aware of and has influenced its content.

20. Our view is that where the case presents issues of complexity, such as in diagnosis, treatment applicability, limited understanding of factors in the index offence, confounding personality variables, or where the nature of the disorder makes it necessary to take a longer view than a snapshot of a few months, then the oral evidence should be presented by the consultant or in the alternative by a trainee under the direct supervision of the consultant during the course of the tribunal, such that both staff are present in the tribunal hearing. In this way most, if not all, the oral evidence would be presented by the trainee. However, the consultant would be immediately available to the tribunal to answer questions of a complexity or importance outside the trainee's experience, and also directly to supervise at first hand the trainee's performance. We have one further conclusion in this regard,

relating to the views of the Home Office. The Home Secretary is as a matter of course likely to oppose the discharge of a restricted patient. This is because, unless and until the Home Secretary is supplied with evidence from the clinical team indicating suitability for discharge, he must assume that the criteria for detention are met. Additionally, he acts through Home Office officials as a valuable filter to the RMO's decision-making to ask questions independently on risk and response to treatment. By this means the public has an additional protective mechanism beyond relying solely upon the views of the RMO which may be well-founded but partial. We have considered carefully what happens when the Home Secretary does not merely make a general statement that in the light of all the evidence the patient is not suitable for discharge, but instead raises specific and detailed points of objection, based on the evidence in the form of reports supplied to the Home Office, and by this means opposes discharge based upon specified issues. We conclude that such circumstances should lower the threshold at which the consultant should attend the hearing in person.

21. It could be argued that for a consultant to attend all such hearings would be an onerous drain on consultant time. We do not accept such a proposition. In a medium secure unit where a consultant may have 15 in-patients, perhaps 60 per cent of whom are subject to Home Office restrictions under the Mental Health Act, this would equate to some 10 patients. These patients are likely to be in the category of those whose disorder has been present for more than a few months and are as a consequence likely to be eligible to have a tribunal hearing once in each 12 month period. Of these, not all will have specific objections lodged by the Home Office, in the manner described, before their tribunal hearing. Even if all of them did fall into this category, this therefore is still a total of 10 patients per year. Allowing for annual leave, this equates to an average of one tribunal hearing a month. That is hardly onerous. It is also not onerous when one considers that, far from being random and at short notice, tribunal hearings for such patients can be fixed many weeks in advance, incorporating the RMO's availability as well as that of other parties. We conclude, therefore, that in the circumstances described in this part of our report, it should be the norm for consultants to appear at a tribunal hearing to give oral evidence and that this norm should be departed from only in exceptional circumstances.

22. We now turn to John Barrett's tribunal hearing in October 2003. The written medical evidence was provided by Dr Ferris. The oral evidence was provided by Dr Dhar who had been in post in Dr Mezey's team since September, having replaced Dr Ferris, thus having known John Barrett for only a few weeks. The date of the tribunal hearing was known some 11 weeks in advance, having been fixed on 31st July. Dr Dhar told us that his knowledge of John Barrett was sufficient for him to be able to give oral evidence to the tribunal. Given his snapshot view of the case, having been presented with reports, prepared by others, supportive of discharge, and with an indication from his supervisor Dr Mezey that he was an appropriate person, we conclude that it was not unreasonable for him to have reached that view. Dr Mezey also told us that because of Dr Dhar's level of experience, in effect being toward the end of his training, she believed that it was appropriate that he attend to give oral evidence in substitution for her.

23. John Barrett's case was complex. The risks to the public were potentially substantial. His clinical progress had been erratic. There were concerns evident from members of the team as late as August 2003. The Home Office provided strong and specific objections. For these reasons, given our foregoing comments, we conclude that Dr Mezey was mistaken in her judgment not to attend the hearing.

24. The tribunal is an independent judicial body which, in order properly to discharge its functions in balancing the rights of the individual against the risks he may present, requires the best quality evidence. It is essential that the multi-disciplinary team do not prejudge the outcome. It is also the case that the RMO is a representative of the Trust which has a separate interest in ensuring that it discharges its responsibilities for the good of the individual and of society as a whole. The Trust must be satisfied, by the exercise of its rights as an employer, that those who give evidence on its behalf do so from a position of appropriate skill and experience.

The thoroughness of the hearing

25. The nature of a hearing before the tribunal is inquisitorial, not adversarial.[129] In all cases there is clearly a public interest involved but in restricted cases this is reinforced by the role of the Home Secretary as a: "*vitally interested party*",[130] who "*is the only party capable of representing any interest that the public may have in opposing an application for… discharge*".[131]

26. An inquisitorial procedure where all the witnesses are in agreement puts a heavy burden on the tribunal to examine the evidence critically and with care as part of the process of deciding whether or not it is satisfied of the relevant matters under section 73 of the Mental Health Act. It is essential that the evidence is adequately tested if poor decisions are to be avoided and if there is to be public confidence in the thoroughness of the process.

27. There is no transcript of the hearing and we received a letter from the judge saying that he no longer has his note of the evidence. But we do have a typewritten note made immediately afterwards by John Barrett's solicitor. We reproduce an extract from this as Appendix B. Our impression is that questioning of witnesses by the tribunal was superficial. This may be because the note is an incomplete record, but we think it is probably an accurate impression, given that evidence was taken from five witnesses in a hearing lasting less than an hour. Our impression is also reinforced by the tribunal's written reasons on which we comment below.

28. While there may be cases where a short hearing is sufficient because the reports are comprehensive and the evidence is uncontested, we consider this was not such a case. The Home Secretary had expressed strong opposition to discharge and had put forward reasoned objections. As the Home Secretary was not represented, it was the responsibility of the tribunal to ensure that his objections were put to witnesses. According to the solicitor's note of the hearing, this was done. For example, the note records Dr Dhar as saying that:

[129] W v Egdell [1990] Ch 359.
[130] Campbell v Home Secretary [1988] AC 120, per Lord Bridge at p. 126.
[131] R (Home Secretary) v MHRT (AO as interested party) [2004] MHLR 170.

John Barrett does respect the need for medication contrary to HO view and also the reasons why it is effective. The team will need to work on spotting a possible relapse in the future and cannot be too complacent. John Barrett has engaged with the care plan and his leave has been useful and sufficient.

The sufficiency of the testing by means of unescorted leave was also raised with Ms Sturdy. According to the note, "*her view is that he has had enough leave already*". John Barrett was also asked about his insight and his attitude to treatment and he was specifically questioned by the tribunal president about his attitude to cannabis. Our impression from the solicitor's note is that these matters were covered but not in a way that effectively tested the evidence.

29. Given the public interest in a decision of this kind, we would have expected a more thorough inquiry into the evidence. For example, neither the solicitor's note nor the written reasons mention John Barrett's attitude to the January 2002 index offences. Yet Dr Ferris's report stated that he continued "*to minimise some aspects of the offence and to believe that he had been provoked by the victim*". The only mention in any of the reports of regret for what he had done was that, when he discussed the offences with Dr Farnham, he "*appeared to express some shame and guilt at the offence, and the likely effect on his victim*".[132] His attitude to the offences and his victims appears not to have been explored at the hearing. There was apparently no inquiry into how he would spend his time after discharge, even though a need for structured activity had been identified as an important factor in maintaining stability. It was said in the second social circumstances report that "*he continues to attend his* [in-patient] *OT programme …and he has also been applying to local colleges for courses as a sports instructor*". The situation was far from clear but, according to the note, clarification was not sought at the hearing. Perhaps the most significant point is that, in the Home Office's words, John Barrett "*tend*[ed] *to minimise the extent and severity of his illness, and the risk of relapse*". These words were taken directly from Dr Ferris's report. This was an issue that merited critical scrutiny but what was apparently sought from Dr Dhar was reassurance, which he was able to give.

[132] There were in fact three victims.

30. We accept that we have had the time to look at John Barrett's case in much greater detail than would be possible for a tribunal, but we base our observations on what we believe it is reasonable to expect of a tribunal. A hearing of between 45 and 54 minutes for a case of this kind is remarkably short. If the tribunal had spent longer on the case it is likely that its inquiry would have been more thorough, but that is to assume that the members knew what to ask. It is not for this Inquiry to make general recommendations about the conduct of tribunals. However, given our concerns about the hearing, **we recommend that John Barrett's case, even if it is not representative, should be reviewed by the Department for Constitutional Affairs with a view to improving tribunal procedures in restricted cases.** The questions that merit particular attention concern the sufficiency of information provided to tribunals in restricted cases, for example in relation to risk assessment and risk management, and the knowledge and skills required of tribunal members who sit in restricted cases. All legal members of the tribunal are entitled to sit on unrestricted cases, however to preside over a restricted case, the lawyer must either be a Circuit Judge or a Recorder who is also a QC. There is no corresponding requirement upon lay and medical members that differentiates those eligible to sit on restricted cases. Another issue for such a review is the role of the Home Office in tribunal proceedings, which we consider below.

The tribunal's written reasons

31. The adequacy of reasons given by tribunals is susceptible to judicial review at the suit of the parties and is also a matter of public interest:

> *What is at stake in these cases is the liberty of detained patients on the one hand, and their safety as well as that of other members of the public on the other hand. Both the detained persons and members of the public are entitled to adequate reasons.*[133]

[133] R (Ashworth Hospital Authority) v MHRT [2002] MHLR 314, per Dyson LJ at paragraph 76.

The handbook issued to tribunal members contains advice about reasons, which has been approved by the Court of Appeal:

> *Tribunals must give detailed reasons, based on the evidence and the logical application of sound judicial principles, for their decisions… The reasons need not be elaborate but they must deal with the substantive points which have been raised and must show the parties the basis on which the Tribunal has acted.*

The Joint Home Office – Mental Health Review Tribunal Guidance which was issued in October 2004 contains the following paragraph on reasons:

> *It is essential that accurate, good quality reasons are given by the tribunal for any decision that they reach. Poorly expressed, or inaccurate, reasons can lead to decisions being challenged. It is also important to bear in mind that the written reasons will be the only explanation that the Home Office will usually have for the tribunal's decision, as the Home Secretary will not normally have been represented at the tribunal, so will not have heard the oral evidence that the tribunal have.*[134]

32. Confining ourselves to the question of John Barrett's insight, in our view the tribunal's reasons failed to deal adequately with the Home Secretary's observation on this point that: "*Mr Barrett tends to minimise the extent and severity of his illness, and the risk of relapse*". As we have said, Dr Ferris's report made the same points as the Home Secretary, while coming to a different conclusion about discharge. It is true that Dr Farnham, who had met John Barrett only once, was more positive about his insight, saying:

> *He appears to have done a great deal of meaningful psychological work addressing insight and compliance, and, although it is always possible that individuals may have picked up some 'training' in relation to appropriate responses to questions aimed at exploring insight and compliance, it appears*

[134] Joint Home Office – Mental Health Review Tribunal Guidance, October 2004, paragraph 3.4.

to me that Mr Barrett has made genuine and significant psychological advances in these areas.

The tribunal's findings, that: "*he has developed insight"* and that "*he now has appropriate insight into the issues raised by the Home Secretary"*, do not demonstrate whether the tribunal accepted, or rejected, the evidence that John Barrett tended to minimise the severity of his illness and the risk of relapse.

33. While judicial review is available to a party – including in a restricted case the Home Secretary - who considers that a tribunal has failed to provide adequate reasons for its decision, it is not the primary purpose of judicial review proceedings to serve as a corrective to poorly expressed or inadequate reasons. This issue also needs to be dealt with administratively. **We recommend that the Home Office should scrutinise the reasons in every case where a restricted patient is discharged. In those cases where they are considered inadequate but it is decided not to apply for judicial review the Home Office should make representations to the regional chairman of the tribunal about the quality of the written reasons.** We would urge the same course on other parties to tribunal proceedings. We appreciate that the regional chairman is not able to interfere in a judicial decision but he could draw the criticisms to the attention of the tribunal members concerned, including the lay and medical members as well as the legal member. This is also a matter that could be addressed through training of tribunal members.

34. Rule 23 of the Mental Health Review Tribunal Rules 1983 provides that:

the decision by which the Tribunal determines an application shall be recorded in writing; the record shall be signed by the president and shall give the reasons for the decision…

The decision form in this case did not comply with this requirement and we have no doubt that had the president read the typed form he would have corrected the numerous typographical and grammatical mistakes. **We recommend that the regional chairmen remind presidents and tribunal staff of this requirement.**

The Home Secretary's role in the proceedings

35. In restricted cases, the Home Secretary represents the public interest in tribunal proceedings. In a case such as this where all the evidence supports discharge and the Home Secretary takes the contrary view, it is essential that the procedure ensures his view is taken into account and used to test the evidence. This should normally be achieved by effective inquisitorial questioning of witnesses by the tribunal. However, in this case we doubt whether due weight was given to the Home Secretary's reasons for opposing discharge.

36. It is open to the Home Secretary in every restricted case to be represented at the hearing, either by an official from the mental health unit or by a solicitor or barrister. Where the Home Secretary is represented questions can be asked of witnesses on his behalf. The Home Secretary may also file his own expert evidence, for example by instructing a consultant forensic psychiatrist to provide a report on the patient.

37. Current Home Office policy is to be represented only very rarely:

> *Typically, there are only about a dozen or so hearings a year at which the Home Office is represented. While it is impossible to set down rigid criteria for those cases where the Home Office will seek representation, the following indicates the type of case where the Home Office may consider representation. This is, of course, without prejudice, to the Home Office's position that it may seek representation in any case where it feels it is appropriate. The Home Office assessment is that the patient poses a particularly serious risk if discharged or there appears, from the reports submitted, to be a genuine prospect of discharge.*
> *Representation is normally reserved for the small minority of cases where the risk to the public is assessed as particularly grave. Typically, cases where there appears to be a prospect of discharge from a high secure hospital, or perhaps, where Absolute Discharge is recommended from medium security where there are serious concerns about public safety.*

38. It was reasonable that John Barrett's case was not seen as one of the small minority where the risk was particularly grave. It was therefore consistent with the policy for the Home Secretary not to be represented. But the case highlights a different sort of problem, which is that where all the evidence, except the Home Office statement, points towards discharge, the Home Secretary's views may carry little weight with the tribunal. **Where, as in this case, the Home Secretary is strongly opposed to a discharge which is supported by the multi-disciplinary team responsible for the patient, we recommend that consideration should always be given to the Home secretary being represented.** We believe that if he had been represented on 10th October 2003 the hearing would have been demonstrably more thorough. This is not to say that the outcome would have been different.

39. In most cases the Home Secretary will continue not to be represented and his views will be communicated to the tribunal by his written statement. We consider that statements could be drafted so as more effectively to direct the tribunal's attention to the substantive points that are of concern to the Home Secretary and also to the evidence on which they are based. Taking the statement in this case as an example, and confining ourselves to the points made in it, arguably it would have been more effective if the relevant part had said:

> The Home Secretary strongly opposes discharge at this time and believes it is premature.
>
> He invites the tribunal to consider the following points:
>
> - Mr Barrett tends to minimise the extent and severity of his illness and the risk of relapse – see Dr Ferris's report.
> - Mr Barrett as recently as May this year stopped his medication, which shows a lack of insight into his illness and into the need for medication.
> - When he stopped medication the symptoms quickly returned which shows the fragility of his mental state.
> - Taking these points together, the Home Secretary considers that the risk of relapse and of further violence is such that discharge should not be ordered until Mr Barrett has developed further insight.

- The Home Secretary notes that in May 2003 it was said that Mr Barrett should have a period of regular unescorted community leaves before his discharge from hospital – see Ms Sturdy's report dated 20th May 2003. The Home Secretary considers that Mr Barrett has not yet had sufficient leave to test his stability when outside hospital and his capacity to resist the temptations to which he will be exposed, such as drugs and alcohol.

40. If the statement had been drafted in this way we doubt whether the tribunal in its written reasons would have dealt with the Home Secretary's objections in such general terms, without making detailed findings on the evidence. **We therefore recommend that the Home Office, in consultation with the tribunal, reviews the format of statements it prepares in restricted cases.**

Chapter 2.8 - Home Office

Introduction

1. In this chapter we describe the Home Office's role under the Mental Health Act 1983 in the management of restricted patients. We then consider the reporting to the Home Office in John Barrett's case and the consideration given to reports by the Home Office. We make a number of recommendations.

The restricted patient regime and reporting requirements

2. On 20th September 2002, following his conviction for three offences under the Offences Against the Person Act 1861, John Barrett was made subject to a restricted hospital order under sections 37/41 of the Mental Health Act 1983. A restricted hospital order is made only where the sentencing court is satisfied that:

> *Having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, …it is necessary for the protection of the public from serious harm…*

The classic judicial statement about the nature of a restricted hospital order, as compared with an unrestricted hospital order, is to be found in the case of R v Birch:

> *No longer is the offender regarded simply as a patient whose interests are paramount. No longer is control of him handed over to the hospital authorities. Instead the interests of public safety are regarded by transferring the responsibility for discharge from the responsible medical officer and the hospital to… the Secretary of State and the MHRT.*[135]

3. It is not only that a restricted patient cannot be discharged by the RMO or the hospital managers. Section 41(1) of the Mental Health Act provides that he cannot be granted leave of absence from hospital (under section 17) or transferred to another

[135] R v Birch (1989) 11 Cr. App. R. (S.) 202.

hospital (under section 19) without the Home Secretary's consent. The Home Office has issued guidance to RMOs on making requests for leave,[136] from which the following two paragraphs are taken:

> *6. The Secretary of State recognises that well thought out leave, which serves a definable purpose and is carefully and sensitively executed, continues to have an important part to play in the treatment and rehabilitation of restricted patients by assisting their progress towards eventual discharge into the community. It also provides valuable information to help responsible medical officers, and the Home Office in managing the patient in hospital, and to all parties including the tribunal when considering discharge into the community.*
>
> *7. It is important that leave programmes should be designed and conducted in such a way as to sustain public confidence in the arrangements as a whole, and so as to respect the feelings and possible fears of victims and others who may have been affected by the offences.*

We consider elsewhere in this report the requests made to the Home Office for leave in John Barrett's case and we say nothing more about this here.[137]

4. Section 41(6) requires the RMO for a restricted patient to report annually to the Home Secretary on the patient's progress.

5. Where, under section 73 of the Act, a tribunal orders the discharge of a restricted patient this will be conditional unless the tribunal is satisfied that *"it is not appropriate for the patient to remain liable to be recalled to hospital"*. A conditionally discharged patient continues to be subject to a restriction order and the Home Secretary can recall him to hospital by warrant at any time under section 42(3).

[136] Guidance to Responsible Medical Officers on leave of absence for patients subject to restrictions under sections 41, 45A and 49 of the Mental Health Act 1983 and under the Criminal Procedure (Insanity) Acts (12th September 2001).
[137] Refer to Chapter 2.3

6. A conditionally discharged patient will usually have a supervising psychiatrist and a social supervisor and be subject to conditions imposed either by the tribunal or by the Home Secretary. It is the responsibility of the patient's supervisors to report regularly to the Home Office on the patient's circumstances. The normal requirement for both supervisors is to report one month after conditional discharge and three-monthly thereafter.

7. The purpose of the reporting requirements following conditional discharge is explained in the Notes for the Guidance of Supervising Psychiatrists:

> *It is the Home Secretary's continuing function following the conditional discharge of a restricted patient, to be satisfied that danger to the patient or to others is being minimised by effective supervision, and by appropriate support in the community. Where he is not so satisfied, he will consider the use of his power of recall to hospital. His ability to act effectively is reliant on the quality of the information he receives from individual supervisors. While it will not always be possible to predict and thus prevent dangerous behaviour, it is important that the supervisor provides constant and reliable support to the patient and regular and honest reports to the Home Office. Experience shows that mere crisis intervention does not suffice.* [138]

The Notes make clear that: *"It is crucial to the safe management of restricted patients in the community that supervisors' reports are delivered regularly and in good time".*

8. At Annex A of the Notes is a sample form which psychiatric supervisors are encouraged to use. It requires them to provide specified information including the frequency of their meetings with the patient. Paragraph 42 of the Notes provides further guidance on what needs to be included in reports by supervising psychiatrists:

[138] Mental Health Act 1983, Supervision and After-Care of Conditionally Discharged Restricted Patients- Notes for the Guidance of Supervising Psychiatrists: Home Office, Revised 2003, paragraph 18.

In every case, reports should include a detailed account of the patient's current mental condition, including any changes since the last report and the apparent reasons for those changes… If the supervising psychiatrist has identified any signs of deterioration in the patient's mental health or behaviour, these should be described in detail… A repeated theme in reports into homicides committed by discharged restricted patients is the reluctance of supervisors to send reports to the Home Office which showed clients in an unfavourable light. It is absolutely crucial to the effectiveness of the Home Office's supervisory role that reports should be comprehensive and honest. Reports should never overlook or minimise problems for fear of jeopardising the patient's progress.

Where it is necessary to readmit a conditionally discharged patient, whether or not it is intended to ask the Home Secretary to issue a recall warrant, the Notes require the supervising psychiatrist to notify the Home Office *"at once"*. Equivalent guidance on reporting is provided for social supervisors.[139]

Reporting on John Barrett during the period before conditional discharge

9. While he was on remand John Barrett was transferred by the Home Secretary from prison to the Shaftesbury Clinic under sections 48/49 of the Mental Health Act (transfer direction and restriction direction). He was admitted on 16th April 2002. The statutory requirement to report annually to the Home Office under section 49(3) is identical to that under section 41(6).[140] It follows that the RMO's first annual report was due on 15th April 2003. When it was not received on time, a reminder was sent to Dr Mezey on 2nd May 2003. Further reminders were sent on 10th June and 10th July. The report, dated 14th July, written and signed by Dr Mezey's SHO was received three months late by the Home Office on 16th July. It was an accurate and sufficiently full summary of John Barrett's progress since admission and it also conveyed the team's views about his suitability for discharge. The statutory requirement is for an annual report by the RMO, but the Home Office did not take exception to a report by an SHO

[139] Notes for the Guidance of Social Supervisors, Mental Health Act 1983, Supervision and After-Care of Conditionally Discharged Restricted Patients, 1997.
[140] Refer to paragraph 4 above.

which was neither countersigned by Dr Mezey nor stated that she had read and approved it. We consider this to be an example of poor practice. **We recommend that the Home Office should insist that annual statutory reports are signed, or countersigned, by the RMO.**

Reporting on John Barrett during the period after conditional discharge

10. By the time the next annual statutory report was due in April 2004 John Barrett had left hospital under the conditional discharge that was ordered on 10th October 2003. As we have seen, this imposed on his psychiatric and social supervisors the requirements to which we have referred above, to report within one month of discharge and every three months thereafter. Psychiatric and social supervisors' reports were therefore due by 10th November 2003, 10th February 2004, 10th May 2004 and 10th August 2004.

11. Dr Mezey, as the supervising psychiatrist, provided only one report, dated 29th April 2004, during the period of conditional discharge (10th October 2003 to 2nd September 2004). The social supervisor, Ms Sturdy, provided reports on 10th November 2003, 4th February 2004, 18th May 2004 and 10th August 2004.

12. The Home Office sent three reminders to Dr Mezey in 2004, on 11th February, 22nd April (which elicited the report of 29th April) and 2nd August. The 2nd August reminder was pursuant to what Dr Mezey had stated in her report of 29th April - that her next report would be sent *"following our next CPA in July"*. The Home Office wrote back to confirm this would be acceptable. In fact the next CPA meeting after 29th April took place on 18th May and there was no CPA in July, but this did not relieve Dr Mezey of her responsibility to report in July, three months after the report of 29th April. We are not satisfied that Dr Mezey gave the Home Office reporting requirements the importance they deserved. We criticise her failure to provide reports to the Home Office when they were due.

13. The reporting format adopted by Ms Sturdy was that recommended by the Home Office in the guidance notes for social supervisors. She reported on the frequency of her meetings with John Barrett and on his progress, using standard headings covering

accommodation and finances, activities, major relationships, mental health, and future plans. Her reports also dealt with the practical matters which fell within her remit as social supervisor. Generally her reports were full and accurate. Under the heading of activities, for example, she reported in November 2003 that John Barrett had decided not to continue with the college course he had started before his discharge and that he was looking at alternative courses. In February 2004 she reported that he had decided against doing another college course but was occupying himself with writing music and "*collaborative work with other musicians*". In May she reported that: "*the music project*" had finished and that since then "*he has not had any structure in his week, which has led to him feeling bored and has had an impact on his well-being*". In August she reported that the collaborative music project had resumed but "*at a more manageable pace*" and that he had also recently started attending a community sports group organised by one of the Shaftesbury Clinic's occupational therapy staff. In her reports, as required by the Home Office guidance, Ms Sturdy invariably asked and answered the question: *"Does the patient show signs of becoming a danger to himself or others?"* The opinion she always gave was that there were no signs that John Barrett was becoming dangerous.

14. We make only two small criticisms of Ms Sturdy's reports to the Home Office. First, that she did not say in her report of 10th August 2004 that JW had for a short time moved out of the flat she shared with John Barrett, although she did report that JW "*had decided to look for accommodation of her own*". Secondly, Ms Sturdy reported on 10th August that:

> *Mr Barrett's close family remain concerned about his welfare. He has telephone contact with his mother and sees his brother. I have occasional telephone contact with them*

But she failed to mention that John Barrett's brother had on 27th July specifically drawn her attention to behaviour and attitudes which he believed were evidence of a deterioration in John Barrett's mental state and that John Barrett's mother had spoken to her similarly on 30th July. Nonetheless, Ms Sturdy did draw attention in her report to JW's concerns, to John Barrett's variations in mood and his experiencing indistinct voices, and to the positive urine test on 4th August. This provided sufficient

information to alert the Home Office to the possibility that John Barrett was deteriorating. There is no reason to believe that the inclusion of the additional information, which we consider should have been in the report, would have made a difference to the way it was received by the Home Office.

15. Dr Mezey's only report during this period, that of 29th April 2004, did not adopt the format recommended in the Guidance Notes. It failed, significantly in our view, to record the frequency of meetings between John Barrett and a psychiatrist, but did say he had been seen "*regularly* " by Dr Mezey's SpR. It also recorded that he had been seen by Dr Mezey herself on one occasion since discharge, which was on 23rd April. The report included a full account of that meeting and specifically referred to the whispering voices John Barrett had experienced the previous week. Dr Mezey said that in her opinion this: "*did not represent a relapse but was merely a brief set-back in response to him having to cope with the current stress*" caused by the work he was doing with Mr A; that work, though stressful, "*has benefited him in terms of his confidence and self-esteem generally*". She said that the whispering voices "*had only lasted 48 hours and, indeed, as soon as the pressure of work had lifted the symptoms had disappeared*". Importantly, in her view:

> *They were not* associated with any other *mental state abnormality. His mood is good, he is sleeping well, his appetite and weight are steady. He denied any paranoid symptomatology, in particular symptoms which were associated with his last admission. He denied feeling vulnerable or threatened when he was outside and had not experienced any sense of being followed.*

16. Dr Mezey described John Barrett in her report as "*extremely insightful*". She also commented that his response to the return of the voices had been entirely appropriate, in that he had contacted the hospital for advice and of his own accord increased the dose of his anti-psychotic medication. The report ended with the assurance that: "*he will continue to be seen on a regular basis by myself and the specialist registrar…*"

17. We accept that this report was an accurate reflection of Dr Mezey's clinical assessment and that of the team. When we asked her what she had in mind when describing John Barrett's insight in this way, she told us:

> *He was insightful in that he understood the illness. In the way I suppose that we use the term, and certainly with psychotic patients one of the concerns is about lack of insight very often, in terms of his understanding of the illness and the importance of treatment he was insightful… maybe "extremely insightful" is possibly pushing it a bit, but at the time I wrote that I would have written it because he was compliant with medication, was not taking drugs, was coming to see us, and was well.*

Dr Mezey also told us that John Barrett's insight fluctuated and that when she wrote her report to the Home Office, having recently assessed him, her opinion was that he was extremely insightful. We comment elsewhere on John Barrett's insight which we consider was partial. We believe that his understanding of his mental illness was always constrained by the belief that to some extent his past paranoid ideas were based in reality and that his illness was caused by cannabis. But we accept that during the period of conditional discharge he appeared to understand the importance of treatment and in April 2004 there was reason to believe that he was complying with medication and engaging with the team. In our opinion Dr Mezey's attribution *"extremely insightful"* gave an unduly reassuring impression, but we acknowledge that in her report she did set out the evidence on which her view was based.

18. In so far as the report sought to reassure the Home Office about the frequency of medical reviews, it is matter of concern that we have not found evidence to support Dr Mezey's statement that John Barrett had been seen *"regularly"* by her SpR. We have commented on this elsewhere.[141] In our opinion it would have been better if, before writing her report to the Home Office, Dr Mezey had found out how often John Barrett had been seen by Dr Dhar since discharge. If she had attempted to do this by looking for entries by Dr Dhar in the notes, she would presumably have found only one, that of 6th March 2004. She would then have presumably asked Dr Dhar, who by 29th

[141] Refer to Chapter 2.4

April 2004 had left the Shaftesbury Clinic, how frequently he had seen John Barrett. Only having done this would she have been in a position to tell the Home Office. The point is that because the reporting format that Dr Mezey used allowed her to resort to the formula that John Barrett had been seen *"regularly"*, which no doubt she believed and which may have been true, there was no need for her to look into the matter properly. There was thus a risk of her inadvertently misleading the Home Office.

Home Office oversight of reports

19. Although it was clearly Dr Mezey's responsibility to provide reports when they were due, we consider that the Home Office's response when she failed to do so was unsatisfactory, particularly following conditional discharge. They were slow in sending their first reminder, on 11th February - three months after the first report was due, and a further two months had passed before they wrote again. The follow-up letter of 22nd April was polite rather than firm:

> *I wrote to you on 11 February 2004 requesting a report on the above-named conditionally discharged patient, and I should be grateful to know if you are yet in a position to let me have a reply.*

In our view there was a need for greater urgency and less deference. It should have been of considerable concern to the Home Office, John Barrett having been discharged in the face of strong Home Office opposition in October 2003, that they had not received the psychiatric supervisor's report within a month, let alone the six months that had passed by 22nd April 2004.

20. We should record that it is not uncommon for reports to the Home Office on restricted patients to be late. We learned this from Mark Darby of the Home Office Mental Health Unit, who told us:

> *We have actually put considerable effort both into putting increased resources and increased priority to chasing late reports in the past two years, but also to explore what we could do where we just have particular supervisors who steadfastly refuse to produce the reports. We have in certain cases taken it up*

with the Chief Executive of the Trust concerned, sadly, if I was being kind, with a patchy response. There have been cases where I have written to a chief executive, faxed a chief executive and written again and had no response. Similarly, we have contacted directors of social services in respect of social reports. Sometimes this route is effective. The problem we have is if escalating the matter to director of social services in respect of social supervisor or the chief executive of a Trust does not yield the necessary information, we are pretty much at the end of the road.

In 2005 the Home Office tightened their procedures for chasing late reports on conditionally discharged patients. The new procedure is to speak by telephone to the psychiatric or social supervisor, as the case may be, if they have not sent a report in the past three months. The Home Office told us that this is far more effective than sending reminder letters: *"In essence, it is easier to ignore a letter or deal with it tardily, than to ignore repeated phone calls"*. The lengthy gaps in reporting that we have identified in this case of over six months, before 29th April 2004, and over four months thereafter when no report was written by Dr Mezey, may therefore be less likely to arise in future. Failure by supervisors to provide reports deprives the Home Office of information which is essential to the proper discharge of the Home Secretary's responsibilities in relation to conditionally discharged patients. Regarding the poor response from Trust chief executives to which Mark Darby referred, it should also be understood that, as in this case, failure to comply with reporting requirements lays the Trust open to criticism.

21. We have considered the adequacy of the Home Office response to the reports that were received during the period of conditional discharge. It is important first to emphasise that, as the Notes for Guidance make clear, the Home Office depends on receiving both accurate information and good advice about risk from the authors of reports on restricted patients. The Mental Health Unit does not have other sources of information about individual patients which can be used to gauge the accuracy of what is being reported and neither does it have the expertise to challenge professional advice. For example, we consider that it was entirely reasonable for the Home Office to accept Dr Mezey's description of John Barrett's condition and her opinion about the

significance of the indistinct whispering voices, as communicated in her report of 29th April 2004.

22. However, taking the whole sequence of reports received during the period of conditional discharge, it is perhaps surprising that the Home Office did not once seek clarification or ask pertinent questions about John Barrett's deterioration and whether there was an increase in risk. After all, the Home Office had strongly opposed John Barrett's discharge and might therefore have been expected to be especially vigilant in his case. In summary, the information was that symptoms (in the form of "*whispering voices"*) had returned in April 2004 but remitted after 48 hours (29th April report); that they had returned again in May, this time as "*intrusive voices"*, and he had been admitted informally to hospital but discharged after a few days when the symptoms had again remitted (18th May report); that they had returned yet again, as "*indistinct voices"*, that he had used cannabis, and that his relationship with JW was in trouble and she was looking for alternative accommodation (10th August report). We consider that, at least by August if not before, the information communicated to the Home Office was worrying. But the advice they were receiving from the team was consistently reassuring. The final paragraph of Ms Sturdy's 10th August report said:

> *Mr Barrett will continue to be seen by a member of the multi-disciplinary team at least fortnightly. I see him fortnightly with alternate appointments at the clinic and then jointly with the CPN at home. Additionally, he will be seen by the Specialist Registrar with me on 19th August. The psychologist will be sending him an appointment for an initial assessment in relation to the above matter* [his low self-esteem and managing the voices using psychological techniques]. *I will continue to have contact with those people who have close relationships with him, as well as monitoring issues such as finances, drug use and structured activity via my appointments with him. His next CPA review is due to take place on 7th September 2004.*

23. We accept the evidence from the Home Office that, on the basis of Ms Sturdy's report of 10th August, it was reasonable for them to conclude that the risks were still being effectively managed at that time. However developments in July and early August indicated a possible increase in risk which we consider should have been

apparent to the Home Office from the information contained in her report. The Home Office should always have in mind when reading supervisors' reports whether the risk has increased since the previous report was received. If there has been an increase in risk the Home Office should consider whether they require further information or would wish to discuss the case with the patient's supervisors. By August 2004 in John Barrett's case they had not received a report from the psychiatric supervisor for more than three months and yet Ms Sturdy had told them of developments on which they would reasonably have expected the psychiatric supervisor to report. In our view, as soon as the Home Office had read Ms Sturdy's report of 10th August they should have contacted Dr Mezey's office to ask for her overdue report. This would have been to follow up the reminder letter that had been sent to her on 2nd August. As it happens, had they done so they would have been told that Dr Mezey was on annual leave.

24. We consider it was a weakness that the Home Office did not appreciate that there was increased risk in the summer of 2004. But we acknowledge that although we do not agree with it, the view of the team at the time was that the risk had not increased. We consider that in general the Home Office would be in a better position to form a view if the standard question about risk in the Home Office's suggested reporting format was changed. We have said that Ms Sturdy posed the question: "*Does the patient show signs of becoming a danger to himself or others?*". Her answer, reasonably in our view, was always "*No*". However, if the question had been, *"As compared with the situation at the time of your previous report, is there an increased risk of violence now or in the near future?"*, we think it at least possible that the answer on 10th August, if not before, would have been "*Yes*". By asking the question in this way the emotive word "*danger"*, with its connotation of an immediate and life-threatening risk, is avoided and the report writer is required to reflect on change over time. If the supervisor's report contained information suggesting increased risk, and yet concluded that there had been no increase in risk, it would be open to the Home Office to ask for a fuller explanation. An increased risk does not necessarily imply that risk can no longer be safely managed. If the reporter were to answer our suggested question affirmatively, the next question would be: "*How then is that increased risk being managed?*" **We recommend that the standard question be changed.**

25. We have already said that Dr Mezey did not use the suggested format from the Notes for Guidance for her report dated 29th April 2004. If she had done so she would have had to provide information about the frequency of medical appointments with John Barrett, a matter on which we have commented above. **We recommend that the Home Office's standard reporting format should be mandatory for both psychiatric and social supervisors.**

26. Our final observation on the supervisors' reports arises from the failure fully to implement the tribunal's conditions. We consider it a weakness in the reporting format that it does not require the writers of reports on conditionally discharged patients to set out the conditions and to say whether or not they have been implemented by the team and whether or not the patient has complied. **We recommend a change to the reporting format to require that these matters be included in all reports on conditionally discharged patients.**

27. We have drawn attention to the requirement in the Notes for Guidance for Supervising Psychiatrists that the Home Office be informed *"at once"* by the psychiatric supervisor when a conditionally discharged patient is admitted to hospital. This did not happen on either occasion when John Barrett was admitted in 2004. When we asked Dr Mezey about this she referred to paragraph 50 of the Notes for Guidance:

> *If the supervising psychiatrist has reason to fear for the safety of the patient or of others, he may decide to take immediate local action to admit the patient to hospital for a short period either with the patient's consent or using civil powers such as those under sections 2, 3 or 4 of the Mental Health Act 1983. Whether or not such action is taken, and even if the social supervisor does not share the supervising psychiatrist's concern, the supervising psychiatrist should report to the Home Office at once so that consideration can be given to the patient's formal recall.*

28. We accept that Dr Mezey did not think in May nor on 1st September that there was reason to fear for anyone's safety. However, it appears to us that both informal admissions were covered by paragraphs 53 and 54 of the Notes. The relevant text is:

53. …An immediate report to the Home Office must always be made in a case in which:

c) the patient's behaviour or condition suggest a need for further in-patient treatment in hospital;

54. …MHU must be notified at once of the need to readmit a conditionally discharged patient to hospital.

29. We understand this to require notification at once where there is a need to readmit a conditionally discharged patient to hospital, even where in the supervising psychiatrist's opinion there is no risk to anyone's safety. The possibility of recall arises in every case where a conditionally discharged patient requires in-patient treatment. The discretionary power of recall is the Home Secretary's alone. He needs to be told if the patient has been admitted to hospital so that he can decide whether or not to exercise his power. **We recommend that the Home Office should consider whether further guidance is needed on this point.**

30. In fact the Home Office did learn of the May admission because Ms Sturdy's referred to it in her report dated 18th May. We consider that the Home Office should have noted that the psychiatric supervisor had omitted to inform them and they should have reminded Dr Mezey of the requirement and asked for a report on the admission, particularly in view of the apparent inconsistency between the reassuring view conveyed by the 29th April report, from which we have quoted above, and the deterioration shortly thereafter. **We recommend that whenever the Home Office becomes aware of an admission of a conditionally discharged patient which was not reported by the psychiatric supervisor a letter be sent to the psychiatric supervisor requesting an explanation of the circumstances.**

Chapter 2.9 - Multi-agency Public Protection Arrangements

Introduction

1. John Barrett was not registered under multi-agency public protection arrangements (MAPPA) despite being within MAPPA criteria because of his offending history. There was a Trust policy on MAPPA, which came into force in March 2004, but it had not been implemented in John Barrett's case before September 2004 when he killed Denis Finnegan. We do not wish to speculate about whether registration under MAPPA would have altered the course of events, but the implementation of MAPPA by the Trust falls within our terms of reference and we therefore consider the matter here.

Public protection arrangements in John Barrett's case

2. Ms Sturdy telephoned the public protection unit at Wandsworth police station, which was the point of contact with the police for public protection, to inform them of John Barrett's conditional discharge in October 2003. Police made a record but no other action was taken. It appears to have been treated as a routine call notifying the police that a restricted patient had been discharged into the community. No steps were taken thereafter by the Trust to bring John Barrett within MAPPA, notwithstanding the introduction of the Trust policy in March 2004 to which we refer below.

MAPPA – the law

3. MAPPA's origins are in the Criminal Justice and Court Services Act 2000. The relevant provisions are now to be found in the Criminal Justice Act 2003, which came into force in April 2004. The criteria for inclusion within MAPPA are identical in both Acts. They require arrangements to be made for three categories of offender. John Barrett fell within the second category: *"violent… offenders sentenced since 1st April 2001"*. The qualifying violent offences in his case being those committed on 8th January 2002.

4. The Criminal Justice Act 2003 did not change the criteria for inclusion, but it extended the scope of MAPPA by imposing a duty on public bodies outside the criminal justice system, including NHS Trusts, to co-operate with the responsible authority for MAPPA. In practical terms this duty imposes the following obligations:

- A general duty to cooperate in the supply of information to other agencies in relation to risk assessment and risk management.
- A duty on professionals to consider, as part of the care planning process, whether there is a need to share information about individuals who come within the MAPPA criteria.
- The need to develop protocols between agencies for exchanging information and other forms of cooperation.

The Trust's MAPPA policy

5. The Trust's MAPPA policy was finalised in March 2004, to be implemented with immediate effect in anticipation of the new obligations imposed by the 2003 Act which came into force in April 2004. According to Ms Goddard the MAPPA policy went through the usual policy implementation process:

> *The clinical policies and procedures at that time were chewed-over by a policy implementation group which was chaired by Mark Clenaghan although he was not involved with the Forensic Directorate at that point. There were representatives from all of the Directorates on that committee. The final clinical policies were passed by the executive directors, and at that point that meeting also included all of the heads of the profession and the clinical directors; so the clinical director for the Forensic Service would have been there, head of psychology, etc. would also have been there. Thereafter the expectation would be that it would be cascaded down through the general management line.*

6. The Trust's March 2004 policy correctly identifies the criteria for registration under MAPPA and it describes the kind of information that has to be shared with other

agencies in the interests of public protection. The policy states that the registration of individual patients:

> *Is the primary responsibility of the RMO and that the RMO must document any reasons why a decision has been taken not to inform MAPPA. This justification must be discussed and confirmed in writing in the patient notes with the respective clinical director.*

The policy also provides that

> *It is the responsibility of the RMO to ensure that the appropriate Public Protection Unit is contacted, and that the assessed risk can be managed in an integrated manner.*

The policy sets out the procedure for the assessment of patients, including the requirement to assess the level of risk between level 1 bronze, level 2 silver and level 3 gold – with gold being the highest risk.

Implementation of the MAPPA policy

7. In April 2001 each of the 32 London boroughs established a Multi-Agency Public Protection Panel (MAPPP) and a police public protection unit to discharge the statutory duty. Local borough commanders were given responsibility for establishing these arrangements and engaging relevant local agencies. The police play a coordinating role in relation to MAPPA. An essential element of the successful implementation of MAPPA by other agencies, such as NHS Trusts, is effective communication with the police about individuals who meet the criteria for inclusion.

8. Under the Trust policy, there was a clear requirement after March 2004, though not before, to have a system in place for identifying patients who met MAPPA criteria and deciding what action to take in individual cases. Ms Goddard confirmed in her evidence to this Inquiry that the policy should have been implemented straight away:

> *Once the policy has been ratified then it becomes enacted if you like, but realistically there will always be a lead-in in terms of people understanding exactly what that is about and when we can arrange for the training to take place.*

The policy describes what was required for implementation:

> *The implications of this policy need integrating into the clinical risk management processes and Care Programme Approach used by teams, so that any client meeting the MAPPA criteria is identified and referred. This should be undertaken at Directorate and team meeting level.*

We have not found any evidence that this was done within the Forensic Directorate when the policy came into effect in March 2004. On the contrary, Ms Goddard told us that:

> *It was either at the time of the John Barrett incident or just before it that Caroline* [Leveaux] *was going through this process of making sure everyone was MAPPA-ed.*

Ms Leveaux told us that systems were not in place to make the policy effective while John Barrett was a patient of the Forensic Service:

> *I have to say I wasn't particularly aware of MAPPA* [in October 2003 when John Barrett was conditionally discharged], *which is terrible, but I don't think we were and Susan* [Sturdy] *did what she* [was] *meant to do at that time, and the* [Public Protection Unit at Wandsworth Police Station] *responded in the way they understood at the time. The systemic failure was that we then did not have something in place that would later have said 'OK, let's go to all of our patients, is there anybody really ought to be MAPPA?' That is where we failed.*

We agree with these observations. Ms Sturdy acted correctly in October 2003 and at that time there was no statutory requirement on the Trust to do more. The systemic failure to which Ms Leveaux referred was the Trust's lack of implementation of its own

policy the purpose of which was to discharge its statutory duty of cooperation under the 2003 Act.

9. As for training under the MAPPA policy in the Forensic Service, according to Mr Clenaghan there was no formal training before September 2004, five months after the policy came into force. However, he told us that since September 2004:

> *Training for this policy has happened in a number of ways. As with any policy, there is a process of consultation, agreement and implementation. The MAPPA policy has particular relevance within the Forensic Service due to the high proportion of patients that meet the criteria. A seminar took place in 2005 with* [the] *Met. Police lead on MAPPA. This was well attended by approximately 50-60 clinicians mainly in the Forensic Service.*

10. There appears to have been much discussion of MAPPA in the Forensic Service in 2004 but rather less action. According to Dr Oyebode, the Trust's medical director and a consultant forensic psychiatrist:

> *There were a lot of views about it – we spent hours, days, trying to resolve this. Some people have views about breach of confidentiality. We sought legal advice, we have been to King's Fund. There were some narrow views, in my perception. I took the view and I told the Board that with forensic patients it is actually easier. A lot of people who come into the Forensic Service already have a conviction, so the information you are giving to MAPPA is already in the public domain anyway. It is in court. So we went through all that debate and there were arguments back and forth and in the end, the Chief Executive said, 'I'm sorry. You have to do it, because it's my responsibility and I want it done'. We then had to trawl through all the patients in Forensic and we agreed that all the patients in Forensic should be MAPPA-ed.*

Dr Oyebode draws attention to the relevance of MAPPA to the Forensic Service. But it is our understanding that the trawl to which he referred had not taken place by September 2004. If it had, John Barrett was missed. Apart from the initial notification

to the police, we have seen no evidence that any consideration was given to MAPPA in John Barrett's case.

Conclusion

11. We conclude that, having written a policy which met its statutory obligations under MAPPA, the Trust failed to implement it effectively. It recognised the need for training but it did not ensure that the necessary training took place. It failed to devise an implementation strategy, with priorities and timescales. In promulgating the policy, the Trust failed to give priority to the Forensic Service, as we consider it should have done, and to ensure that the process took place of assessing individual forensic patients against eligibility criteria. Implementation was left to managers at local level but without clarity as to how compliance by the RMOs was to be achieved. There was no auditing or compliance monitoring under the policy before September 2004. In John Barrett's case there was a complete failure to consider his eligibility for MAPPA.

12. We think it self-evident that in implementing MAPPA arrangements across the Trust, priority should have been given to patients of the Forensic Service. Among the forensic patients, public protection arrangements are of greatest immediate relevance to those living in the community or otherwise spending time outside secure hospital conditions. In our view the Trust should have required a list of all forensic patients to be drawn up against the MAPPA criteria. We see no reason why this could not have been done in April 2004. Failing that, it should have become a requirement to consider MAPPA eligibility as part of CPA care planning. If John Barrett had been considered in this way at the CPA meeting on 18th May 2004 it would have been immediately apparent that he fell within the second criterion for inclusion in MAPPA and that, accordingly, the Trust was required to pass relevant information about him to the authority responsible locally for co-ordinating MAPPA. In our view this could have been done without any breach of medical confidentiality. Questions of confidentiality might have arisen at a later stage, had further information been sought from the Trust, but the process of notification and registration should have been speedy and straightforward.

13. The way MAPPA was handled is representative of more general failures and problems of organisation and management, which we discuss elsewhere.[142] There was a tendency for senior Trust management, in delegating to local managers, not to follow through on the implementation of policies and not to put in place an adequate implementation strategy, including necessary staff training. The management of clinicians within the Forensic Service was weak. A consequence was that a Trust policy approved and promulgated through an open process involving representatives from the whole Trust was subjected to further scrutiny and criticism by senior clinicians. According to Dr Oyebode this was a factor in delaying implementation. Clinicians in the Forensic Service had a tendency to interest themselves more in intellectual debate, albeit in this instance about the fundamentally important matter of medical confidentiality, than in the practical implementation of Trust and government policy.

14. There is acknowledgement among both managers and clinicians that the Trust's performance in implementing MAPPA in 2004 was poor, but it is not clear to us that there is a willingness to analyse what went wrong and to learn lessons. Instead of seeing this for what it is, a relatively straightforward matter that was handled badly, there is a tendency to suggest that it was complicated and raised difficult issues, as if it was only to be expected that implementation would be problematic and slow. On the contrary, we think the Trust should have been able to implement its own MAPPA policy effectively and without delay.

15. It is because we have concluded that the failure to implement MAPPA was systemic that we have not sought to draw attention in this chapter to the role of particular individuals in relation to John Barrett.

[142] Refer to Chapter 2.1

Chapter 2.10 - Internal Inquiry

In this chapter "the panel" refers to the internal inquiry panel, and we distinguish the internal inquiry (lower case) from this Inquiry (initial capital).

1. We are required by our terms of reference: *"To review the Trust's internal investigation and assess the adequacy of its findings and recommendations"*. In this chapter we first describe the formal and procedural aspects of the Trust's internal inquiry. We then summarise its main findings and recommendations. We conclude with our observations on the inquiry process, with particular reference to the dissemination of the report.

Formal and Procedural Aspects

2. The internal inquiry was set up in September 2004, shortly after Denis Finnegan's death. Its 47-page report was completed in March 2005 and was approved by the Trust Board on 24th March 2005.

3. The terms of reference were:

1. *To understand the circumstances and management of John Barrett from the time of his previous admission to the Trust* [12th May 2004], *during his relapse and up to his admission to Halswell Ward on 1st September 2004.*
2. *To clarify what happened during the time between the admission of John Barrett and the homicide of Denis Finnegan. This to include:*
   - *2.1 Clinical decisions around the granting of leave*
   - *2.2 Use of Trust policy in relation to leave*
   - *2.3 Use of Trust policy in relation to abscond*
   - *2.4 Communication within Team and beyond*
3. *To investigate the policy and practice of admitting patients informally to secure wards and to make recommendations as to how practice can be improved.*
4. *To understand fully how the incident was managed with*

reference to Trust policies and procedures and to make recommendations as to what steps the Trust could take to reduce the likelihood of reoccurrences.

5. *To conduct the inquiry in an open and transparent manner, so that areas of improvement can be clearly understood and acted upon.*

4. The internal inquiry panel was chaired by Ms Chegwidden, a non-executive director of the Trust. Its membership comprised a senior police officer, a consultant forensic psychiatrist from a neighbouring NHS Trust, a general adult consultant psychiatrist from within the Trust, a nursing expert from the private sector and an assistant director of social services. The Trust's clinical governance assistant director was appointed as an observer and the Forensic Directorate service manager acted as secretary to the inquiry panel. The explanation given in the internal inquiry's report for appointing four external members to the panel was *"the seriousness of the event and because at this time the Department of Health was discussing revising the process to condense internal and external inquiries"*.

5. The internal inquiry panel had access to John Barrett's records held by the Trust, going back to his first contact with mental health services in 1997. They interviewed relevant Trust staff and others with a close interest, including JW. The interviews were recorded and transcribed.

Findings

6. The report started with a chronological account of John Barrett's contacts with mental health services since 1997 which included a detailed summary of what happened between May and September 2004. There is no need here to repeat this. We confine ourselves to those points where that account is inaccurate or misleading.

- The chronological account is inaccurate in referring to the reason for the informal admission in May 2004 as *"a recurrence of hearing auditory hallucinations in the form of 'whispering voices'"*. In its later discussion of that admission the report correctly refers to these as *"intrusive auditory hallucinations"*.

- The chronological account states that on 1st September 2004, having been admitted as an informal patient, John Barrett was *"free to leave at any time"*. This is misleading since in respect of any informal patient there is power under section 5 of the Mental Health Act to prevent the patient leaving hospital pending a formal assessment for detention under the Act.[143]
- The chronological account states incorrectly that Dr Anakwue, who clerked in John Barrett on 1st September, *"spoke with* [Dr Mezey] *questioning the necessity of the admission"*. In fact he did not speak to Dr Mezey at all that day and he did not otherwise question the need for the admission.
- The chronological account states that the police, having been told that John Barrett had absconded while on leave, *"were unable to take any action"* because he was *"informal and his conditional discharge had not been rescinded"*. In fact the police did take action. They went to John Barrett's home in the early hours of 2nd September but he was not there. Had they found him there, they would not have been able to return him against his will to Shaftesbury Clinic because he had not been recalled or otherwise formally detained under the Mental Health Act.
- The chronological account states incorrectly that the information received from JW on the morning of 2nd September was that the taxi in which John Barrett was travelling was heading for Richmond Park. She said only that he had taken a mini-cab and she provided the details of the mini-cab company, which was as much as she knew at the time.

7. The report then analysed the case under a number of headings. We retain the internal inquiry's headings in the following summary.

Risk Assessment and Management

8. In relation to the period 12th May to 1st September 2004 the internal inquiry said that the team's assessment was that the risk John Barrett presented of immediate

[143] It is clear from the notes that had John Barrett not been granted leave from the Shaftesbury Clinic and insisted on being allowed out he would have been detained under section 5(2) of the Mental Health Act and assessed with a view to detention under a civil section or formal recall.

serious violence was low. This was because he was considered to be someone who presented as low risk when well. However, the inquiry panel found that:

> *There was evidence available to the team at the time of admission in September 2004 suggestive of relapse including hearing of whispers…showing aggressive behaviour towards strangers including staring…this was very similar to the reaction before the index offence in January 2002.*

The panel did not say they thought the team had failed to give sufficient weight to these factors, but that is the clear implication of what the internal inquiry said about risk. They also commented that admitting John Barrett informally on 1st September, and to Halswell Ward *("an in-patient unit for patients who are relatively stable and do not require acute care")* and then immediately giving him unescorted leave, led nursing staff to underestimate the level of risk he presented. The panel considered that this perception of risk contributed to the lack of urgency of response when he failed to return from leave. They also noted that had John Barrett been registered with MAPPA this would have provided additional information for the police which could have been of assistance when they were notified on 1st September that he was absent without leave.

Comment

We agree that before 1st September admission there was clear evidence of relapse, which indicated increased risk. But, as Dr Mezey and others confirmed to us in evidence, the team saw no reason to alter their assessment of risk which remained as stated in the most recent risk assessment document of 18th May 2004. It was that document which, together with the other factors referred to in the internal inquiry report, led nursing staff to believe that the risk was not serious and immediate. The nursing evidence to this Inquiry was that neither the perception that the risk was low nor John Barrett's informal status affected the manner in which the absent without leave procedure was implemented. We were told that this was done in the same way and with the same degree of urgency as if he had been a detained patient. The only information that could have changed nurses' perceptions of risk was, as recorded in the multi-disciplinary notes, that Dr Mezey and Ms Sturdy were to be notified if John

Barrett failed to return from leave so that they could ask the Home Office to recall him. However, the entry in the notes to that effect, which we accept was an accurate record of what Dr Mezey said, did not explicitly refer to increased risk if he failed to return.

Clinical Input and roles of members of the Clinical Team

9. The internal inquiry set out the tribunal's conditions and stated that:

> *Recall under these conditions would be justified if there was a significant deterioration in mental state that might cause* [the patient] *to become a significant risk*.

The panel concluded that the condition that John Barrett was to see a *"psychiatric team member as required but at least once a month"* clearly referred to a doctor. The panel noted the gap of 11 weeks when John Barrett was not seen by a doctor and they found that this unacceptable. They considered that up to and including John Barrett's assessment by Dr Mezey on 2nd August, there was insufficient evidence of deterioration to justify recall. We understand them to mean by this that it would not have been legally possible for the Home Secretary to have recalled John Barrett if he had been asked to do so. They appear to have considered that, even taking account of information from JW and family members, only one of the relapse indicators in the care plan, whispering auditory hallucinations, was present and that this did not indicate an increase in risk. The panel noted that on 2nd August Dr Mezey accepted what John Barrett told her about his mental state and behaviour in the preceding days, in preference to the reports she and other members of the team had received from JW and family members. The panel also commented on the lack of clarity and consistency in terminology in the multi-disciplinary notes when referring to John Barrett's auditory hallucinations, the implication being that the term *"whispering voices"* misleadingly suggested something other than auditory hallucinations.

10. The panel considered that the position changed significantly between 2nd and 31st August. The most important new information during that period was the occasion reported by JW when, on 19th August, John Barrett had stared in a hostile way at a

stranger. Taken together with John Barrett's presentation when assessed by Dr Dein in August, there was in the panel's opinion clear evidence of relapse, in terms of the relapse indicators in the care plan. Nonetheless, the internal inquiry's report says that *"he was not recallable at this stage"*.

11. The panel commented on the respective roles of clinical team members. They found that the level of medical input was *"insufficient because it relied too heavily on other disciplines within the multi-disciplinary team to assess John Barrett's mental state"*. They went on to conclude that:

> *There was an absence of an independent judgement by Dr Mezey and her Specialist Registrars based on frequent out-patient and community visits. Therefore, the clinical input was insufficient considering the potential risk given John Barrett's history and what was known of his ability to mask symptoms.*

We take the implication of this to be that if John Barrett had been seen more frequently it is possible that the team would have concluded, on or before 31st August 2004, that the relapse in his mental state was sufficiently serious to have increased the risk he presented to others to a level which warranted recall.

12. The panel considered the input from other disciplines in the team. They concluded that the care co-ordinator under CPA should have been a CPN, rather than a social worker, because the most important elements in the risk management plan were compliance with treatment and monitoring of mental state. They concluded that the CPN adopted a subordinate role and had an inadequate understanding of John Barrett. The panel also considered the role of psychology in John Barrett's treatment. They recorded that during his in-patient stay he had six sessions with a consultant clinical psychologist. They noted that when he started experiencing auditory hallucinations in 2004 John Barrett believed there was nothing the team could do to help him cope with the voices. However, the panel did not criticise the lack of psychological input during this period and they commented that it was unclear whether it would have made any difference to John Barrett. They also commented on the way that the team managed

their contact with JW and John Barrett's family. They concluded that this was not satisfactory and that:

> *There needs to be a clear strategy around involving family, and there needs to be clarity around how this is managed alongside information from the patient.*

Comment

We agree with the internal inquiry's analysis of the evidence. The only point of difference is that we consider there was, on the basis of what the team knew during the summer of 2004, enought evidence of increased risk associated with deteriorating mental state that it would have been lawful for the Home Secretary to have recalled John Barrett to hospital earlier than 31st August.

Our only other observation is that we consider the team should not have allowed John Barrett to believe nothing could be done to treat what were symptoms of a mental illness. By deciding on 2nd August 2004 to refer him to a psychologist, rather than adjusting his anti-psychotic medication, Dr Mezey may have reinforced his belief.

Admission and Leave

13. The internal inquiry pointed out that informal admission to the Shaftesbury Clinic was unusual. They found that the way in which John Barrett was admitted amounted to coercion because he was told *"that if he did not comply, then recall would be considered"*. In the panel's view: "*forcing a patient to accept admission in this way is unacceptable practice"*. They found that there was *"a systems problem with access to Adult Services open ward beds for informal Forensic Service patients at short notice"*, but they noted that no such bed was sought on 1st September when John Barrett was admitted informally. The panel criticised the decision to admit John Barrett informally, instead of asking the Home Secretary to recall him:

> *The panel found that the team misjudged the essential balance between managing risk and allowing liberty to John Barrett. Too much liberty was given*

to John Barrett, in spite of indications both immediate and historical that John Barrett was high risk and 'hard to read'.

14. The panel welcomed the decision of the Shaftesbury Clinic, following the death of Denis Finnegan, to prohibit informal admissions, and noted the agreement with Adult Services to allow informal admission of up to two forensic patients to their beds.

Comment

We agree with the internal inquiry that the informal admission was coercive and that its use, in preference to requesting recall, reflected a tendency to underestimate the level of risk presented by John Barrett. We also agree with the internal inquiry that informal admissions to secure units are problematic and anomalous. It is clear that John Barrett was unhappy about being admitted to a medium secure unit and nurses were understandably troubled when faced with a patient who had supposedly agreed to come into hospital but who was complaining because he objected to being admitted to the Shaftesbury Clinic which is a medium secure unit.

Diagnosis and Treatment Strategy

15. The internal inquiry reviewed John Barrett's psychiatric history and the changes in diagnosis. They favoured a diagnosis of paranoid schizophrenia rather than persistent delusional disorder. They suggested that:

Uncertainty about diagnosis was one factor that may have contributed to the underestimation of his risk.

They pointed out that paranoid schizophrenia is more volatile and in the majority of cases is more responsive to treatment, while delusional disorder tends to be more stable and rapid changes in mental state are unusual.

16. The panel considered whether John Barrett was also suffering from a personality disorder. They concluded, in the absence of evidence of persistent problems of personality not linked to mental illness, that a diagnosis of antisocial personality

disorder was probably not warranted. They considered that it was reasonable for the clinical team to conclude that John Barrett's aggression and violence were associated with a psychotic illness rather than with a personality disorder.

Comment

We share the internal inquiry's preference for a diagnosis of paranoid schizophrenia and we agree with them that the diagnosis of delusional disorder affected the team's understanding of risk associated with deterioration of mental state. We also agree with their conclusion about personality disorder. We do not consider that a diagnosis of personality disorder would have served a useful purpose in John Barrett's management.

Team Structure and Communication

17. While not considering it to be a factor that contributed to Denis Finnegan's death, the panel were critical of the structure of the in-patient teams in the Shaftesbury Clinic, where on each ward there were patients of a number of different consultant psychiatrists. They welcomed the proposed reorganisation, which has now taken place, to create ward-based teams headed by a consultant psychiatrist whose patients are all on the same ward.

18. The panel drew attention to failures of communication on 1st September. In particular, they criticised the nursing handover from the morning to the afternoon shift, Dr Mezey's grant of leave over the telephone, the failure of nurses to read entries made in the multi-disciplinary notes, the failure of nurses to communicate with Dr Mezey and Ms Sturdy after John Barrett failed to return from leave, and the practical difficulties in communicating with Dr Mezey out of hours.

Comment

We agree with this analysis, except only that we do not share the internal inquiry's expectation that nurses in the Shaftesbury Clinic at that time would routinely have read the notes of a patient who had absconded. We consider that the failures of

communication identified by the panel were partly attributable to weaknesses in the strategic management and organisation of the Forensic Directorate at that time.

Policies and Procedures

19. The panel considered policy and practice relating to absence without leave, risk assessment, record-keeping, and MAPPA.

20. They criticised as slow and incomplete the abscond process followed by Ms Hassan when John Barrett failed to return from leave. In relation to risk assessment, they considered that the documentation, which recorded the risk as being low, should have been amended when John Barrett's mental health deteriorated in August. They found an inherent contradiction in granting unescorted ground leave while at the same time considering instigation of the recall procedure – the latter implying that risk was not low. They criticised the team for assuming *"a level of predictability and cooperation"* which was not consistent with John Barrett's ability to mask his symptoms.

21. They found that there were significant gaps in the multi-disciplinary files between October 2003 and March 2004 when the only records are entries made by the social worker and the minutes of the team's weekly referral meetings. They criticised the use of parallel social services notes, where full entries were made, and the inadequate recording of social work contacts in the multi-disciplinary notes.

22. In relation to MAPPA, the panel noted that following John Barrett's discharge in October 2003 Ms Sturdy had notified the Wandsworth public protection unit but there was no further contact and he was not formally registered under MAPPA. They attributed this to the fact that MAPPA policy was undeveloped at that time and there was a poor understanding of MAPPA by the clinical team. The panel considered that had John Barrett been formally registered under MAPPA there would have been a fuller exchange of information which could have affected the police response on 1st and 2nd September 2004: *"this may have involved a visit to John Barrett at his location in North London"*. The panel noted that by the time their report was written a process was in place *"to monitor referral to MAPPA"* which by then was a statutory obligation.

Comment

We agree with the internal inquiry's analysis on all these points. Like them we can only speculate on whether registration with MAPPA would have affected the outcome. If John Barrett had been registered as he should have been, it is possible that the police would have made contact with JW and asked her where he was staying on the night of 1st September – and that she would have told them.

23. The internal inquiry concluded with some observations on the circumstances leading to the January 2002 offences. They questioned whether John Barrett had been followed up by the CMHT with sufficient energy and commitment in 2000 and 2001. They criticised the scope of the 2002 joint inquiry with St George's Hospital because it did not review John Barrett's contacts with mental health services. They also criticised the failure to notify the victims of the 2002 offences when John Barrett was discharged from hospital in October 2003, although they acknowledged that contact had been made with St George's. They considered that as part of its MAPPA protocols the Trust should put in place a process to alert victims of violent crime to the perpetrator's discharge from hospital.

Comment

We consider elsewhere in this report the management of John Barrett's care in 2000 and 2001. We agree with the internal inquiry's observations about notifying victims but we accept that, at the request of the Home Office, the team did make efforts to do this in 2003 when John Barrett started to have section 17 leave in the local community.

Recommendations

24. The internal inquiry made the following recommendations, on which we comment below.

Area of practice	Recommendation
1. Risk Assessment and Management	1.1 The Department of Health should consider the establishment of common risk assessment standards for secure units. 1.2 In the meantime, the current risk assessment procedure to be reviewed across the Forensic Directorate. 1.3 Response to family concerns should be clear and a strategy developed for family involvement. 1.4 Leave outside the clinic is not to be provided for patients admitted to the Shaftesbury Clinic until the patient has been assessed by the RMO and the leave is agreed by the multi-disciplinary team. 1.5 Leave outside the clinic should not be agreed over the telephone. 1.6 MAPPA must be applied to all patients who meet the MAPPA criteria. Compliance should be subject to regular audit.
2. Clinical Input and Roles of the Clinical Team	2.1 A nurse development strategy must be developed, through joint working with the Nursing Directorate 2.2 Strong systems for performance management and personal development of staff must be put in place across the Directorate. This should link to clinical supervision 2.3 The Forensic Directorate should carry out a full review of the frequency with which medical practitioners see community patients and reach agreement on minimum expectations of all grades with the Medical Director. The review should be shared with the Safety Committee and a further audit should be carried out within 6 months. 2.4 Roles of other team members should routinely be agreed in terms of purpose and frequency of contact and this should be specified on the patient's care plan. 2.5 The Forensic Directorate needs to ensure that expert leadership is in place. This needs to be based on a benchmarking process with other secure units, particularly in relation to senior nurse cover out of hours. 2.6 Procedure around contacting doctors out of hours needs to be reviewed and systems must be robust.

3. Admission and Leave	3.1 The Panel supports the Forensic Directorate decision not to accept any informal admissions. 3.2 The Panel supports the agreement with Adult Services for informal admission to be speeded up.
4. Structure of Team and Communication	4.1 The Panel supports the Forensic Directorate plans to move to ward-based multi-disciplinary teams. 4.2 Patient welfare, safety and security must be maintained at all times. Systems of communication with and between all staff must facilitate this. In particular, there must be clear and unambiguous methods for contacting staff out of hours. 4.3 Communication needs to be improved at all interfaces particularly at nurse handover. Best practice should be reviewed and implemented within 3 months.
5. Policy and Procedure	5.1 The Directorate needs to clarify local practice around safety and security . 5.2 The Directorate needs to review the operational policies of wards to ensure they reflect national standards and best practice. 5.3 The Directorate must audit its adherence to the Trust single care record policy on a regular basis to ensure that notes are written up into the central file. 5.4 MAPPA training to be provided for all in the Trust at induction and with routine updates. 5.5 The Forensic Directorate needs to review how policies and procedures (and changes in these) are communicated to front line staff and compliance monitored. This should include an emphasis on taking personal professional responsibility for maintaining and updating knowledge and skills. Regular supervision sessions should verify knowledge of key policies and procedures.

Risk Assessment and Management

25. We are not aware of any Department of Health initiative in relation to the first recommendation. The case for this recommendation was not set out in the internal inquiry report and we consider that such an approach may carry significant disadvantages. With regard to the second recommendation we have mentioned elsewhere in this report the London-wide initiative for establishing common risk assessment procedures for secure units. We are not aware of any Trust strategy for

involving families. Recommendations 1.4 and 1.5 have been implemented. We deal with MAPPA in Chapter 2.9.

Clinical Input and Roles of Clinical Team

26. We agree with these recommendations. There is now a nurse development strategy, together with strengthened systems for performance management. We describe these elsewhere. There was an audit in 2005 of the frequency with which doctors were seeing their patients. It was based on information entered into the Computerised Information Management System (CIMS) between April 2004 and February 2005. However, it was acknowledged that information and been entered into CIMS inconsistently and was therefore unreliable. The outcome was that consultant psychiatrists have been directed to spend a minimum amount of clinical time seeing patients. We are not aware that this has been audited. We are not aware of steps taken to implement recommendation 2.4 but we consider that in John Barrett's case there was clarity about frequency of contact with other team members. It was exceptional that in his case the care co-ordinator was a social worker rather than a CPN, and we do not consider that change is required to the CPA policy in this regard. We are aware that, as part of a wider initiative to improve clinical leadership and team working in the Forensic Service, the Trust has decided to appoint a nurse consultant, although the appointment still had not been made when we interviewed Professor Chambers in April 2006. In evidence to this Inquiry nurses, doctors and Trust managers have all told us that there are now in place adequate arrangements for contacting doctors out of hours.

Admission and Leave

27. We note the decision of the Forensic Directorate which addresses what we have already referred to as the anomalous situation of patients being admitted informally to medium secure units. If a practicable solution has been found within the Trust, which maintains continuity of patient care by the Forensic Service, we support its implementation.

Structure and Team Communication

28. We agree with these recommendations. The first has been implemented. According to the evidence we have received from doctors, nurses and Trust managers, the change has improved team working and communication between different disciplines within the Forensic Service. We are also aware of the initiative taken by the Trust to improve nursing handover by requiring doctors to attend. We question the need for this but accept that it is a matter for the Trust to decide. We have made our own suggestion about the communication to ward-based nurses of important information about the management of individual patients.[144]

Policy and Procedure

29. We agree with these recommendations. Our general observation is that the Trust has effective processes for policy formulation and review but that implementation is inconsistent and slow. We have not carried out a systematic review of Trust policies and procedures, but we comment in chapters 2.1 and 2.9 on policy implementation and the Trust's response to recommendations made by previous reviews and inquiries.

30. There are some issues that the internal inquiry did not consider which in our opinion should have formed part of any analysis of the shortcomings they identified. Some such issues emerged from the reviews by HASCAS and Mr Mc Donald which we describe in Chapter 2.1. These include the management of clinicians, management and organisation more generally within the Forensic Service and staff training.

Our observations on the Internal Inquiry Process

31. We asked Ms Chegwidden, who chaired the panel, what she saw as the purpose of the internal inquiry:

> *I felt it was quite important that we respond fairly rapidly and robustly to what had been a very appalling incident, which had clearly attracted a lot of*

[144] Refer to Chapter 2.6, paragraph 8.

press attention and was bringing the hospital into some degree of disrepute… it was important to make sure it was a very rigorous inquiry and that was the reasoning behind getting on with it quite quickly and drawing up those particular terms of reference.

32. She was aware that there was going to be some kind of external inquiry but the form of that inquiry was not known at the time:

At some point the Healthcare Commission was mentioned, and there were various forms of external inquiry posited, but we always knew there would be something.

33. Ms Leveaux, who was then service manager for the Forensic Directorate, summarised how she saw the internal inquiry's role:

We saw the purpose of the internal inquiry as being the moment when we looked at what had happened to try and amend obvious and immediate problems as soon as possible to make the unit safer. We saw it as different from the external inquiry in terms of timing and scope. In terms of timing, external inquiries take a year or more after the event and we understood that the internal process was to understand risks and amend these without waiting a year. We also thought we could use it to give [Denis Finnegan's] *family information on what happened at an earlier stage. In terms of scope, we thought our role was to put down what had happened from what we could find from initial interviews. Some members of the panel thought our role ended there and the Trust should decide what to do, but it was agreed that it should go beyond that to draw conclusions as to what would help prevent such an event again in the short term and propose change.*

I did not think that it would be used instead of an external inquiry at the time when I agreed to be the secretary to the panel. However, there was subsequent discussion around whether having a panel which had external members might fulfil both purposes. I think that the Trust thought this might be the case due to some indication at the time by the [Department of Health] *that they would move to one structure, based around root cause analysis.*

34. We agree with the decision to confine the internal inquiry by its terms of reference to the period between the admission in May 2004 and Denis Finnegan's death. The internal inquiry was set up promptly and produced its report in a reasonable time, given its range and the thoroughness of the review. Before the report was completed, three specific concerns which emerged in the course of the inquiry were reported to the Trust's chief executive by a letter dated 18th December 2004. These were the structure of the multi-disciplinary teams in the Shaftesbury Clinic, the amount of direct clinical input from consultant psychiatrists and the frequency with which patients were reviewed. Some of the panel's recommendations, such as those relating to informal admissions and the process for making decisions about leave, were implemented before the internal inquiry concluded its work.

35. Whatever was expected at the time by way of a subsequent external inquiry, we consider that it was appropriate to ask people from outside the Trust to sit on the internal inquiry. This not only brought in necessary expertise but also ensured a sufficient degree of objectivity and independence. It is notable that the panel was critical of Dr Mezey to a degree that would, in our view, have been unlikely had all its membership been drawn from the Trust.

36. It is clear from the evidence we have received, including transcripts of panel discussions, that members of the inquiry panel were diligent and approached the task with open minds. As required by principles of procedural fairness, key individuals whose performance was subject to criticism were given the opportunity to comment on the findings in draft.

37. It appears that the logistical and administrative demands of such a far-reaching inquiry were underestimated by Trust management. Notwithstanding the energy and commitment of the service manager, Ms Leveaux, the secretarial support for the panel appears not to have been adequate. An example of the problems which arose was that neither the panel nor those interviewed ever saw the transcripts of the interviews, because they were not ready in time. They received instead a summary based on handwritten notes taken by the inquiry secretary.

38. The inquiry panel made arrangements to communicate their findings to members of Denis Finnegan's family. This was mishandled. At first the intention was to allow family members to read the full report but not to retain a copy. They were then told that they would be sent copies of the full report, but only if they entered into confidentiality agreements drawn up by the Trust's solicitors. We understand that only one family member was willing to do this and the others were provided instead with a 26-page summary of the report. This included a detailed chronological account as well as the panel's major criticisms and recommendations. Apart from conferring anonymity on members of John Barrett's care team, it is not clear to us that the summary omitted anything of significance. Understandably, the decision to provide them with only a summary of the report eroded the confidence of Denis Finnegan's family in the openness and objectivity of the inquiry and created a perception that the Trust was trying to obstruct external scrutiny. It also added to their distress.

39. An unintended consequence of the inconsistent management of disclosure to Denis Finnegan's family was that John Barrett was inadvertently misled into believing that while they would be given the opportunity to read the report they would not be permitted to retain copies. What had been said to John Barrett about dissemination of the report was apparently overlooked in the muddle and haste when disclosure was made to Denis Finnegan's family. This was unfortunate, particularly as the task of communicating with John Barrett was undertaken by Professor Eastman who thereby found himself in the invidious position of having told John Barrett in good faith that Denis Finnegan's family would not retain copies of the report, only for the Trust to reverse its original decision without informing either Professor Eastman or John Barrett.

40. Denis Finnegan's family had a vital interest in the internal inquiry's findings. In considering disclosure to them the Trust had to protect John Barrett's right to a fair trial and to respect for his private and family life as required by Article 8 of the European Convention on Human Rights. We consider that neither consideration precluded disclosure of the full report to Denis Finnegan's family. We can see no legal basis for the distinction between allowing them the opportunity to read the report in full and providing them with a copy to retain. We accept that it was reasonable, given

the publicity this case has attracted, for the names of Trust employees mentioned in an internal inquiry report to be withheld.

41. Our final observation about dissemination of the internal inquiry's report is that it was not made available to Trust staff, even including a number of those who had direct personal involvement in John Barrett's care. It was apparently considered sufficient for staff to have a summary of the internal inquiry's findings and to be informed of its recommendations. We appreciate that sensitivity was required in the dissemination among staff of a report which was critical of individuals, some of whom were still working in the Forensic Service. But we consider that the internal inquiry's own terms of reference, which directed it to be *"open and transparent"*, required that its report should be made available to all staff in the Forensic Service, and possibly more widely in the Trust. We were struck by how few of the front-line staff we saw in the course of this Inquiry knew about the internal inquiry's detailed findings. This contributed to a perception that its report was of little importance. Another consequence of the Trust's lack of openness in its handling of the report was that some staff were left with the impression that they had been criticised unfairly or, alternatively, that there had been a cover-up.

Conclusion

42. We consider the internal inquiry was thorough, given the time constraints in which it operated and the limited availability of its members. We agree on the whole with its analysis, conclusions and recommendations. We commend in particular the initiative taken in December 2004 to alert the Trust's chief executive to issues of immediate concern.

43. We are satisfied that, having accepted the internal inquiry's recommendations, the Trust developed a strategy for implementation. Effective action has been taken on such matters as the proper authorisation of leave and the move to ward-based multi-disciplinary teams. But for reasons we discuss in Chapter 2.1, the Trust still has considerable work to do to effect necessary change in the Forensic Service.

44. Our reading of the inquiry's report is that its analysis of the failures of clinical management and of poor clinical decision-making pointed to systemic problems in the Forensic Service. This conclusion is unavoidable if the report is taken together with the other reviews of the Forensic Service that pre-dated the internal inquiry. We consider that had the internal inquiry articulated these broader concerns, which undoubtedly were felt by Ms Chegwidden, the report might have had a greater impact beyond implementation of its specific recommendations. However, we accept that the way in which the internal inquiry performed its role was in keeping with its terms of reference. It would therefore not be fair to criticise the panel for being unduly narrow in its approach.

Chapter 2.11- Recommendations

Unusually for an inquiry of this kind, arising from our examination of John Barrett's care and treatment we do not make specific recommendations affecting the clinical management of patients by the Trust's Forensic Service. To have done so would have been to duplicate work already done by others who have reported in recent years on the Trust and the Forensic Service. We make reference to some of these other reviews and their recommendations in chapter 2.1 above. It is our expectation that this report, and in particular the findings and detailed comments we make in chapters 2.3 – 2.6, should inform and guide the work of the service improvement team which we recommend is brought into the Forensic Service.

Chapter	Recommendation	
2.1	South West London and St George's Mental Health NHS Trust	We recommend that a service improvement team, taking a national perspective, work with the Trust and the Forensic Service to turn around the performance of the Service, to identify failings and put in place systems and processes that are robust and effective with regular monitoring to ensure safe and effective patient care.
2.7	The thoroughness of the hearing	We recommend that John Barrett's case, even if it is not representative, should be reviewed by the Department for Constitutional Affairs with a view to improving tribunal procedures in restricted cases.

	The tribunal's written reasons	We recommend that the Home Office should scrutinise the reasons in every case where a restricted patient is discharged. In those cases where they are considered inadequate but it is decided not to apply for judicial review, the Home Office should make representations to the regional chairman of the tribunal about the quality of the written reasons.
	Written record of tribunal decisions	We recommend that the regional chairmen remind presidents and tribunal staff of this requirement.
	The Home Secretary's role in the proceedings.	Where, as in this case, the Home Secretary is strongly opposed to a discharge which is supported by the multi-disciplinary team responsible for the patient, we recommend that consideration should always be given to the Home secretary being represented. We recommend that the Home Office, in consultation with the tribunal, reviews the format of statements it prepares in restricted cases.
2.8	Reporting on restricted patients	We recommend that the Home Office should insist that annual statutory reports are signed, or countersigned, by the RMO.
	Reporting on risk	We recommend that the standard question on the patient's current risk to others be changed.

	Reporting format	We recommend that the Home Office's standard reporting format should be mandatory for both psychiatric and social supervisors.
	Home Office oversight of tribunal conditions	We recommend a change to the reporting format to require that the conditions imposed by a tribunal on discharging the patient, and their implementation, be included in all reports on conditionally discharged patients.
	Re-admission of conditionally discharged patients	We recommend that the Home Office should consider whether further guidance is needed on the law and procedure relating to the re-admission of conditionally discharged patients to hospital. We recommend that whenever the Home Office becomes aware of an admission of a conditionally discharged patient which was not reported by the psychiatric supervisor a letter be sent to the psychiatric supervisor requesting an explanation of the circumstances.

PART THREE

Appendices

Appendix A -The sentence imposed on John Barrett for killing Denis Finnegan

Introduction

1. We here consider the basis on which John Barrett's life sentence was given, since it has elements differing both from the usual sentences for homicide, and from sentences commonly passed on those who are mentally disordered. We also explain the institutional arrangements for determining whether at a future date he will be released back into the community.

Life sentences

2. If a person pleads guilty to, or is found guilty of, murder the sentence is fixed by law – the judge has to pass a mandatory life sentence. This actually means imprisonment for an indeterminate period, based upon two components. First, the length of detention necessary for retribution and deterrence (commonly known as the tariff); this tariff component of the sentence is set by the trial judge at the time of sentencing. Secondly, an additional period, whose duration is unknown at the time of the sentencing, and is based upon the risk the person presents. This additional period is therefore calculated on the basis of assessments during the course of the prison sentence, resting upon analysis of factors in the index offence and background history, and the person's progress and behaviour in prison. These assessments, and the overall circumstances of the case, are reviewed at intervals by the prison authorities and by the Parole Board which is independent both of the prisoner and the prison authorities.

3. The Parole Board do not examine the case in the early stages of a mandatory life sentence, when release is not possible because the tariff has not yet expired. They first do so at a point shortly before tariff expiry, because this would be the point at which the requirements of retribution and deterrence have been fulfilled and the only factors then sustaining the imprisonment are those relating to risk to the public. The Parole Board's purpose is to assess risk and to determine when, post-tariff, a prisoner can safely be released because the risk can be seen to be sufficiently reduced. In a case where the risks are judged too great to allow the prisoner to be released immediately, the Parole Board may make recommendations which will shape what

offending work is to be done with the prisoner thereafter with a view to reducing risk. The parallels with detention in a mental health facility are obvious, since in such a setting it is the continuous assessment which allows formulation of views on risk and its management, and ultimately discharge into the community.

4. Current legislation requires that a person subject to a determinate (fixed) sentence of imprisonment greater than four years must be released at the two-thirds point of the sentence length. This two-thirds point, indeed the total duration of the period of incarceration, takes into account any time spent in custody on remand before sentencing. The rest of the time until the expiry of the three-quarters point of the sentence duration is spent not in prison, but in the community subject to licence conditions. These may require a specific residence, or require or preclude certain types of contact or occupation. We have explained the reason for this in that part of our report addressing risk management. Breach of the licence conditions by a determinate sentence prisoner can result in recall to prison until the ultimate expiry date of the sentence.

5. If a life sentence prisoner, having been released, breaches licence conditions he may then be recalled to prison – though not for a definite period. Unlike the prisoner sentenced to a determinate sentence of imprisonment, however long, the indeterminate nature of the life sentence means that after recall – which will have been because of behaviour linked to risk – the prisoner may then spend a further period, conceivably life-long, in prison because the risk is considered too high for release.

6. In addition to the mandatory life sentence for murder, criminal justice legislation now also provides for the automatic imposition of a life sentence, unless the circumstances are exceptional, where an offender has reoffended seriously and thus accrued two serious offences of certain types, for example serious violence. This is because such repeat offending represents an individual of heightened risk to others, and this risk is therefore managed by means of the indeterminate sentence as already explained. This is known as an automatic life sentence. In imposing an automatic life sentence, the judge announces the length of sentence he would have passed had the court not been obliged by law to impose an automatic life sentence. The judge is then

required to state the 'specified period', which is between one half and two thirds of the hypothetical determinate term, less any time spent on remand. This, in effect, identifies the earliest point at which release would have occurred had the sentence been determinate. The expiry of the specified period is, for an automatic life sentence prisoner, the earliest date at which the Parole Board's consideration of the case could lead to release on life licence. It does not mean that such release will occur. It is simply the first point at which it could occur, if the risk to others is by then assessed as sufficiently low.

Diminished responsibility

7. Where a perpetrator of homicide was mentally disordered at the time of the killing in a manner which was contributory to it, there is open to him a defence of diminished responsibility. This defence, if successful, alters the offence from one of murder to manslaughter. This has the effect of untying the judge's hands so that instead of being required to impose a mandatory life sentence for murder, a variety of sentencing options become available. These include a discretionary life sentence but also a determinate sentence of imprisonment and an order under the Mental Health Act committing the person to hospital (hospital order).

Automatic life sentence

8. On 25th February 2005 the court accepted John Barrett's plea of not guilty to murder but guilty to manslaughter on grounds of diminished responsibility. This would normally have afforded the judge a wide discretion in passing sentence. However, as John Barrett already had previous convictions for serious violence in the form of the 2002 offences which had first brought him to the Shaftesbury Clinic, the judge had no choice but to impose an automatic life sentence. It was irrelevant for this purpose that John Barrett was mentally ill and in need of psychiatric treatment.

9. Having announced a life sentence, the judge was then required to set the period of imprisonment that the offence would have warranted had a determinate sentence been passed. Initially in John Barrett's case this was 32 years. The judge subsequently revised this, several days later, to a period of 16 years, with a specified period of 7 ½

years, that being half of 16 years less the period of six months spent on remand. John Barrett must therefore serve at least 7 ½ years before he can be released. If he had gone to prison, rather than to a secure psychiatric hospital, the Parole Board would not have been asked to examine the case until shortly before this period had elapsed. Thereafter, he would not automatically have been released, but only if and when the risk was judged by the Parole Board to be sufficiently low.

Effect of transfer of life sentence prisoner to hospital

10. Having been remanded into prison following his arrest on 2nd September 2004, it was already apparent that John Barrett was suffering from mental illness. Acting upon independent medical recommendations, the Home Secretary authorised his transfer from prison to Broadmoor Hospital, under sections 48/49 of the Mental Health Act, for psychiatric treatment. He was admitted there on 21st December 2004. Following imposition of the automatic life sentence on 25th March 2005 John Barrett did not go to prison but he returned to Broadmoor where he remains, detained under sections 47/49 of the Mental Health Act.

11. There is, however, now an important difference from the time he was detained at the Shaftesbury Clinic because, in addition to being detained as a restricted patient under the Mental Health Act, he is also subject to an over-arching sentence of life imprisonment. This means that he cannot be released by a tribunal. He is entitled to ask the tribunal to review his case, but the only options open to them are to continue his detention under the Mental Health Act or to remit him to prison to continue serving his sentence. Until such time as a tribunal find that John Barrett's mental disorder no longer warrants detention in hospital under the Mental Health Act his case will not be referred to the Parole Board, irrespective of the expiry of the specified period in his life sentence. Only if a tribunal consider that detention under the Mental Health Act is no longer justified will his case be referred to the Parole Board for their consideration, independently of the tribunal, of release on life licence.

Appendix B - Note by John Barrett's solicitor of the evidence given at the mental health review tribunal on 10th October 2003

Evidence of RMO[145]

RMO supported conditional discharge.

Update since report: Nothing in the last 2 months to change the team's opinion. A s.117 meeting was held and everything is ready for discharge. JW also attended this meeting. It is time to move on.

He should reside at his flat.

We planned overnight leave which has now happened – there were no problems.

Supervision would be by Dr Dhar (4/52), Susan Sturdy and a CPN

He will make a referral for a substance misuse course.

Re the statutory criteria[146]:

MI – Yes, delusional disorder
N&D – No
Health/Safety – No
Recall – Yes

On questioning by ERA (John Barrett's solicitor)he added that:
JB does respect the need for medication contrary to the HO view and also the reasons why it is effective. The team will need to work on spotting a possible relapse in the future and cannot be too complacent.

JB has engaged with the care plan and his leave has been useful and sufficient.

Evidence of Sue Sturdy

He has maintained progress.

There has been more leave since her report.

JB is ready to go.

There is a need for ongoing medication and openness.

She will see him weekly for at least 3 months.

[145] The medical evidence was given by Dr Dhar who was not the RMO.
[146] The statutory criteria are reproduced in Chapter 2.7 paragraph 8.

He is as well as she has ever seen him.

She feels that she knows him well enough to supervise him especially with the help of JW.

Her view is that he has had enough leave already.

JB's brother is based [outside London] and they see each other about twice every month.

In response to ERA's questions she felt that leave did not need to be further tested as the HO suggested. Rather, she feels that all matters are now in place for the conditions to be met. She added that JB will referred the Community Drug Team to address substance misuse issues.

Evidence of the nurse

JB has been engaging with OT and is now ready for discharge.

Evidence of JB

JB explained that he is aware that he has a mental illness and will be careful if discharged. He will leave any decisions in the hands of the doctor.

As regards medication, he explained that he cannot stop it as it is the very thing that has kept him stable. He is happy to submit to drug tests for cannabis.

As regards preventing a relapse, he will stay in contact with the team and has JW for support.

The Chair asked him about how he would deal with social pressure not to take marijuana. JB said that he would not use it after what he has been through. As regards medication, he will stay on it if discharged.

Evidence of JW

She feels that there has been a huge shift this time and this is the first time that JB has recognised that he has a mental illness. He is ready to leave but will need after-care.

She has arranged to take some time out of work to help JB if discharged.

Appendix C - Glossary

ASW - approved social worker

CMHT - community mental health team

CPA - care programme approach

CPN - community psychiatric nurse

MDT - multi-disciplinary team

MHRT - mental health review tribunal

MHU - Mental Health Unit

OT – occupational therapist

RMO - responsible medical officer

PCT - primary care trust

PICU – psychiatric intensive care unit

SHO - senior house officer

SpR - specialist registrar