THE GREY REPORT

Report of the Independent Inquiry Team into the Care and Treatment of Kenneth Grey to East London and The City Health Authority

November 1995

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Membership of Inquiry Team

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Terms of Reference

1. To investigate all of the circumstances prior to, and surrounding the admission, treatment and continuing care of Mr Kenneth Grey - his leaving hospital and the death of his mother on the 1st January 1995.

2. To examine the extent to which Mr Grey's care corresponded to statutory and other obligations of the Mental Health Act 1983 and all the relevant guidance from the Department of Health.

3. To identify any deficiencies in the quality and delivery of that care, both the internal and external collaboration and individual agency responsibilities.

4. To examine the effectiveness of the practice and the exercise of individual agency responsibilities in respect of absence without leave.

5. To make recommendations for the future assessment and care of people in similar circumstances including the mentally disordered so as to avoid possible harm to parents and the public.

6. To prepare the report including the recommendations to East London and the City Health Authority.

INTRODUCTION

Kenneth Grey murdered his mother on New Year's Day 1995.

By then he had been absent without leave for 30 days from a psychiatric ward of Hackney Hospital, where he had been discharged from being compulsorily detained under the Mental Health Act just some 4 hours before he went missing.

There have been many independent inquiries into homicides by mental patients over the last year or so and this Report is just one of many which have been commissioned and will by no means be the last.

As the Director of Nursing and Specialist Services of Tower Hamlets Healthcare Trust so succinctly put it:

> **"How many more inquiries do we need to tell us that the challenge is around the co-ordination of care."**

Are lessons being learnt from these reports?

Can past mistakes teach us how to deal appropriately with similar future problems?

Are the recommendations contained in these reports heeded and acted upon?

Recommendations which we make are addressed to the Health Authority but because of the inter-relationship of the prison, probation, health and social services, we suggest that an interagency group is established to examine our conclusions and recommendations to establish clear implementation plans, with a clear timetable.

In this Report, we have attempted to highlight some of the areas where we feel mistakes were made. Our purpose is not to point the finger of blame at any particular individual but to make recommendations which we hope will go some way to ensure that the same mistakes are not made again, and that appropriate procedures and competent personnel are put in place to safeguard the patient and the public and to ensure and reinforce efficient future management of people with mental disorders.

We are well aware of the political background in the months leading up to the relevant period - the "fall-out" from the Tomlinson Report; the creation of a single East London development agency known as the City and East London Family and Community Health Services ("CELFACS"), encompassing all community and mental health services in Newham, Tower Hamlets and Hackney and then the abandonment of this single agency. This led to the subsequent creation of the 3 new Community Trusts. The mental health community services in City and Hackney were divided into 4 locality teams during this period of time. We know that this was a time of considerable upheaval and indeed unrest in the area, and can see how easy it was at that time for those with managerial responsibilities to "take their eyes off the ball" and become preoccupied with the changes going on rather than getting on with the job in hand.

The assessment of Kenneth Grey, his transfer from Pentonville to Hackney and his subsequent treatment and care took place against this background. This situation created inadequacies which in turn led to a down scaling of the perceived level of risk with regard to Kenneth Grey. He was seen as yet another standard transfer from prison who had no place in a busy Psychiatric Intensive Care Unit ("PICU"). We saw no evidence of systematic assessment of the risk of dangerousness to himself or others. We accept that Kenneth Grey showed no signs of threatening or violent behaviour whilst at Hackney.

The spirit and purpose of the Care Programme Approach (CPA) requires that individuals who are in contact with specialised mental healthcare should have access to a comprehensive range of mental health services. Within the context of the CPA, Kenneth Grey should have been subject to:

i) A comprehensive assessment of his health and social needs;

ii) The provision of a Key Worker;

iii) A comprehensive care plan;

iv) Regular and planned reviews.

In addition, most complex and needy cases (this would include mentally disordered offenders) should have access to planned multi-disciplinary input. From the evidence presented to the Inquiry, Kenneth Grey was not cared for or treated within the framework or spirit of the CPA. Indeed it was generally acknowledged that the Care Programme Approach had not yet been properly embraced in Hackney. The Care Programme Approach Manager admitted to us:

> **"The spirit of the CPA has not been taken on board very well. We have said we want to put into place a systematic care plan and review, but it is hard to change people's practice."**

The CPA was clearly not implemented but at the same time we recognise that genuine and strenuous efforts were and are being made to develop the mental health services in Hackney and in particular the community services.

At first sight Kenneth Grey's case seems to have no real similarity to other cases which have been the subject of Inquiry . He had no long-standing history of psychiatric illness and the entire period with which we have been concerned - from his first signs of mental abnormality to the date of the murder - spanned less than 3 months. We are also not aware of any other reports where the prison and probation services are crucial to the care of the patient. But as we heard the evidence we soon realised that this case was not only an echo of former inquiries but also had far-reaching implications relevant to all of the multi-disciplinary parties who are responsible for the care, treatment and management of people suffering from mental illness.

We are sympathetic to the fact that Kenneth Grey killing his mother could not be predicted, but are convinced that steps could have been taken which might have prevented it from happening.
It seems to be well established that prison doctors feel that prison is no place for anyone who is mentally ill and this leads to a drive to transfer such prisoners to local psychiatric wards and secure units. This causes great difficulty for local health providers who already have a shortage of beds. Some action may

already have been taken to remedy problems of poor assessment, communication and high demand from the prisons and it may be that firmer links are now being established between the prison, hospital and locality team services, but it is essential that these are based on sound and mutually understood protocols identifying shared and individual responsibilities.

To say there was a lack of understanding of the Mental Health Act 1983 in this case - particularly regarding transfer arrangements from prison to hospital - is an understatement. The errors made at the hospital about Kenneth Grey's legal status whilst at Hackney led to a misguided decision to implement section 2 in place of section 47. This, plus an incomplete assessment under section 2 of the Mental Health Act 1983 ("MHA"), set in motion the chain of events which led to Kenneth Grey's premature move away from the "safety net" of the hospital services.

We at one time remarked to ourselves during our deliberations that this case reminded us of a sprint relay race, where Kenneth Grey was the baton passed from hand to hand, and as he was passed on to the next participant in the race, so the previous runner handed over responsibility for him and that individual's race was over and the next runner had to take up the running with no further assistance from the rest of the team. When Kenneth went AWOL, the baton was dropped and no-one assumed responsibility for him. Communication, team cooperation and continuity are crucial elements in effective mental health care, and unfortunately, in Kenneth Grey's case there seems to have been a singular lack of all three. This was due to many factors, some of which were:

(a) temporary and locum medical and MHLT staff

(b) absent Consultants and named nursing staff

(c) poor medical and nursing record keeping

(d) wrong interpretation of the MHA

(e) failure to implement the CPA

We have been assured that mental health services have been a priority for the Health Authority since it was created in 1993 and we accept that there have been a number of significant developments in terms of bringing together community based teams which are developed jointly with the local authority. We were extremely glad to learn from our enquiries that the Trust has recently drawn up draft Policies and Procedures which they are in the process of implementing in the near future which will address many of the areas about which we have expressed concern in this Report. We can only hope that they will bring them into effect quickly, efficiently and effectively. We are aware that some of the recommendations which we make may already have been implemented. We are however aware that there is not what was described to us as a "Mental Health Strategy for Hackney". Such a strategy is essential. It must be based on a clear analysis and understanding of local needs. It should establish agreed priorities and these must then be systematically and vigorously pursued.

KENNETH GREY: SYNOPSIS

- Kenneth Grey was born on the 14th July 1970 to Jamaican immigrant parents. His parents separated when he was a young child and he remained living with his mother in the Wood Green area of North London, having intermittent contact with his father. He also had a half-brother, ten years old than himself, with whom he had had little contact over the years.

- It is clear from what Kenneth himself told us (as well as from the history given by him to the various psychiatrists who prepared reports for the criminal proceedings, the witness statement for the criminal proceedings of a neighbour, and his account given to the Approved Social Worker who assessed him in hospital) that Kenneth never had a good relationship with his mother. She was a devout Jehovah's Witness who was both extremely strict and extremely restrictive with Kenneth. She apparently would not allow him to play with other children in the neighbourhood who were not Jehovah's Witnesses, forbade him to celebrate birthdays and religious festivals and would discipline him and punish him by hitting him, often with a belt or "whatever was lying around" (as he put it to one of the psychiatrists). It is apparent that Kenneth's mother's desire to indoctrinate him into her religion was a source of conflict between them from an early age.

- From the age of about 13, Kenneth started to use cannabis and he then began to steal in order to buy drugs. He had been taken into care in July 1985 when he was just 15. He gradually began to experiment with other drugs and had been repeatedly before the Courts for a variety of offences since February 1986. The majority of his convictions were for burglary and theft and he had also been convicted for possessing cannabis on a number of occasions. He had three convictions for offences of violence. The first was in March 1986, when he was 15, and he was convicted of causing actual bodily harm. In November 1992, when he was 22, he was again convicted of causing actual bodily harm and he said that he was under the influence of drugs and alcohol at the time.

- On the 22nd June 1994, Kenneth Grey was sentenced to one year in prison, having been convicted on three charges of shoplifting (one whilst on bail for the earlier offences) and one charge of common assault which arose from an assault on a Store Detective who he hit because he would not release him when he apprehended him shoplifting in January 1994. He told one of the psychiatrists that he was not under the influence of drugs at that time. He had spent time in Detention Centre and Youth Custody, had been fined and done Community Service and also been placed on probation, prior to the sentence of imprisonment in June 1994.

- Prior to sentencing in 1994, Kenneth Grey was the subject of extensive probation assessments. Pre-sentencing Reports show that he had a serious drug problem and that he was maintaining that his reasons for committing thefts and burglaries were to finance his heroin addiction. It was acknowledged by the probation officers that he could not address his offending behaviour without first dealing with his drug problem, and one of the proposals in the Reports was that he should be remanded on bail while an assessment was made at Phoenix House, a residential drug rehabilitation centre. Kenneth was accepted by Phoenix House following an assessment and funding was agreed, however, he absconded from Phoenix House after only one day.

- Kenneth Grey was sentenced to 12 months imprisonment on the 22nd June 1994 and was sent to Pentonville Prison. His earliest date of release with remission was the 25th November 1994. While in custody, his behaviour began to be more and more bizarre until in October 1994, he was seen by one of the Medical Officers at Pentonville Prison. By this time he was expressing grandiose and delusional ideas and was seen in mid-October 1994 by a locum Consultant Psychiatrist from the Psychiatric Intensive Care Unit at Hackney Hospital, who did not consider him as being mentally ill at that time. Kenneth Grey had no prior history of any mental illness.

- Matters deteriorated in the middle of November when he had become threatening towards staff and other patients, and was displaying increasingly bizarre and grandiose ideas. He was seen at Pentonville by a Forensic Psychiatrist who carried out an assessment and considered him to be floridly mentally ill and he was transferred to the Psychiatric Intensive Care Unit (PICU) of Hackney Hospital on the 23rd November 1994 under Section 47 of the 1983 Mental Health Act.

- Kenneth Grey remained on the Secure PICU Ward until the 2nd December 1994, but the Section 47 Order was replaced on 25th November 1994 by a Section 2 MHA Order, under the mistaken belief that the Section 47 expired on Kenneth Grey's release date.

- In the afternoon of the 2nd December 1994, the Section 2 Order was discharged almost immediately prior to Kenneth Grey's transfer from the Secure Ward to an Open Ward. Within 2 hours of arriving on the Open Ward, Kenneth Grey went missing from the Hospital and never returned.

- On the evening of the 1st January 1995, Kenneth Grey murdered his mother, apparently following an argument with her about religion. He was arrested immediately and it is clear that he was psychotic at the time of the murder.

- Kenneth Grey was charged with the murder of his mother and on the 25th July 1995 he appeared at the Old Bailey where his guilty plea to manslaughter on the grounds of diminished responsibility was accepted. Expert psychiatric evidence was called by both the Prosecution and the Defence, but the sentencing Judge was apparently persuaded by the evidence of the Prosecution expert that Kenneth Grey was suffering from a drug induced psychosis at the time of the murder and that he was no longer showing any signs of mental illness.

- Kenneth Grey was sentenced to 7 years imprisonment, but we have recently been informed that the Attorney General's authority has been obtained to refer Kenneth Grey's sentence to the Court of Appeal on the basis that it is unduly lenient.

PENTONVILLE

Kenneth Grey was sentenced to one years's imprisonment following 3 separate offences of shoplifting (one whilst on bail pending pre-sentencing reports) and a conviction for common assault and arrived at Pentonville Prison on 23.6.94. His EDR (earliest date of release) was 25.11.94.

On assessment by a prison psychiatrist on arrival (standard procedure) he was said to be shocked at the length of his sentence (12 months for shoplifting) but nothing else was recorded regarding his mental state at that time. He told her he was an epileptic and a heavy heroin user (on a daily basis) and that his offending was related to funding his drug habit.

[Kenneth Grey was never consistent in his various accounts of his drug taking.]

Initially Kenneth Grey was somewhat disruptive and had to be disciplined by removal of working privileges, but he was subsequently transferred to duties serving food and eventually worked his way up to the position of Number 1 on the hotplate - a position of considerable trust. It meant that he was unlocked all day and there was a lot of interaction with prison staff and other inmates.

At first Kenneth Grey had a good relationship with the prison staff, and there was a great deal of good-natured banter between him and them. He apparently always had a smile on his face and caused no problems to staff at all. This changed, however, at some time around the end of September/beginning of October when Kenneth Grey began to say that he was God or the King of Africa or Captain Kirk of Star Trek. At first staff treated it as a joke, but eventually they realised that he was serious. The situation got worse and he became more aggressive, on one occasion confronting the Principal Prison Officer in his office, demanding to use his computer to change his E.D.R. (Earliest Date of Release). On this occasion he was described as intimidating.

Kenneth Grey's behaviour caused enough concern for the staff to ask one of the prison psychiatrists, Dr. Pierzchniak, to see him on 10.10.94 in the Segregation Unit (where Grey had been sent as a disciplinary measure following some incident the details of which are unknown).

In conversation with Dr. Pierzchniak, Kenneth Grey came out with grandiose ideas and delusions which were considered serious enough by Dr. Pierzchniak to seek a second opinion from a catchment area psychiatrist.

On 14.10.94, Doctor Bouwer and Dr. O'Neill from Hackney Hospital attended Pentonville and interviewed Kenneth Grey. Their conclusion was that he was "not mentally ill at present."

Kenneth Grey's behaviour continued to deteriorate and he became increasingly threatening and intimidating. By 11.11.94 matters had got to the stage where the Principal Prison Officer took the unusual step of writing a letter to the Psychiatrist on duty at the prison hospital setting out his concerns about Kenneth which ended with the plea "Help!"

Kenneth was seen by the Duty doctor, Dr. Lewis on 11.11.94 who considered him to be "floridly psychotic" and he was admitted to the hospital wing where he remained until his transfer to Hackney Hospital under Section 47 of the Mental Health Act 1983 on 23.11.94, just 2 days before his E.D.R.

We discovered when interviewing Kenneth Grey's Probation Officer that he would have been subject to ACR (Automatic Conditional Release) licence on release having been sentenced to a term of imprisonment of between 12 months and 4 years. This would have meant that strict conditions could have been applied to his licence eg. that he attended a drug misuse project, and any conditions of licence would be supervised by the Probation Service and they would have the power to return him to court if concerned about his behaviour. He would have to sign the licence on release from prison which would be countersigned by the Governor, and report immediately to his Probation Officer. In the event, the Probation Service was not informed of Kenneth Grey's transfer to Hackney Hospital until the day of his EDR, 25.11.94 and he never signed the licence although he remained subject to ACR.

We also learned from the Probation Officers that Kenneth Grey had fairly extensive previous convictions for burglaries and thefts and we discovered for the first time that he had two convictions for ABH, one in 1986 and another in 1992 as well as the Common Assault conviction in 1994.

They also told us that at the time of sentencing in June 1994, they were aware that Kenneth Grey was homeless and living rough and that he had a serious drug problem. It was the intention of the Probation Service to find Kenneth Grey accommodation on his release from Pentonville and to refer him to the substance misuse project.

We also now know from seeing the pre-sentencing reports that Kenneth Grey was unreliable in his reporting to his probation officers, had had his accomodation at Seafield Lodge Bail And Probation Hostel withdrawn because he broke their rules and had left Phoenix House (a drug rehabilitation centre where he had been accepted for a 6 week assessment pending sentencing) after only one day although he appeared to be trying to deal with his heroin problems by privately purchasing Methadone. His Probation Officer John Lewis was recommending to the sentencing judge a short 6 month Probation Order during which time he would be encouraged to find accommodation in a suitable drug rehabilitation project.

Dramatis Personae

Prison Officer Afrin

Principal Officer on "A" Wing at Pentonville.
Wrote the letter dated 11.11.94 to prison duty doctor.

Dr. Ann Lewis

Duty Psychiatrist on 11.11.94 when Kenneth sent to prison hospital by P.O. Afrin.
She saw Kenneth over that weekend (11-13) and signed a Medical Report on 15.11.94 (declaring Grey to be suffering from mental illness which required him to be detained in hospital for treatment) for the purpose of a transfer to hospital under S.47 M.H.A.

Dr. Indrani Anthony

Another prison psychiatrist who saw Grey on 16.11.94 and signed the second Report necessary for transfer under S.47 M.H.A.

Dr. Peter Pierzchniak

The prison psychiatrist who felt that Grey was sufficiently deluded on 10.10.94 to call in the Hackney Hospital psychiatrists for assessment to see whether he needed hospital treatment at that stage.

It was Dr. Pierzchniak who had Kenneth re-allocated to himself on 14.11.94 and called in the forensic psychiatrist, Dr. Boast, to re-assess Grey for transfer to hospital.

Dr. Colin Bouwer

A South African Psychiatrist acting as a Locum Consultant on P.I.C.U. (Psychiatric Intensive Care Unit) at Hackney Hospital for a 3 month period from the end of September 1994. He had a contract to lecture at Bart's and an Honorary consultancy on P.I.C.U. went with the contract. No-one could tell us exactly when Dr. Bouwer last attended P.I.C.U.

He visited Kenneth in Pentonville on 14.10.94 at Dr. Pierzchniak's request but did not consider him to be mentally ill at that time.

He signed the Section 2 papers on 24.11.94.

Dr. Jane O'Neill

Senior Registrar to Dr. Bouwer at Hackney Hospital. Visited Kenneth with Dr. Bouwer on 14.10.94.

Accepted and arranged Kenneth's admission to P.I.C.U. at Hackney Hospital following Dr. Boast's assessment of him on 17.11.94.

Dr. Neil Boast

Consultant Forensic Psychiatrist at Hackney Hospital.

Saw Kenneth in Pentonville at Dr. Pierzchniak's request on 17.11.94. Assessed him as being floridly deluded and requiring transfer to hospital under Section 47 M.H.A.

Dorithe Goode

Probation Service Assistant assigned to Kenneth Grey from the date of his sentence: 23.6.94. As his sentence was for 12 months and he was therefore subject to Licence, he should have been assigned a more senior Probation Officer. She saw Kenneth Grey on one occasion whilst he was in prison.

PENTONVILLE "DIARY"

23.6.94

Arrival at Pentonville. Seen by Dr. Anthony.

Told her he was an epileptic and a registered drug addict, using 2g of heroin intravenously a day. Dr. Anthony records this in her personal notes. The only note entered in Kenneth Grey's medical record by Dr. Anthony was:

> **"Shocked at the sentence of 1 year. Not suicidal."**

There was no mention of his drug habit or his epilepsy.
No drug test/screen was carried out.

26.8.94

Kenneth Grey reported that he had had what he thought was an epileptic fit, describing flashing lights and an aura-like state. He was allocated to Dr. Talal (non-psychiatric) for his epilepsy.

10.10.94 - 14.10.94

On 10.10.94 Kenneth Grey was "up for adjudication" having been involved in some unknown trouble for which he would have to go before the duty governor. He was therefore seen that morning by the duty doctor (Dr. Pierzchniak) to be assessed as to his fitness to be adjudicated.

That morning he seemed perfectly normal, but the same afternoon prison staff were concerned enough about Kenneth Grey's behaviour to ask Dr. Pierzchniak to see him again. He was saying he was "**Javeh**" (God) and that he could walk out of the segregation unit whenever he wanted. Dr. Pierzchniak saw Kenneth who told him that he was a genius, a specialist in infertility, that he owned the sky, that he was an agent for many famous people (he showed the doctor a magazine containing photographs of famous personalities whom he claimed to have made famous). He also gave the doctor a page of hieroglyphics he had "**written without thinking**" as further proof of his genius.

Dr. Pierzchniak felt that Grey needed observation in hospital but felt that this would not be possible without his agreement in the absence of very disturbed behaviour. Grey insisted he "**was not mad**" and did not want to be in hospital. Dr. Pierzchniak was not at that time aware of any problems being faced by the staff on "A" Wing and felt that Kenneth Grey was functioning adequately on the Wing. He did however feel that some follow-up was necessary and therefore requested a visit by a psychiatrist from the appropriate catchment area hospital ie. Hackney.

On 14.10.94, Dr. Bouwer and Dr. O'Neill interviewed Kenneth in Pentonville. Dr. Bouwer's notes refer to "**a history of life long grandiosity, pscudophilosophical thought contents about life, meaning of life and the body**". He concluded that Grey was "**not mentally ill at present**".

Dr. O'Neill wrote a Psychiatric Report the same day as the visit in which she wrote:

> **"We had a lengthy interview with Mr. Grey. Mr.Grey was preoccupied by various pseudo-philosophical issues. He described many theories which to Mr.Grey seem more like possibilities than fact. He said that it was possible that time was standing still and that we were not human but in fact computer like and living on another planet. He talked about beams from another planet controlling computer chips in people's heads. He discussed the possibility that when someone died that the computer could be removed from one person and be put into a newborn baby. Mr.Grey was quite grandiose in his attitude."**

In her evidence before the Panel, Dr. O'Neill told us:

> **"Something was not right but I didn't think he was psychotic. I think I had some concern"**

Dr. Pierzchniak told us that he saw Kenneth Grey's symptoms as classical symptoms of schizophreniform psychosis and was surprised that Dr. Bouwer saw the same symptoms but came up with different conclusions.

<u>Weekend of 11.11.94 - 13.11.94</u>

On 11.11.94 P.O. Afrin took the unusual (for him) step of writing to the duty psychiatrist at the prison hospital setting out his concerns about Kenneth Grey's bizarre behaviour which he said had begun some 6 weeks previously. The letter ended:

> **"He is becoming a danger to and in danger from other inmates on "A" Wing. Help!"**

P.O. Afrin told us very graphically that Kenneth Grey had becoming increasingly threatening and intimidating. In response to our asking whether he was easily intimidated he said:

> **"Not at all. Inmates try to intimidate you every day. A lot you don't think twice about but with Grey he radiated menace...We sighed a sigh of relief when he was walked across to the hospital...He had retreated into his own world."**

Dr. Lewis was the Duty Doctor that weekend and told us it was obvious that Grey needed to go into the prison hospital as he was **"so obviously deluded"**. He was therefore admitted. She saw him again over the weekend and recorded that he was refusing oral medication. She described him to us as:

> **"So floridly psychotic that there was no rational part of him to communicate with".**

However the notes she made on his medical record were nothing like as graphic. On 11.11.94 she recorded:

> **"Officer Afrin said this man is <u>very</u> threatening and upsets staff & inmates. Inmate said he wanted to go to NASA & do space travel - he doesn't need to train."**

On 13.11.94 she made the following entry:

> **"Refuses oral medication. His psychotic behaviour & management are a long term problem, & I feel that precipitate action is not indicated. We must manage him conservatively over the weekend, & try long term plans made for him with adequate assessment over next week. Very alarmed at the idea that anyone thinks he might be mad - it's true about the space travel isn't it ? He won't believe this is a prison hospital."**

Dr. Pierzchniak came back on duty after the weekend and re-allocated Kenneth Grey to himself on 14.11.94. His note for that day in the records reads:

> **"Continues to say that he is a king and should be unlocked. Says that he hears voices "my conscience". They tell him to do things. As a result of his beliefs, he thinks that he is exempt from any prison rules. This results in serious disruption every time he is unlocked. This is accompanied with threatening behaviour.**
>
> **This cannot go on.**
>
> **Needs treating but refuses oral medication."**

He prescribed an anti-psychotic injection as well as diazepam to sedate him which was apparently administered after Kenneth Grey threw his lunch tray at staff who had gone to give him his lunch later that morning, following which it is recorded **"a violent episode ensued."** There are no further details.

Dr. Pierzchniak confirmed to us that Kenneth Grey was **"a frightening individual when he was at his most psychotic"** and was quite clear in his own mind that he did not think that what he saw in Grey was a drug-induced psychosis although he accepted the availability of drugs in prison.

P.O. Afrin had also told us that drugs were available to the inmates in Pentonville. Indeed he said that **"The use of cannabis is endemic"**. He said he would be surprised if Kenneth Grey did not have regular access to cannabis, but said there was no evidence that he was taking Class A drugs and felt with his experience he would be able to recognise the signs if he were. P.O. Afrin was also quite sure that Kenneth's behaviour was not drug-induced. He said to us:

> **"I would be amazed if it was something that he took. His behaviour changed completely he became a completely different character....There was a very marked deterioration in his behaviour over the period of time we held him. Noticeably so".**

15.11.94 - 17.11.94

Dr. Pierzchniak thought that Kenneth Grey should be assessed again for admission to hospital and this time he called in a Consultant Forensic Psychiatrist from Hackney Hospital, Dr. Neil Boast.

Dr. Boast said he would visit Kenneth on the 17th.

In the meantime, on the instruction of Dr. Yisa, Head of Medical Services at Pentonville, Dr. Lewis completed Section 47 papers on the 15th and Dr. Anthony on the 16th. It appears that Dr. Pierzchniak was not aware that the forms had already been signed.

Kenneth appears to have calmed down with the medication, but was **"still preoccupied with his bizarre and grandiose ideas."**

Dr. Boast assessed Kenneth on 17.11.94.

He told us; **"At the time he was very mentally ill."**

His entry in the prison hospital notes reads:

> **"He became elated as the interview progressed after initially being suspicious. He believes he is God & created all we see. He set up & runs NASA. He owned(s) the supermarket where he committed the theft.**
>
> **He is clearly mentally ill.**
>
> **He lacks insight & will undoubtedly not keep an Outpatient Appointment.**
>
> **I think S47 - hospital is desirable."**

On 25.11.94 Dr. Boast wrote to Dr. Pierzchniak summarising his findings. His conclusion in that letter was:

> **"It is clear that Mr Grey has become floridly mentally ill in the latter part of his prison sentence. Given his condition and lack of insight I do not think that he would comply with any programme of treatment in the community. I see no other option but for him to be transferred to hospital under section 47 of the 1983 Mental Health Act and support your recommendation. I and a member of the nursing staff both thought that Mr Grey's condition placed him in the area where intensive care and medium security overlaps. Having discussed the matter with Dr. O'Neill she is of the view that he could be managed in intensive care and as he is so close to the end of his sentence I think this is appropriate..."**

<u>20.11.94 - 23.11.94</u>

The following entries were made in Kenneth Grey's medical notes:

> **"20/11/94. "I died for man's sins. "Sing Hosanna to me." But pleasant and no management problems.**
>
> **"22.11.94.Patient believed he was for discharge would not go in cell was restrained & placed into AS2 at 0830"**

"22/11/94. A further incident today. Clearly believes he is not subject to prison rules and can determine his own EDR. Has been refusing oral medication. Needs Clopixol Acuphase 150mg. Keep in unfurnished cell"

"Bed available Hackney P.I.C.U. tomorrow p.m. ....Needs 4 person escort"

A bed became available at Hackney Hospital on 23.11.94 and Kenneth Grey remained on the Prison hospital wing until then. There are no entries in the hospital medical notes between the 17th and the 20th. There was no discharge summary. However we were told that the prison hospital notes usually went with the patient to hospital.

Kenneth Grey was given a long-lasting sedating injection the day before his transfer.

DISCUSSION

1. As much of Kenneth Grey's offending seems to have been drug related, and he was admitting heavy drug use at the time of his admission to Pentonville, this would have been an opportunity to evaluate the problem and set up a treatment programme whilst in prison.

2. There seems to have been no discussion between Dr. Pierzchniak and Dr. Bouwer/Dr. O'Neill following Dr. Bouwer's examination of Kenneth Grey on 14.10.94. Given what was recorded by Dr. Bouwer in the medical notes and Dr. O'Neill's letter, it is very difficult to understand the statement **"there is no evidence of major psychiatric disorder."** If an assessment plan and/or treatment had been initiated at this stage, could this have made any difference? ie.. He only became intimidating/violent after their visit. Could his aggression have been avoided by earlier treatment or at least an assessment?

3. There appears to have been no referral to Kenneth Grey's Probation Officer when he became ill, either in October or November. No attempt appears to have been made to made in October, despite Dr. Pierzchniak's concerns about Kenneth Grey's mental health, to contact the probation service to find out what would happen to him on his release which was fairly imminent. The probation service was not informed about Grey's illness until after his transfer to Hackney Hospital.

4. P.O. Afrin and Dr. Pierzchniak gave us a very clear picture of Grey as an extremely intimidating and menacing man when psychotic. This is not reflected in the prison hospital notes and these would be all the receiving hospital staff would have to go by in assessing Grey's risk factor.

5. The medical notes are more like "diary entries" than clear clinical observations. The picture they gave was very different to the picture of Kenneth as described to us in evidence.

6. There was no referral letter from Dr. Pierzchniak to Dr. Boast, merely a telephone call. We feel it would have been better if Dr. Pierzchniak's obvious concerns about Kenneth Grey had been put in writing and placed on his file so that anyone involved with his future care and management would have the advantage of knowing what those concerns were.

7. Dr. Boast recorded in the notes and confirmed to us in his evidence that he did not think that Grey would voluntarily comply with any treatment in the community and therefore needed to be transferred to hospital under section 47. This should have been noted when considering whether to remove the section only 2 weeks later.

8. Dr. Boast noted the gradual increase in disordered thinking during his interview with Kenneth on the 17th. A brief appraisal of him may well not have noticed any abnormality of thought.

9. There was no "Discharge Summary" of any kind which might have highlighted some of the real concerns about Grey. Such a Discharge Summary should, in our view, have contained at least a differential medical diagnosis and a history of Kenneth Grey's recent behaviour, including his violence and constant wish to change his EDR.

10. We are concerned that the Probation Service appears not to have taken any steps concerning Kenneth Grey other than visit him once in August. His EDR was approaching and he was known to be homeless and an habitual drug user whose habit led him to crime in order to fund it.

11. We feel that Hackney Hospital should have been informed that Kenneth Grey was on Licence, either by Pentonville on transfer (apparently his Licence remained at Pentonville) or by the Probation Service (although we are aware that through an oversight, they had not appreciated that Kenneth Grey was in fact on Licence.)

12. The Section 47 papers were signed by doctors who did not know the patient well, in advance of a definite decision to transfer him and before a bed had been identified for him either at Hackney Hospital or the Regional Secure Unit. It appears that they completed the paperwork at the direction of the Head of Medical Services and we therefore question whether there was a true independent assessment of Kenneth Grey's mental state. Although legal procedures were correctly followed, we feel that the papers should have been signed by Dr. Pierzchniak who was Kenneth Grey's allocated medical officer and Dr. Boast, the independent outside forensic psychiatrist who had been called in to decide in a difficult case in which there had already been disagreement. What happened seems to be more about institutional pressures, haste, efficiency and convenience than the interests of Kenneth Grey. A S.47 Order is after all an Order which deprives the patient of his liberty and permits detention in hospital with compulsory treatment if required for up to 6 months in the first instance.

13. The information about Kenneth Grey transferred between Pentonville and Hackney Hospital was of poor quality. It did not explain why prison officers who did not seem to be readily intimidated felt so threatened by him. It did not comment on how disturbed his behaviour had been prior to being given medication and the effect of more than a week of treatment with neuroleptics which undoubtedly modified his mental activity. There was no emphasis on his drug abuse or information about his contacts with the probation service. There was no independent history, no report of his social circumstances and no explanation of why this man had been sentenced to 12 months in prison for shoplifting a suit, batteries and some jeans.

HACKNEY HOSPITAL

Kenneth Grey was transferred to P.I.C.U. at Hackney Hospital on 23.11.94 under section 47 M.H.A.. The Responsible Medical Officer (RMO) for P.I.C.U. at that time was Dr. Colin Bouwer, a Locum Consultant from South Africa. His Senior Registrar was Dr. Jane O'Neill. The medical staff at the hospital mistakenly believed that Kenneth's section 47 order expired on the day of his E.D.R. ie.. 25.11.94. They therefore thought that they would have to re-section him under section 2 of the M.H.A. in order to further assess his mental state. Section 2 forms were completed by Dr. Bouwer and a Dr. Prasad on 24.11.94 and the Mental Health Locality team was contacted so that an Approved Social Worker (ASW) could carry out the necessary assessment of Grey to complete the application for admission for assessment under section 2.

Kenneth was seen by the ASW, Vestna Bennett, on 25.11.94. She interviewed him at length and concluded that he required further observation and assessment and therefore signed the requisite forms. She later wrote up her notes and completed an ASW's Report which should have been logged and filed at the Locality Team's office, but was not.

In that report, it is recorded that Kenneth told Vestna Bennett that he had not lived with his mother since he was 14 years old and had not been in contact with her for over 2 years. Vestna Bennett telephoned Kenneth's Mother (Ms. McGlashan) later that evening who confirmed that she had not been in contact with Kenneth for over 2 years and was not interested in discussing him and put the phone down.

Kenneth was told of his right to appeal against his compulsory detention to a Mental Health Review Tribunal and he decided to launch such an appeal.

The medical and nursing notes from P.I.C.U. show that Kenneth was showing bizarre and grandiose ideation throughout his stay on the ward although there is no record of any violence or aggression during this time.

Kenneth's mother visited him on 27.11.94. She expressed her surprise that her son was in a mental hospital and wanted to see Dr. O'Neill to discuss matters.

Kenneth's mother attended the ward round on 1.12.94 at the invitation of the medical staff. On that occasion, the doctors took a history from her of Kenneth's background. At the ward round, there was a discussion between the nursing staff and the doctors about Kenneth's situation and a decision was made to transfer him the next day to an open ward for continuing assessment ie.. still under section 2. It was also decided to permit him to go on escorted walks. He had one that afternoon.

At lunchtime the next day - Friday the 2nd December, Dr. O'Neill discovered that there was to be a Mental Health Review Tribunal hearing of Kenneth's appeal on the following Monday ie.. the 5th. She went to see Kenneth on that Friday afternoon and recorded in the notes: **"Denies any psychotic symptoms. Calm. sleeping well. Mood normothyme."**

At 3.15 p.m. on the 2nd December Dr. O'Neill discharged the section 2 and at 5 p.m. Kenneth was transferred to the open ward - Brett Ward - as an informal patient.

Within a couple of hours of his transfer to Brett Ward (no-one knows the precise time) Kenneth Grey went missing and never returned to the hospital again.

On 9th December (? 14th. There is a discrepancy in the records) he was discharged in his absence.

Dramatis Personae

Dr. Mooney

Junior Doctor (SHO) who admitted Kenneth to P.I.C.U. on 23.11.94 and carried out an assessment of him on admission. He was also present at Dr. Bouwer's ward round on 24.11.94 and Dr. O'Neill's ward round on 1.12.94. He made several entries in the medical notes.

Dr. Bouwer

See under Pentonville above.

Dr. O'Neill

See under Pentonville above.

Lyn Sambanj

Kenneth's Key Nurse on P.I.C.U.

Paul Dobson

Charge Nurse on P.I.C.U. who admitted Kenneth.

Julie Makuzwa

The Named (Key) Nurse for Kenneth on Brett Ward.

Staff Nurse Roojee

Nurse who admitted Kenneth to Brett Ward and was on duty when he went missing..

Anton Weerekone

The Nurse who came on duty on Brett Ward at 9p.m. on 2.12.94, the night Kenneth went missing.

Dr. Martin Deahl

Consultant RMO on Brett Ward.

Vestna Bennett

ASW with the North West Locality Mental Health Team who carried out the section 2 assessment.

Leonie McGlashan

Kenneth Grey's mother.

HACKNEY "DIARY"

23.11.94

Kenneth was transferred from Pentonville to P.I.C.U. Hackney Hospital on 23rd November, just 2 days before his EDR when he was due to be released from prison. Dr. Mooney assessed him on admission and wrote a lengthy assessment report in the medical notes. The only reference he made to the prison notes were that they reported **"increasingly bizarre behaviour over the last week or so - unreasonable demands - using their computer. Saying he was King of Africa and related to God. Last week got angry because thought he was going home - he now says he got his days confused. apparently needed Acuphase yesterday as aggressive"**

There was no mention of any violent or threatening behaviour. He could not recall whether or not he had seen P.O. Afrin's letter at that time although it was now in Kenneth's file.

Dr. Mooney took a detailed history from Kenneth and described him as having a " **history of aggression and grandiose behaviour."**

Paul Dobson, the nurse who admitted Kenneth to P.I.C.U. told us about the information he had gathered from the prison on transfer:

> **"I remember reading a letter. The information was quite useless. It spoke of how Grey had entered into the office and spoke about wanting to use the computers."**

He told us that he was not sure what the concerns were about Grey and was not aware that he had thrown a meal at the prison officers.

The Nursing Notes for the 23rd state **"No untoward behaviour displayed."**

The Care Plan prepared by Kenneth's Key Nurse, Lyn Sambani, shows that as at 23.11.94 the aim of his care was **"to do a complete mental assessment".**

24.11.94

There was a ward round headed by Dr. Bouwer, the notes of which were written up in the medical notes by Dr. Mooney who accompanied him. These notes include:

> **"Overactive thinking. Describes his thoughts as bouncing around like a rubber ball in a square. Spent nights drawing - people and writing - about a baby formed and how one can make babies in a test tube. Says he has been having the ideas of planets since child."**

Under a misapprehension that the Section 47 would expire on the 25th November, the day of Kenneth's EDR from prison, Dr. Bouwer felt it was necessary to detain Kenneth for assessment under Section 2 MHA. He and a Section 12 approved doctor, Dr. Prasad, completed their part of the section forms on the 24th and the North West Locality Mental Health Team (NWLMHT) were informed of Kenneth's admission to Hackney and the need to complete an ASW Assessment for the section.

The nursing notes showed nothing untoward.

25.11.94

Vestna Bennet was an ASW temporarily with the NWLMHT. She attended Hackney Hospital on being informed about Kenneth Grey. She told us that she did not realise that Kenneth had already been at Hackney for 2 days and thought he had been transferred only that day. She interviewed Kenneth for the purposes of the section 2 assessment and prepared a report from her notes. The report records that Kenneth had been transferred from Pentonville under section 47 which had expired the previous day. However she told us that she was fully aware that a section 47 did not expire on the day of a prisoner's EDR and had queried the necessity for a S.2. She said that it was only because no-one could produce the actual section 47 documents to confirm that he was detained under that section that she went ahead with the assessment. She said that the only documents she saw were the medical records from Hackney which contained only the admitting doctor's notes at that stage. She also said that the only information she was given about Kenneth's behaviour whilst in prison was that: **"He had been behaving in a very bizarre manner, talking to the computer and expecting it to respond to him. He was verbally aggressive."**

The interview took about an hour in all. For the first half hour of the interview Kenneth apparently behaved quite lucidly and rationally. He gave Vestna Bennett a detailed history of his childhood and adolescence, including his criminal activities and drug-taking. He told her that he had not lived with his mother since he was 14 years and had not been in contact with her for over 2 years. He gave Vestna his mother's name and telephone number. He said that he did not need any assistance with rehousing as he planned to return to Plymouth to live with his former girlfriend and would make his own arrangements. However it was clear from the rest of what he told Vestna that this relationship had broken down a considerable time ago.

After about half an hour he suddenly became very agitated and became **"preoccupied by theories and pseudophilosophical ideas and issues."**. He said he wanted to become a king and then thought he was one. He said that his mother was the Queen of England; that his parents originated from Germany and that **"his skin is black but he originates from another spirit"**. He then said he had to leave the room and refused to be interviewed any longer.

Vestna considered him to be in a **"paranoid delusional state"** and sufficiently mentally ill to require assessment and completed the section 2 forms.

Later that evening, Vestna tried to reach Kenneth's Mother by telephone and eventually succeeded at about 10 p.m. She told us that she told Ms McGlashan that Kenneth was in P.I.C.U. at Hackney which was a psychiatric hospital but that his mother had made it very clear, abusively, that she wanted nothing to do with him. She apparently said words to the effect;

> **"I haven't heard from my son for over 2 years. I don't want any contact with him. Don't ring here."**

[Apart from a brief encounter when she was visiting someone else on P.I.C.U. the following day, Vestna Bennett did not see Kenneth again. She does not appear to have filed her report with the NWLMHT. She was not aware that Kenneth had appealed against his detention under section 2 until after the date fixed for a hearing and was not aware that he was missing from the hospital until after the murder. She had gone on leave on 12.12.94 and left the team in January.]

The nursing notes for the 25th record that early in the morning Kenneth had been talking to himself in an angry mood after having his medication. After the completion of the section 2 papers he was told of his rights and had said he was going to appeal. The forms were then given to him and he was guided on how to complete them.

The night duty entry records that he was expressing **"marked grandiose ideas...the hospital cannot keep him here because he is royalty, he is married to the Queen and the Queen herself will come and remove him from here".**

26.11.94

The nursing notes show that Kenneth was still deluded in his thoughts and that one of his main concerns was his freedom. He spent the morning drawing pictures which Lyn Sambani described to us as **"quite weird"**. Some he had brought with him from prison. Paul Dobson remembered one of them as being of a head with dots and circles inside it which Kenneth said were the planets in his head and he could control the orbit.

27.11.94

Lyn Sambani updated her care plan for Kenneth and concluded that he lacked insight into his mental problems.

Kenneth's mother visited him on P.I.C.U. and Lyn Sambani described Kenneth kissing and embracing her. Ms. McGlashan was very concerned that P.I.C.U. was not the right place for her son and insisted that her son was not mad at all. She wanted him discharged but said he had nowhere to go. She wanted to see the doctors to discuss things with them. She was pressing for a transfer to an open ward and wanted the hospital to look into accommodation for him.

The nursing notes describe Kenneth as still having grandiose ideation and a lack of insight into his mental illness. He still did not know why he was being kept in hospital.

28.11.94

Kenneth was noted to be appropriate in speech when interacting with the other patients, but got hold of one of the nurses' books and began reading up on the Mental Health Act. He said he had a better understanding of his section after reading the book and wanted to read more. He said he would cooperate with staff in helping him get better and he asked for his clothes to be cleaned. Lyn Sambani up-dated her care plan again still recording that Kenneth lacks insight and that he still believed he was the Queen's Husband and had the power to influence the planets.

29.11.94

There was a ward round in the morning according to the nursing notes, but neither these nor an entry in the medical notes in Dr. Mooney's hand records who was the senior doctor there.

The morning nursing entry reads:

> **"WR. Walks to be discussed after investigations: EEG and CT Scan to be arranged for him. To stay on PICU till Snr Registrar discusses issues of his background with the mother and results of the investigations are known."**

Later that day an EEG and CT Scan were arranged for the morning of 7.12.94.

He still appeared grandiose that afternoon although he was denying his grandiose ideas.

When asked if he still appeared mentally ill on the 29th, Lyn Sambani told us:

> **"Sometimes he was very unpredictable. I would assess him from day to day...One week was not a long enough period to make an assessment."**

30.11.94

It was recorded in the nursing notes that Kenneth was still talking about his concerns about his freedom.

Lyn Sambani told us that he said he wanted to be discharged to sort out his accommodation and wanted to be free to do what he wanted.

1.12.94

There was a ward round attended by Dr. O'Neill, Dr. Mooney, and Lyn Sambani. Kenneth's mother also attended and was interviewed by Dr. O'Neill as was Kenneth.

Dr. Mooney wrote up the notes of this in the medical notes. He records that Kenneth's mother said that **"she has seen no changes in his behaviour and thinking (she has visited 2-3 a month)"**. She was also worried that his bizarre behaviour may be secondary to drug taking in prison.

According to the medical notes the nurses report remained much the same: **"He is royalty, married to the Queen. Still preoccupied about planets & NASA."**

When interviewed by Dr. O'Neill, Kenneth denied thoughts of Africa/God/planets and said that he was only saying that he was related to royalty to give himself confidence - that he was only joking. He felt he was an expert in fertility - but not now. He still believed about the planets.

Following the ward round there was a discussion about Kenneth's future treatment between the nursing staff and the doctors and it was decided to transfer him next day to an open ward still under section for further assessment. Escorted walks would also be started. He had one that afternoon. Lyn Sambani told us that she would have told Dr. O'Neill that Kenneth was wanting to get out of hospital.

On 1.12.94 Rab McNeill of the NWLMHT was notified by the hospital about Kenneth's appeal hearing in front of the MHRT on Monday 5th December. The ASW would need to prepare a report for the hearing. He admitted to us that he should have done something about this immediately, but in the event Vestna Bennett was not informed about the hearing until the 6th, by which time Kenneth's section had been removed, the hearing had been cancelled and Kenneth had gone AWOL. The NWLMHT were not informed that Kenneth's section had been discharged or that he was absent without leave from the hospital.

2.12.94

A Staff Nurse on P.I.C.U., Abdul, made a telephone call to the North West Locality Mental Health Team (NWLMHT) to establish who was the Key Worker for Kenneth Grey. The call was taken by Eddie Davies, Lead Practitioner, who had no prior knowledge of Grey and therefore asked for some more information from Abdul who told him about Grey's transfer to Hackney from Pentonville under S. 47 and the subsequent S.2 application which had been endorsed by Vestna Bennett. He also told Eddie Davies that Kenneth Grey was appealing against his compulsory detainment and that a Social Report was required for the Tribunal hearing.

Dr. O'Neill learned for the first time around lunchtime that Kenneth's appeal was to be heard by the Mental Health Review Tribunal (MHRT) on Monday the 5th. She told us that the plan on the 1st was to transfer Kenneth to the open ward still under section. She told us that the change of plan to discharge the section was a clinical decision on assessing him the next day and not seeing "**any abnormalities in his presentation. I asked him specifically about his previous delusional beliefs, which he denied. I did an assessment of risk and I believed there was no history of violence. I did not think tht he was dangerous, a risk to himself or others. I felt his mental state was normal I therefore did not have grounds to continue to detain him on section 2**". She very honestly admitted to us that if the Tribunal hearing had not been on the Monday, she probably would have continued the section. However she feared that if Kenneth appeared well on the Monday, the Tribunal would discharge the section. She believed that she did not have the grounds to continue to detain him on section 2 and was required to discharge the section unless she could show that he continued to show signs of mental illness. She confirmed to us that at the time the section 2 had been imposed ie.. 25th November Kenneth was clearly mentally ill.

Dr. O'Neill discharged the section 2 at 3.15 on the afternoon of Friday 2nd December. At 5 p.m. Kenneth was transferred from P.I.C.U. to Brett Ward as an informal patient.

It appears that it was an extremely rare if not unique occurrence that a section was removed simultaneously with a transfer from a secure ward to an open ward.

Kenneth's "Named Nurse" on Brett Ward was Julie Makuzwa. At the time of his transfer she was on leave and did not return until 5.12.94, three days after Kenneth went AWOL.

The Admitting nurse on Brett was Staff Nurse Roojee. He had a conversation of about 1/2 to 3/4 of an hour with Kenneth and recorded the history he had taken in the notes. The care plan he drew up included **"To do a complete mental assessment".**

S.N. Roojee told us that he would expect that anyone discharged off section 2 (the assessment section) would have already had a full assessment of his mental state carried out. He told us:**"One assessment is not enough to judge a patient."**

He could not tell us exactly when Kenneth left the ward, but said that he first noticed his absence about 8 p.m. He did not record that he was missing in the notes or notify any of the doctors or the security men at the hospital gates because he **"assumed he would return very shortly".**

When the night shift staff nurse, Anton Weerekone, came on duty at 9 p.m., S.N. Roojee told him that they had a new patient who had just popped out and he would come back. Both nurses told us that they would have acted differently if Kenneth had still been detained under a section rather than being an informal patient. SN Roojee said he would have involved all the nursing staff, carried out a search, informed the doctors, informed the police and the "Bleep Holder". As it was he did not look for Kenneth outside the ward. Both knew of the Missing Patient Procedure which included a Missing Patient Form but did not feel it was necessary to fill one out in Kenneth's case. Both men accepted that Kenneth was an unknown quantity to them but relied on the fact that his section had been discharged and therefore assumed that his "risk factor" had been assessed prior to the discharge.

Anton Weerekone told us that, having been told by Mr Roojee that Kenneth would be back, he did nothing other than tell the night co-ordinator that Kenneth had not returned at some time when they called in to do a routine check and he said he tried to telephone Kenneth's mother at about midnight but got no reply and assumed she was asleep and did not want to disturb her further. His entry in the notes reads:

> **"Kenneth was not returned to the ward. At about 3.15 a.m. his mother phoned to P.I.C.U. Told them that Kenneth told her that he was discharged but it is not true. AWOL. He stays with his mother".**

He acknowledged that until Kenneth's mother phoned, he had no idea where Kenneth was. SN Roojee came back on duty the following morning and telephoned Kenneth's mother. She told him she was not happy having Kenneth at home and that he was homeless. She told him that she would bring Kenneth back to the ward that afternoon. SN Roojee told us that after that reassurance, he did not consider Kenneth to be a missing person.

DISCUSSION

1. The real picture of how Kenneth Grey had been behaving in Pentonville does not seem to have been got across to the medical and nursing staff at Hackney. The fact that an experienced and hardened Principal Prison Officer felt that he "**radiated menace**" appears to have been totally unknown to the hospital staff who appear to have considered the problem whilst in prison to be mainly due to Kenneth's obsession with a computer, although they realised that he had grandiose delusions.

2. We were told that the prison records should have gone with Kenneth to Hackney but that the prison officers would not leave them and would require them to be photocopied immediately and then returned. We are not sure into which file (ie.. medical or nursing) they would have been inserted, but it seems as though Paul Dobson saw P.O. Afrin's letter at least at the time of Kenneth's admission, but Vestna Bennett said she saw no documents from the prison two days later on the 25th. Both commented that they believed that the problems encountered at Pentonville had something to do with computers. They appeared unaware of Grey's potential for intimidating and threatening behaviour.

3. Everyone at Hackney that we interviewed wrongly interpreted the effect of section 47 MHA and believed that it lapsed on the date of the prisoner's EDR. It does not. Had they correctly interpreted the section and realised that it had the same effect as a Hospital Order (see section 37 MHA), they could have detained him for an initial period of up to 6 months (which can be renewed) although he could have been discharged at any time by the responsible medical officer, a Mental Health Review Tribunal or the hospital managers. However, unlike a civil admission for treatment, the nearest relative cannot order his discharge under s.23 or apply to a MHRT within the first 6 months and although the patient does have the right to apply to a tribunal within 6 months of the hospital order being made, the hearing would not have to be held within 7 days as required under S.2. Since Dr. O'Neill appears to have been greatly influenced by the imminence of the MHRT in her decision to discharge the s.2, this may have made a significant difference to the outcome of this case.

4. Kenneth Grey was transferred under S.47 and therefore the aftercare provisions of S.117 would have automatically applied. S.117 procedures were not properly in place and were not implemented in Kenneth Grey's case. Once again the wrong interpretation of S.47 and his therefore unnecessary subsequent detention under S.2 led to confusion about Kenneth's management and his rights.

5. Once a decision had been made to place Kenneth under s.2 for assessment, a full and proper assessment of Kenneth's mental state including the risk factor to himself and others should have been completed before any consideration was given to discharging the section. We accept that Kenneth showed no signs of threatening or violent behaviour. Prior to his transfer to Brett Ward the assessment was going well but was incomplete. We share the views of the nursing staff on P.I.C.U. who told us:

> **"We only had seven days with Grey and we could not make a proper assessment."**
>
> **"We were expecting the assessment process to continue when he was moved and be an on-going process."**

We were struck by the fact that the nurses that we interviewed seemed to have an extremely good idea about what constituted a proper S.2 Assessment which includes collecting as much information about the patient from as many people as possible.

Kenneth Grey was only on S.2 for 7 days. The assessment was undertaken without vital information, including his criminal record, his serious drug problem, his unreliability in reporting to his Probation Officers, his failure to stay for more than 1 day at Phoenix House Drug Rehabilitation Centre, the full extent of his behaviour and mental state in Pentonville, and the assessment of the ASW, Vestna Bennett, whose information about Kenneth's relationship with his mother differed drastically from their own. We feel that at least some of this information should have been sought in order to properly assess Kenneth Grey's 'risk factor' to himself and others.

6. Kenneth told the ASW Vestna Bennett that he had not seen his mother for two years and had never had a good relationship with her. This was confirmed by Ms McGlashan when Vestna telephoned her the same night. She said she wanted nothing to do with Kenneth and put the phone down on her. This information was never known to the hospital staff, and at the ward round on 1.12.94 when Kenneth's mother was interviewed, she told the hospital staff that she had seen no change in Kenneth's behaviour or thinking and had visited him 2-3 times a month. Kenneth told us that his mother had not visited him in prison although he had gone to see her on the morning of the court hearing. Kenneth's mother was apparently very insistent at that ward round that her son should not be in a psychiatric hospital and should be released. We do not know if her insistence had any influence on subsequent decisions made in the next 24 hours, but had the hospital staff been aware of the lack of contact and poor relationship that Kenneth had with his mother it might have made them question her history of events and made them less complacent when he appeared to be in contact with her after he went AWOL. They also relied on her to persuade him to return to hospital.

7. Vestna Bennett had also had the experience of a lengthy interview with Kenneth during which he changed after the first half hour from being lucid and rational to being grandiose and agitated. Dr. Boast had had a similar experience when he saw Kenneth on 17.11.94 in Pentonville. Vestna's Bennett's report was not available to the hospital staff, but it does not seem as though Kenneth was interviewed at any length after the 25th before the decision was made to discharge the section. It is possible that had Dr. O'Neill spent more time with Kenneth on 2nd December she might have noticed some continuing signs of mental abnormality which would have persuaded her not to discharge the section.

8. There was only one entry made by the doctors in the medical notes between the 24th November and 1st December. This was a short entry made by Dr. Mooney on the 29th. There is no evidence that any consultant saw Kenneth between the time that Dr. Bouwer saw him on the 24th and signed the s.2 documents and the time that Dr. O'Neill discharged the section.

9. Dr. O'Neill believed she had the power as Senior Registrar to discharge the section. She did not. Where the doctors are concerned, only the RMO or another Consultant who has been delegated as the RMO responsible can sign Discharge and Leave of Absence Forms under the provisions of S.23 MHA. However, we are sympathetic to the fact that Dr O'Neill had been placed in a difficult position by the absence of the RMO with no other consultant cover. We have been informed that a Memo has now been circulated to all Senior Registrars and consultants at Hackney reminding them of this statutory provision.

10. The person accountable for Kenneth Grey's management and care on P.I.C.U. was the RMO, Dr. Bouwer. He seems to have been absent for most of the time that Kenneth Grey was on the ward and it was therefore left to a Junior Medical Officer to speculate over the right course of action and her role in relation to this action. This cannot be right for either the Junior Doctor or the patient.

11. We were gravely concerned that there seemed to be few if any employment and induction protocols for temporary and locum staff. Whilst we recognise the difficulty of recruitment across the mental health professions, we cannot accept that it is good practice to appoint a person to take the lead in a unit as busy as P.I.C.U. at Hackney Hospital by virtue of some kind of honorary position linked to a lecturing post when, despite an impressive C.V., it appears that he had no grounding in English mental health law, no background in the specialty to which he was being asked to contribute and there were no protocols for his induction or for the supervision of his Juniors.

12. Why was the section 2 discharged when it seems as though the main concern on the Friday was that there was a wish to avoid the MHRT doing exactly that on the hearing on Monday. Although not complete, the process of assessment under the section was well under way by 1.12.94. There were several elements of a full multidisciplinary evaluation still to be done and it would have been more than reasonable to put to the MHRT that more time was needed to complete the process. Within the previous 2 weeks no fewer than 6 experienced psychiatrists had formed the opinion that Kenneth Grey was showing sufficient evidence of mental disorder to be detained in hospital for assessment / treatment. These were Dr. Pierzchniak, Dr. Lewis, Dr. Anthony and Dr. Boast while he was in Pentonville, and Dr. Bouwer, and Dr. Prasad who completed the S.2 forms at Hackney Hospital just one week previously. Vestna Bennett the ASW had also accepted the medical recommendations in applying for the Order. Although Kenneth Grey was considerably improved by 1st December, it was too soon to tell if his response was steady or liable to fluctuation. We feel it would be a particularly inflexible and badly advised Tribunal which decided to discharge the liability to be detained in the face of a request for some further time to complete the assessment.

13. We have become aware during our enquiries that there appears to be some concern that Mental Health Review Tribunals in this part of London are likely to discharge orders for detention on the grounds that the patient displays no active symptoms at the time of the Tribunal hearing. If it is correct that this "snap-shot" approach does prevail, we are most concerned about it.

14. Dr. O'Neill's decision to discharge the section in the light of the closeness of the Tribunal hearing seems also to have been influenced by the fact that she was handing over responsibility for Kenneth Grey to the medical staff on Brett Ward and that the Brett RMO would therefore have to attend the Tribunal on Monday without any knowledge of Kenneth Grey to try to persuade the MHRT not to discharge the section. It seems extraordinary to us that the RMO or someone from P.I.C.U. could not have attended instead despite Grey having been transferred. Notwithstanding the assumption regarding the tribunals likely response, it left Brett Ward with no say over the recommendations that could be made to a tribunal over the most appropriate legal status for a patient for whom they were going to have responsibility.

15. The entry made in the medical notes regarding the discharge of the section is brief in the extreme. It says:

> **"Denies any psychotic symptoms. Calm. Sleeping well. Mood normothyme. Discontinue section 2."**

There was no attempt made by Dr. O'Neill to contact Dr. Bouwer prior to discharging the section although she told us that he was contactable by telephone when not at the hospital. She did however, tell us that she had discussed the forthcoming tribunal hearing and Kenneth's current behaviour with the nursing staff. The decision to lift the section was in our opinion premature and not justified on the grounds that assessment had been completed or that sufficient was known about Kenneth Grey, his lifestyle and his illness to take the chance that he would remain in hospital so that a full evaluation (including the risk factor to self and others) could be completed. In our opinion, an assessment should include a review by a multi-disciplinary team of the patient's psycho-social functioning in all its aspects and should address all of the individual's needs, both whilst in hospital and afterwards in the community. Such a multi-disciplinary assessment is, in our opinion, particularly important in PICUs, where it could be argued that assessment needs should be a priority as the turnover of patients is high, there is a high proportion of patients presenting for the first time with severe mental illness and there is a high proportion of acutely disturbed patients. We also feel that in making the decision to discontinue detention under the MHA, there should be some diagnosis established.

16. If it is accepted that the concept of an assessment requires broader involvement from those whose input would be valuable in a longer term package of care for Kenneth Grey, then we must question the non-involvement of the following:

(a) the Probation Officer who had previous and significant involvement with him;
(b) the expertise of a social worker;
(c) the locality mental health team;

17. We also are concerned that diagnostic assessments such as drug screening, EEG and CT scans which had been arranged as part of the assessment and were therefore obviously considered to be a necessary component of it, were not completed prior to the discharge of the section.

18. Brett Ward knew nothing about Kenneth Grey at the time he was transferred. SN Roojee had to form his own impressions of him towards the end of a long shift on a busy ward. He was understandably lulled into a sense of false security by the removal of the section. Transfer at 5 pm on a Friday evening can not be considered the best time to ensure a feeling of security in the patient coming from a locked to an open ward nor is it the best time for the receiving ward.

19. Brett Ward was faced with a `fait accompli' in Kenneth Grey's section being discharged immediately prior to his transfer. The medical and nursing staff on Brett had no say in his legal status at the time that they took over responsibility for him and therefore had to manage him as an informal patient without any control over how they might prefer or need to manage him.

There was no care plan for Kenneth Grey established between the wards before his transfer to Brett Ward and it would have been reasonable for Brett Ward staff to have assumed that he would come from P.I.C.U. with a S.2 still in place. The discharge of the section simultaneously with a transfer from the secure ward to an open ward was considered extremely unusual if not unique by all of the witnesses we asked about it, and there was no witness who considered this to be good or desirable practice.

20. Once again there was a poor handover between P.I.C.U. and Brett Wards with inadequate information being passed on. The transfer of medical and nursing responsibility was abrupt and apparently total. The important principle of continuity in psychiatric treatment appears to have got lost. Kenneth Grey's management reminded us of the children's game "Pass the Parcel".

21. Signs of Kenneth Grey's strong desire to leave the hospital (both verbal clues and behavioral clues such as his desire to have his clothes cleaned) were apparently missed or ignored and were certainly not communicated to the staff on Brett Ward. Nor was his mother's insistence only the day before that her son should not be in a mental hospital.

22. Despite the fact that Kenneth Grey was an informal patient at the time of his arrival on Brett Ward, we are amazed that so little concern was engendered by his going missing almost immediately. No-one looked for him outside the ward nor notified the duty doctor. They did not even contact the gate to ask if they had seen him leave or put in a call to P.I.C.U. to find out more about him. There was no way that they could assess the risk factor to himself or others.

23. We also cannot understand how SN Roojee could have told the night shift nurses that Kenneth **"had just popped out and would be back"**. He had been missing for over an hour by then and had spent the last week in a locked ward and had been nowhere else in the hospital. Where had he **"just popped out" to?**

24. Anton Weerekone had never even met Kenneth. He was already missing when he came on duty at 9 pm. Even if Kenneth had just "popped out" somewhere, he was clearly absent without leave and should have been back by then. It was the beginning of December and late at night and nobody knew what clothes he was wearing. It was not until Kenneth's mother phoned P.I.C.U. at 3.15 am that it was even recorded that he was AWOL.

25. There was a perfectly good Missing Patient Procedure in place at the time and the staff on Brett Ward were well aware of it. They did not put it into motion despite the fact that Kenneth fell into the category of a missing person as defined in the policy document ie. **"an inpatient who has left the ward without the consent of a member of staff"**. This appears to have been because Kenneth was an informal patient. No allowance appears to have been made for the fact that only a very few hours beforehand he was still under a section.

26. We were very concerned that a key/named nurse who was on leave should be allocated to a patient being transferred from a locked ward. It seems to us to be crucial that someone who is going to be primarily responsible for a patient is there to receive him at such a critical time.

27. Almost everyone we interviewed from the hospital mentioned the pressure on beds, especially on P.I.C.U. and we are aware that such pressures can also influence decisions and that there may have been a greater need for someone more ill than Kenneth Grey to have a bed on the secure ward. We accept that the decision to transfer him to an open ward was appropriate and reasonable, but not the decision to discharge the section nor the timing of the transfer.

28. Kenneth Grey had been transferred under s.47 which should automatically trigger s.117 aftercare procedures. Because of the misinterpretation of Kenneth's legal status after his EDR, he was placed under s.2 instead. The NWLMHT told us that they considered him to be under s.2 rather than s.47 therefore without the statutory requirement for initiating s.117 procedures. The nursing staff told us that they thought they would have had more time to co-ordinate an aftercare plan for Kenneth. One of the witnesses told us that their view of Kenneth Grey was that he would have been in hospital for short term treatment and would soon be out and therefore **"why spend all that time on aftercare."**

29. The hospital staff believed that because an ASW from the NWLMHT had carried out a s.2 assessment, Kenneth had been referred to the team as a whole. We can understand how that assumption was made, but in fact Vestna Bennett had not filed her report and the team appeared to be unaware of Kenneth's existence.

ABSENT WITHOUT LEAVE

Kenneth left Brett Ward some time between about 7pm and 8pm on the night of Friday 2nd December. His mother telephoned P.I.C.U. at about 3.15am Saturday morning to say that he had turned up at her home saying that he had been discharged by the hospital. It was only after this call that Kenneth was recorded in the notes as being AWOL.

Over the next couple of days there was telephone contact between the ward and Kenneth's mother invoking the hope that he might return to the hospital, but he did not. The NWLMHT were never informed that Kenneth was AWOL and other than requesting a report on 1.12.94 for the MHRT hearing on 5.12.94, no further contact was made with the Locality Team by the hospital staff. After the 7th December there appeared to have been no further contact with Kenneth's mother. On the 9th December (or the 14th) he was discharged from the hospital.

It is not clear what happened over the next 3 weeks although Kenneth told us that he was staying with friend in Leytonstone and that he visited his mother 2 or 3 times a week. Otherwise we do not know where he was or what he was doing. He admits to taking some cannabis and heroin during this period of time. He said that at first his mother tried to persuade him to go back to hospital and then stopped, but he felt she still wanted him to.

He told us that his strange thoughts got worse and that it was as if he was someone else. He told us that this had happened to him before when he was about 16.

In the evening of New Year's Day Kenneth strangled his mother.

Our understanding of what happened that night comes from the witness statements from the criminal proceeding against Kenneth. We did not ask him to tell us the details of what happened. It appears that he had gone to her flat that evening and had been behaving so strangely that she went upstairs to a neighbour's flat and called the police to send someone as her son was acting very strangely. Apparently she had also called out of a window and asked another neighbour to call the police. She did not stay upstairs however, she returned to her flat and her son. A short while later she went back upstairs to her neighbour and called the police again. Once again she returned to her own flat only to appear at her neighbour's front door again a few minutes later asking to be let in. The neighbour let her in. Kenneth was behind her and his mother tried to shut him out but he forced his way in. The neighbour describes him as very aggressive, demanding to know why she was hiding from him. Ms. McGlashan started to say over and over again **"Jehovah have mercy on me"** which seemed to incense Kenneth who started shouting **"Don't patronise me. Say God is the Devil".** When his mother said that she could not because Jehovah was her religion, Kenneth grabbed her throat shouting **"Say it, say it"**. The neighbour then escaped from the flat and by the time the police arrived about 5 minutes later, Kenneth's mother was dead. Kenneth was arrested within minutes on the stairs of the block of flats where his mother lived by the police answering the 999 calls..

We know from the psychiatric records that Kenneth was seen whilst in custody by Dr. Amanda Hoar, Consultant Psychiatrist, on 2.1.95 and told her that he was Prince Charles and God. He repeated some of the same grandiose and delusional beliefs which he had expressed at Pentonville and Hackney and also that he thought Dr. Hoar was a martian in human form. He commented that at Hackney they had not believed that he was God but that they would now know without a doubt that he was God. Dr. Hoar recorded:

"Mr Kenneth William Grey is suffering from Manic Depressive Disorder Manic Type. His mental state is such that he is unable to give a coherent account of events saying he is God and people don't die."

On the 3rd January Kenneth was sent to the Hospital Wing at Pentonville Prison where he remained until 10.3.95 when he was transferred under s.48 MHA to the secure psychiatric wing at Stockton Hall Hospital. On 7.4.95 he was admitted still under section to Camlet Lodge, Regional Secure Unit at Chase Farm Hospital.

Kenneth was charged with the murder of his mother and on 25.7.95 appeared at the Old Bailey where his guilty plea to manslaughter on the grounds of diminished responsibility was accepted.

Expert psychiatric evidence was called by both the prosecution and defence, but the Judge was apparently persuaded by the evidence of the prosecution expert, Dr. Harry Kennedy, who had overall care of Kenneth at Camlet Lodge, that Kenneth was suffering from a drug-induced psychosis at the time of the murder.

Kenneth was sentenced to 7 years imprisonment and is currently at Blundeston Prison, near Lowestoft where we interviewed him. We understand that the CPS are considering an appeal against the leniency of the sentence.

Dramatis Personae

Vestna Bennett
See under Hackney above.

Staff Nurse Roojee
See under Hackney above

Anton Weerekone
See under Hackney above

Dr. Thakore
A locum Consultant psychiatrist at Hackney.

Dr. Caryl Barnes
SHO to the consultant RMO on Brett Ward.

Eddie Davies
Lead Practitioner NW Locality Mental Health Team.

Rab McNeill
NW Locality Team Manager

Nand Gopaul
Clinical Nurse Manager at Hackney.
Senior Nurse on call on 2.1.95 when hospital informed that Kenneth had murdered his mother.

Dr. Ann Hoar
Consultant Psychiatrist who saw Kenneth in custody the day after the murder.

Dr. Pierzchniak
See Pentonville above.

Dr. Coid
Consultant Psychiatrist who reported on Kenneth after the murders.

Dr. Harry Kennedy
Consultant Psychiatrist with care of Kenneth at Camlet Lodge. Gave expert evidence on behalf of prosecution at the Old Bailey. Gave evidence to us.

Myra Lawson
Senior Probation Officer

AWOL DIARY

3.12.94

SN Roojee telephoned Kenneth Grey's mother, Ms McGlashan later on Saturday morning when he came back on ward duty, and she told him that she was not happy having Kenneth with her and that he was homeless. She said that she would escort him back to the hospital that afternoon. Later that afternoon she left a message that Kenneth had gone shopping with her and had told her he was coming back to the ward. He did not return.

4.12.94

Nothing was done by the hospital during the day other than to record in the nursing notes that Kenneth Grey remained AWOL. The night shift entry notes a telephone call from Grey's mother inquiring about him, saying that he had left her home to return to the ward. However he failed to return.

5.12.94

Kenneth Grey's mother phoned in the morning to see if he had returned. The nursing notes comment that the MHRT hearing planned for that afternoon had been cancelled and that a message had been left with the NWLMHT for an allocated Key Worker to contact the ward.

Dr. Barnes recorded in the medical notes:

"Transferred from P.I.C.U. over w/e. Left ward & hasn't returned. NS (nursing staff) phoned mother who has seen him in the street but he hasn't visited her. NS to do home visit. Locality team informed."

This was the first entry in the medical notes since Kenneth Grey's transfer to Brett Ward on the afternoon of 2nd December.

The Brett nursing staff telephoned Grey's mother again in the afternoon who had not heard from him and was concerned for his safety.

6.12.94

The medical notes record a ward round with Dr. Thakore. There was then the following entry:

"Gone AWOL. Not on any 1983 MHA sxn. Discussed with Abdul on PICU; they contacted the Home Office and they say he has served his sentence. Is thought to be homeless. Locality Team informed of his plight."

The morning nursing notes record:

> **"Dr. Thakore also confirmed that we need not inform the police of Kenneth's AWOL due to him being informal.**
>
> **Have referred Kenneth to Sharon Spencer the Duty Social Worker at Tottenham Social services who deal with the N22 Catchment area. This is a new name to their offices and so**

we are to inform them of any development in locating Kenneth. Informed Sharon of Kenneth being AWOL and gave her full details/contact numbers."

7.12.94

The medical notes contain an entry made by Dr. Barnes:

> **"NS to contact Police to circulate his info & express concern that he needs to be in hospital. Mother hasn't seen him at all."**

[As far as we are aware, the Police were not contacted]

The nursing notes state:

> **"Remains AWOL. No further news heard of Kenneth. Staff believe that Kenneth should be in hospital as he posed a threat to the community when he is at large due to his past history."**

The night shift entry reads:

> **"I received a phone call from Kenneth's mother @ 10.45 p.m. approx. She said Kenneth had been to visit her and had left the house ten minutes previously. She said he told her he had contacted the ward earlier that day. I could find no record of that happening. She said that Kenneth appeared fine to her. She did not know where he had gone after leaving the house or his whereabouts.**

8.12.94

There is no entry in the medical notes. The nursing notes state: **"Remains AWOL".**

9.12.94 - 14.12.94

There was a ward round with Dr. Deahl, the RMO for Brett Ward, Dr. Thakore and Dr. Barnes, during which it was decided to discharge Kenneth Grey in his absence that day and to inform the Locality Team. The medical notes record that there had been unsuccessful home visits by the nursing staff [Julie Makuzwa, Kenneth's named nurse on Brett, told us that she was not aware of anyone making a home visit] and that the Home Office and Police had been informed.

The nursing notes record the discharge as being the 14th December, with daily entries till then recording that Kenneth remained AWOL. There is an entry made in the afternoon of 10.12.94 by SN Roojee; **"Contacted his mother's address. There was no reply"**

29.12.94

A Discharge Summary was prepared by Dr. Barnes on this date recording Kenneth's date of discharge as the 9th December and giving a diagnosis of: **"Query Bipola Affective Disorder"**
No follow up was arranged.

Dr. Barnes never met Kenneth Grey.

1.1.95

Kenneth Grey murdered his mother.

2.1.95

Hornsey Road Police Station contacted Hackney Hospital to inform them of the murder. The call was taken by the duty doctor and the Bleep Holder Senior Nurse who then contacted Nand Gopaul in his capacity as Senior Nurse on call that day, telling him of the murder and informing him that Kenneth Grey's case notes could not be found in the medical records office or on the wards. Nan Gopaul then tried to get some information about Grey from the hospital computer. The only information available was the date of his admission, an address and the name of his next of kin. He told us he would have expected to have found at least the name of his RMO, the fact that he had gone missing and the fact and date of his discharge from hospital on the computer. Kenneth Grey's case notes were not discovered until the following morning by Doctor Deahl's secretary.

3.1.95 - 23.6.95

Following his arrest, Kenneth Grey was kept in police custody until 3rd January when he was remanded back to Pentonville. He was considered by the police to be unpredictable, floridly mentally ill and possibly suicidal. He claimed to the assessing prison doctor, Dr. Pierzchniak, that he was only charged with assault and had had an argument with someone and said in a conspiratorial voice:

"I know where I am, not Pentonville. You can stop acting now and let me out...I'm the commander...I am king of you all"

He believed prison staff might have access to his thoughts and he claimed to hear the voice of his conscience telling him what to do and that it comments on what he does. He also stated: **"I did what I did to prove who I am. Now you can let me go."**

Kenneth Grey was started on antipsychotic medication and was referred by Dr. Pierzchniak to Dr. Jeremy Coid, Consultant Forensic Psychiatrist, who assessed him on 24.1.95 and concluded that the diagnosis was not entirely clear, either Schizo-affective disorder or Delusional disorder, grandiose type. It was proposed to transfer him under S. 48/49 MHA to a bed in medium security once one could be found for him. Dr. Pierzchniak wrote to Dr. Coid again on 22nd February, having completed his section of the S.48 form, informing him that Kenneth Grey had recently become very threatening despite being on medication as he felt that some inmates and prison officers were not respecting his royalty or high position enough. Dr. Pierzchniak emphasised the urgency in transferring Kenneth Grey and noted that the staff at Stockton Hall, a private Psychiatric hospital, had already assessed him.

Kenneth Grey was transferred to Stockton Hall on 10th March where he showed no evidence of psychosis prior to his further transfer to Camlet Lodge Medium Secure Unit on 18th April. He was however on anti-psychotic medication in gradually reducing doses throughout his stay there.

Following his transfer to Camlet Lodge under the care of Dr. Kennedy, his anti-psychotic medication was stopped on 1st May. From then until his court appearance at the Old Bailey on 25th July he remained without medication and without evidence of mental illness.

Dr. Kennedy's evidence that Grey was suffering from a drug-induced psychosis at the time of the murder was preferred by the Judge at Kenneth's trial. He had prepared a report for the Court which contained (amongst others) the following conclusions:

> **"Mr. Grey has had a schizophreniform psychosis with grandiose delusions and equivocal hallucinations, as well as irritability, hostility, and violence, particularly between October and early December 1994. This episode was only partially treated in hospital and had not fully resolved when he went absent without leave from Hackney Hospital on 2 December 1994."**
>
> **"At the time of the killing, there is some evidence that Mr. Grey was psychotic. He held grandiose delusions up until he left Hackney Hospital on 2 December 1994...It is difficult to avoid the conclusion that he was deluded at the material time."**
>
> **"Should a transfer to hospital become necessary in the future, or should the issue of a disposal under the Mental Health Act be considered by the Court, I would respectfully advise that this would have to be to a special hospital since Mr. Grey is in my view a grave and immediate danger to the public when psychotic."**

Dr. Kennedy told us that Kenneth Grey was a very difficult man to assess. He said that this was the first case that he could recall where he found himself saying that on the balance of probabilities he had to conclude that he was not mentally ill, but suffering from a drug-induced psychosis. He also emphasised the point to us that Kenneth Grey is an inconsistent and unreliable historian. He said that:

> **"Mr. Grey is such a difficult man to assess that it is easy to understand how some assessments may have missed a point here and there...So he is not a reliable man. That is another aspect one has to take into account when assessing him."**

26.7.95 - Date

Kenneth Grey pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to 7 years imprisonment. He was sent to Pentonville and was later transferred to Blundeston Prison near Lowestoft just before we interviewed him there on 21.8.95. He told us that since he had been in Blundeston, he had been put back on medication and was now taking Stelazine. He also told us that he still gets strange thoughts but he knows what is happening to him now whereas he did not before. When describing his past and present `strange thoughts' he said:

> **"It was very real to me..I know it's not real but it was at the time. Now I know it's not real but I still think it every now and then and I question myself, is it?"**

When we interviewed Dr Kennedy the day after we saw Kenneth Grey, he was unaware and surprised to hear that Grey was back on medication and admitting to having `strange thoughts' again.

We have recently been informed that the Attorney General's authority has been obtained to refer Kenneth Grey's sentence to the Court of Appeal on the basis that it is unduly lenient.

DISCUSSION

1. We have discussed above the failure to implement the Missing Patient Procedure. The hospital staff also failed to notify the NWLMHT or Kenneth Grey's Probation Officer that he had gone missing from the hospital. They only discovered he was AWOL after the murder of his mother. Brett Ward did make an attempt to refer him to Tottenham Social Services on 6th December, 4 days after he had left the hospital, but this was an inappropriate catchment area.

2. We were extremely concerned that the hospital computer held no information about Kenneth other than the date of his admission, an address and the name of his next of kin.

3. Under the Licence scheme, the Probation Service was responsible for Kenneth Grey after his release from prison, and therefore still responsible for him after his discharge from hospital. Myra Lawson, Senior Probation Officer, when asked if the licence process should have continued the moment he left hospital, told us:

"What I don't know is...I guess there isn't a system. We were unaware of a system whereby we should have been informed immediately. There should have been a link between the prison and the psychiatric services, advising the responsible people that this man was under licence and therefore the licence had to be signed and agreed upon at a point that he was deemed fit to be released. And therefore he becomes subject to the licence and we would have been alerted and he should have reported to us immediately.

4. Dorithe Goode, the Probation Service Assistant assigned to Kenneth Grey, spoke to both Dr. O'Neill on 29th November when he was still on PICU and was told by her that Kenneth might be discharged soon depending on the outcome of the S.2 assessment. Miss Goode informed Dr. O'Neill that Kenneth would have no fixed abode and the doctor said that she would arrange a planning meeting as he could not be discharged with nowhere to go and that it would be helpful if Miss Goode could attend the planning meeting and she would keep her informed. There was however no further contact (either way) between the hospital and the probation service until after the murder. Once again, we find this to be of some concern.

5. The staff at Hackney Hospital told us that they had assumed that Kenneth Grey had been referred to the NWLMHT as a whole by the involvement of the ASW's assessment for the purposes of the S.2 Order. Yet they did not inform the locality team of Kenneth's disappearance from the hospital. We cannot understand why there was no further communication between the hospital and the NWLMHT.

6. The referral of Kenneth Grey was not properly logged into the NWLMHT system at the time he was referred. The procedures and protocols for ensuring that he became part of the team's responsibilities after the ASW assessment were not effective or not put into effect and there was no allocated worker for him on the team. Operational links with the hospital services were not clear.

7. Kenneth Grey did not appear to have been told of the services of the LMHT.

8. Eddie Davies, the NWLMHT Lead Practitioner, told us that the fact that Kenneth Grey had become an informal patient lowered his priority in locality team's involvement, despite the fact that once he was no longer compulsorily detained he was more likely to be discharged soon into the community. It appears that statutory rights apply rather than real and immediate needs.

9. No Key Worker was assigned to Kenneth Grey after he left the hospital. We consider that one was even more necessary given that he was AWOL from a psychiatric hospital, known to be homeless, and at large in the community.

10. Once he had absconded from the hospital, Kenneth Grey became the responsibility of the NWLMHT. There was no automatic procedure to allocate fixed individual responsibility for following him up to ascertain his welfare after he went AWOL. He should have been the subject of S.117 follow up and the CPA as soon as it was realised that he was not going to return to the hospital.

11. Three formal procedures appear to have got lost somewhere:

    (i) The Licence procedure mentioned in (2) above.

    (ii) S.117.

    (iii) The Care Programme Approach (CPA). This was never triggered because there was no proper assessment carried out to place Kenneth Grey into that category.

12. The responsibility for writing the Discharge Summary was given to a Junior Doctor who had never met the patient. We question the wisdom of this.

13. Although it was reasonable to discharge Kenneth Grey from a bed which he was not occupying, the effect of the discharge appears to have been to close the case for this episode. No plans were made for follow up. This was the point at which the effort to contact an offender patient whose assessment was still incomplete and who had absconded, should have increased, not stopped. There was apparently no local mechanism for solving the problem of maintaining contact with the reluctant patient who needs treatment but does not acknowledge that need.

THE DIAGNOSIS OF KENNETH GREY'S MENTAL DISORDER

- It was clearly difficult for the doctors involved in Kenneth Grey's management to reach a precise diagnosis of his mental disorder, even after the opportunity of prolonged observation before and after his trial. There were a number of factors which could have influenced his mental state in late 1994. He was affected by his experiences in late childhood and adolescence, especially his tense relationship with his mother. His antagonism to her rigid religious views seem to have fuelled the quarrel about God and the devil shortly before her death. He suffered occasional epileptic fits and was irregular in taking anticonvulsant medication.

- The pattern of his behaviour in early adult life is close to that of antisocial personality disorder: he was frequently in trouble with the law, may times for theft and sometimes for assault. He failed to find settled employment or a home of his own. He abused drugs regularly, although not apparently to the point of physiological addiction. He was not a compliant man and did not follow through plans made on his behalf, for example when his Probation Officer arranged for his admission to Phoenix House for a drug rehabilitation programme.

- When he first began to show signs of mental disorder in Pentonville in October 1994, there was a range of differential diagnoses. His state of mind could have been induced by drugs or the effect of their withdrawal. It might have been the aftermath of epileptic fits. It could have been the start of a mood disorder or manic type or of a delusional disorder of grandiose type, or even schizophrenia. He may have been feigning illness or reacting to the stresses of imprisonment.

- We questioned medical and other staff at Pentonville Prison and Hackney Hospital about Kenneth Grey's mental state while they know him. No one thought he was feigning illness. There was no support for the view that the events were in any way related to epileptic fits, not were the clinical features characteristic of postictal psychosis. It was acknowledged that drugs are available in prison but the prison officers were confident that they can readily spot heavy use in a prisoner. The use of drugs would have to be considerable to be the sole or even main cause of the unfolding disorder described to us. Again, the clinical syndrome was not regarded as characteristic of drug intoxication or withdrawal. Further it went on for much longer than is to be expected. The doctors whom we questioned were generally of the opinion that drugs may have provoked an underlying condition or made it worse, but not have been the only cause.

- The disorder followed a changing course from its beginning in the autumn of 1994 until its apparent remission during the early part of 1995. It began as what seemed to prison officers as exaggerated jokiness, then to grandiosity and irritability, followed by delusions and intimidating behaviour. By this time he needed treatment with anti-psychotic drugs, which worked well in reducing aggressive behaviour. Symptoms were coming well under control during his stay in Hackney Hospital but flared again after his departure. He told us that he used illicit drugs during the next few weeks. At the time of his arrest, he was diagnosed as suffering from manic depressive disorder by the general psychiatrist, Dr Ann Hoar. Later, the opinion of forensic psychiatrist Dr Jeremy Coid extended the diagnosis into one of schizo-affective disorder or delusional disorder of grandiose type. Dr Harry Kennedy the forensic psychiatrist concluded that the psychotic behaviour at the time of the killing had been induced by drugs.

- When we talked to Kenneth Grey in Blundeston Prison on 21 August 1995, he described "strange thoughts" going through his head from childhood onwards and periods of deep depression and social withdrawal, notably in his late teens. He said that his use of drugs like heroin had been to stop the thoughts and relax him enough to sleep. It was because the thoughts have returned recently that he asked for some medication and has been given Stelazine with benefit.

- We recognise that diagnosis and assessment in this case was difficult, not least because he was passed so rapidly between a range of clinicians. It would have helped if each transfer had included a cumulative record of what had gone before. It would have been good practice if each doctor who assessed Kenneth Grey's condition had recorded a provisional or differential diagnosis by using the International Classification of Diseases (ICD-10) codings. In that way the receiving doctor would have known much more precisely what his predecessor had concluded.

- We are aware that there is still no certainty about the diagnosis and it is possible that the final conclusion has yet to emerge. Because of what we understood from Kenneth Grey when we saw him and from Dr Kennedy's concerns about a possible return of symptoms, we strongly advise that his mental state should be reviewed at intervals by a consultant forensic psychiatrist who works in or who has access to a maximum security hospital.

RECOMMENDATIONS

1. There should be a continuing education and training programme set up to inform medical, nursing, management and social services staff about the Mental Health Act 1983, in particular the legal status and rights of patients admitted and detained under one of its sections. Given the frequency of transfers to Hackney Hospital from prison, special emphasis should be placed on the ramifications of those sections of the MHA which deal with the transfer to hospital from court or prison.

2. Any patient transferred to hospital under Ss. 47/49 should be seen as being subject to a full and comprehensive assessment of their health and social needs in accordance with the CPA.3.

3. There should be far greater liaison between prison and hospital upon transfer of patients under section. A written summary of any relevant observed behaviour in the prison (including if possible a copy of any Incident Report Form in relation to the prisoner) should be sent to the hospital at the time of transfer. At the very least there should be telephone contact between the Principal Officer on the relevant prison wing and the Charge Nurse on the receiving ward at the hospital to discuss any significant behavioural problems.

4. The Prison medical/nursing notes including copies of the section transfer documents should go straight to the patient's hospital file and remain there until discharge, when they should be photocopied and returned to the prison.

5. The Mental Health Locality Team "MHLT" (and the Probation Service where already involved) should be informed immediately on the patient's admission to hospital under section.

6. The patient should not be allocated to a Named Nurse who is on leave or off sick at the time of admission to hospital or transfer from one ward to another.

7. The Trust must ensure that all doctors who undertake the role of RMO on a permanent or temporary basis are informed of the full range of responsibilities and duties of an RMO, and those which can and cannot be delegated.

8. The medical and nursing notes should be kept if possible in the same file or at least in the same place so that there is ready access to all relevant information.

9. All relevant information about a patient (such as the name of his RMO, the section of the MHA he is detained under and the date of any removal of the section, the fact that he is AWOL and the date of discharge from the hospital) should be logged onto the hospital computer as soon as possible after such detail comes into existence and should be updated with any change.

10. Copies of any notes/report made by an Approved Social Worker for an assessment prior to an application for a S.2 Order should be made available to the hospital within 3 days and read at the earliest opportunity by the RMO or his Junior Doctor and the Named Nurse responsible for the patient and kept on the patient's file(s).

11. An assessment pursuant to S.2 MHA should be long and full enough to be able (as far as possible) to assess the risks to self and others if the section is discharged. This must include the risk of absconding.

12. Such an assessment should include gathering as much information about the patient from as many sources as possible. If the patient has been transferred from prison, the probation service should be contacted to provide any relevant information and a check should be made of his antecedents for convictions involving violence.

13. There should be full consultation with nursing staff before any discharge of section and if possible also with any allocated Key Worker from the MHLT.

14. No-one other than the RMO or another named Consultant can discharge any detention order under the MHA nor grant leave of absence to any compulsorily detained patient. We strongly recommend that this is clearly printed on the forms which need to be signed in order to discharge a section or grant leave of absence.

15. A detention order should not be discharged immediately prior to transfer from a secure ward to an open ward. The section should remain at least long enough for the receiving ward to be able to assess how they need to manage the patient and the risk of absconding/risk to self and others in an open environment.

16. A pending Mental Health Review Tribunal (MHRT) should not be a reason to discharge a section. The following developments are recommended over the operating of MHRTs:

    If the patient is transferred to a new ward immediately or very shortly before the tribunal hearing, the reports for the tribunal should be prepared by the practitioners who know him best.

    There should be regular training for all staff on MHRT procedures and requirements.

    The Trust should invite the Mental Health Tribunal Office to join in a review of the working and the outcomes of recent tribunal hearings and procedures in Hackney Hospital, and draw up proposals for development, including proposals for discussion on the role of MHRTs. We recommend guidelines should be drawn up for the approach in future towards MHRTs.

17. There should be guidelines on good practice and procedures for the transfer and handover of responsibility for patients from one ward to another. These should include:

    Identifying a named nurse for the patient on the receiving ward in advance of the transfer who will be "briefed" prior to the handover on all information relevant to ensure a continuity of care and assessment.

    Having an agreed care plan to cover the transfer and the initial stages of the patient's stay on the new ward.

    Agreement over the preferred legal status for the patient on transfer.

18. A transfer from a secure to an open ward outside normal working hours should be avoided.

19. The Nurse admitting the patient to the new ward should have available and read the nursing/medical notes prior to making their own admission assessment.

20. The patient should be kept under special observation following transfer to an open ward until the staff are satisfied that it is no longer necessary.

21. The Missing Patients Procedure should be implemented in all cases where the patient leaves the ward and nothing is known of their whereabouts. No assumptions should be made that they will return to the ward. Managers should monitor the effectiveness and usage of the Missing Patients Procedure.

22. A link should be established between the patient and a member of the MHLT from the time of admission until the time a Key Worker is allocated if a Key worker is considered necessary.

23. Any involvement of any member of the MHLT should be construed as a referral to the team as a whole and should be logged immediately.

24. Any Key Worker who has been allocated (or a representative if not available) should attend all ward rounds involving their allocated patient and should be part of the decision making process concerning discharge of a section/transfer.

25. The Discharge Summary should be completed by a doctor who knew the patient.

26. A discharge from the hospital should not mean a discharge from the total resource of the mental health service. Once a patient is admitted to hospital they should become the responsibility of the linked catchment locality team until such time as they may be reallocated to a more appropriate team.

27. A case must never be closed and a patient discharged from mental health care in ignorance of the patient's present health and welfare.

28. The Trust should ensure that the Care Programme Approach is fully implemented in line with national guidance, that its implementation is fully audited using available audit tools, and that staff are fully trained to ensure that both the spirit and the letter of the CPA are embraced and adopted.

29. All existing procedures should be reviewed in the light of the discussion and recommendations contained in this report. If there are no procedures in place for areas highlighted in this report, they should be devised and implemented.

30. The Trust should, at the earliest opportunity, set up a meeting with Pentonville Prison medical service, the probation and social services, to discuss the concerns and recommendations outlined in this report. They should further agree an action plan for their implementation and to improve communication and cooperation between their separate agencies.

MENTAL HEALTH ACT REFERENCES

Section 2: Admission for Assessment

1. A patient may be admitted to a hospital and detained there for the period allowed by sub-section (4) below in pursuance of an application (in this Act referred to as "an application for admission for assessment") made in accordance with sub-sections (2) and (3) below.

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

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

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

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

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

Section 37: Powers of courts to order hospital admission or guardianship

1. Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law, or is convicted by a Magistrates' Court of an offence punishable on summary conviction with imprisonment, and the conditions mentioned in sub-section (2) below are satisfied, the court may by order authorise his admission to and detention in such hospital as may be specified in the order or, as the case may be, place him under the guardianship of a local Social Services Authority or of such other person approved by a local Social Services Authority, as may be so specified.

2. The conditions referred to in sub-section (1) above are that -

(a) the court is satisfied, on the written or oral evidence of two registered medical practitioners, that the offender is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment, and that either-

i. the mental disorder from which the offender is suffering is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition;

or

ii. in the case of an offender who has attained the age of 16 years, the mental disorder is of a nature or degree which warrants his reception into guardianship under this Act; and

(b) the court is of the opinion, having regard to all the circumstances including the nature of the offence, and the character of antecedents of the offender, and to the other available methods of dealing with him, that the most suitable method of disposing of the case is by means of an order under this Section.

3. Where a person is charged before a Magistrates' Court with any act or omission as an offence and the court would have power, on convicting him of that offence, to make an order under sub-section (1) above in his case as being a person suffering from mental illness or severe mental impairment, then, if the court is satisfied that the accused did the act or made the omission charged, the court may, if it thinks fit, make such an order without convicting him.

4. An order for the admission of an offender to a hospital (in this Act referred to as "a hospital order") shall not be made under this Section unless the court is satisfied on the written or oral evidence of the registered medical practitioner who would be in charge of his treatment or of some other person representing the Managers of the hospital that arrangements have been made for his admission to that hospital in the event of such an order being made by the court, and for his admission to it within the period of 28 days beginning with the date of the making of such an order; and the court may, pending his admission within that period, give such directions as it thinks fit for his conveyance to and detention in a place of safety.

5. If within the said period of 28 days it appears to the Secretary of State that by reason of an emergency or other special circumstances it is not practicable for a patient to be received into the Hospital specified in the order, he may give directions for the admission of the patient to such other hospital as appears to be appropriate instead of the hospital so specified; and where such directions are given -

(a) the Secretary of State shall cause the person having the custody of the patient to be informed, and

(b) the hospital order shall have effect as if the hospital specified in the directions were substituted for the hospital specified in the order.

6. An order placing an offender under the guardianship of a local Social Services Authority or of any other person (in this Act referred to as "a guardianship order") shall not be made under this Section unless the court is satisfied that the Authority or person is willing to receive the offender into guardianship.

7. A hospital order or guardianship order shall specify the form or forms of mental disorder referred to in sub-section (2)(a) above from which, upon the evidence taken into account under that sub-section, the offender is found by the court to be suffering; and no such order shall be made unless the offender is described by each of the practitioners whose evidence is taken into account under that sub-section, as suffering from the same one of those forms of mental disorder, whether or not he is also described by either of them as suffering from another of them.

8. Where an order is made under this Section, the court shall not pass sentence of imprisonment or impose a fine or make a probation order in respect of the offence or make any such order as is mentioned in paragraph (b) or (c) of Section 7(7) of the Children and Young Persons Act 1969 in respect of the offender, but may make any other order which the court has power to make apart from this Section; and for the purposes of this sub-section "sentence of imprisonment" includes any sentence or order for detention.

Section 47

1. If in the case of a person serving a sentence of imprisonment the Secretary of State is satisfied, by reports from at least two registered medical practitioners-

   (a) that the said person is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment; and

   (b) that the mental disorder from which that person is suffering is of a nature which makes it appropriate for him to be detained in a hospital for medical treatment and, in the case of psychopathic disorder or mental impairment, that such treatment is likely to alleviate or prevent a deterioration of his condition;

   The Secretary of State may, if he is of the opinion having regard to the public interest and all the circumstances that it is expedient so to do, by warrant direct that that person be removed to and detained in such hospital (not being a mental nursing home) as may be specified in the direction; and a direction under this section shall be known as a "transfer direction".

2. A transfer direction shall cease to have effect at the expiration of the period of 14 days beginning with the date on which it is given unless within that period the person with respect to whom it was given has been received into the hospital specified in the direction.

3. A transfer direction with respect to any person shall have the same effect as a hospital order made in his case.

4. A transfer direction shall specify the form or forms of mental disorder referred to in paragraph (a) of subsection (1) above from which, upon the reports taken into account under that subsection, the patient is found by the Secretary of State to be suffering; and no such direction shall be given unless the patient is described in each of those reports as suffering from the same form of disorder, whether or not he is also described in either of them as suffering from another form.

5. References in this Part of the Act to a person serving a sentence of imprisonment include references-

(a) to a person detained in pursuance of any sentence or order for detention made by a court in criminal proceedings (other than an order under any enactment to which section 46 applies);

(b) to a person committed to custody under section 115(3) of the Magistrates' Courts Act 1980 (which relates to persons who fail to comply with an order to enter into recognisance to keep the peace or be of good behaviour); and

(c) to a person committed by a court to a prison or other institution to which the Prison Act 1952 applies in default of payment of any sum adjudged to be paid on his conviction.

Section 49

1. Where a transfer direction is given in respect of any person, the Secretary of State, if he thinks fit, may by warrant further direct that that person shall be subject to the special restriction set out in Section 41 above; and where the Secretary of State gives a transfer direction in respect of any such person as is described in paragraph (a) or (b) of Section 48(2) above, he shall also give a direction under this Section applying those restrictions to him.

2. A direction under this Section shall have the same effect as a restriction order made under Section 41 above and shall be known as "a restriction direction".

3. While a person is subject to a restriction direction the responsible Medical Officer shall at such intervals (not exceeding 1 year) as the Secretary of State may direct, examine and report to the Secretary of State on that person; and every report shall contain such particulars as the Secretary of State may require.

Section 50: Further provisions as to prisons under sentence

1. Where a transfer direction and a restriction direction have been given in respect of a person serving a sentence of imprisonment and before the expiration of that person's sentence the Secretary of State is notified by the responsible medical officer, any other registered medical practitioner or a Mental Health Review Tribunal that that person no longer requires treatment in hospital for mental disorder or that no effective treatment for his disorder can be given in the hospital to which he has been removed, the Secretary of State may -

(a) by warrant direct that he be remitted to any prison or other institution in which he might have been detained if he had not been removed to hospital, there to be dealt with as if he had not been so removed; or

(b) exercise any power of releasing him on licence or discharging him under supervision which would have been exercisable if he had been remitted to such a prison or institution as aforesaid.

and on his arrival in the prison or other institution or, as the case may be, his release or discharge as aforesaid, the transfer direction and the restriction direction shall cease to have effect.

2. A restriction direction in the case of a person serving a sentence of imprisonment shall cease to have effect on the expiration of the sentence.

3. Subject to subsection (4) below, references in this section to the expiration of a person's sentence are references to the expiration of the period during which he would have been liable to be detained in a prison or other institution if the transfer direction had not been given.

4. For the purposes of section 49(2) of the Prison Act 1952 (which provides for discounting from the sentences of certain prisons periods while they are unlawfully at large) a patient who, having been transferred in pursuance of a transfer direction from any such institution as is referred to in that section, is at large in circumstances in which he is liable to be taken into custody under any provision of this Act, shall be treated as unlawfully at large and absent from that institution.

Section 66: Applications to Tribunals

1. Where -

(a) a patient is admitted to a hospital in pursuance of an application for admission for assessment; or

(b) a patient is admitted to a hospital in pursuance of an application for admission for treatment; or

(c) a patient is received into guardianship in pursuance of a guardianship application; or

(d) a report is furnished under Section 16 above in respect of a patient; or

(e) a patient is transferred from guardianship to a hospital in pursuance of regulations made under Section 19 above; or

(f) a report is furnished under Section 20 above in respect of a patient and the patient is not discharged; or

(g) a report is furnished under Section 25 above in respect of a patient who is detained in pursuance of an application for admission for treatment; or

(h) an order is made under Section 29 above in respect of a patient who is or subsequently becomes liable to be detained or subject to guardianship under Part II of this Act, an application may be made to a Mental Health Review Tribunal within the relevant period-

i. by the patient (except in the cases mentioned in paragraphs (g) and (h) above) or, in the case mentioned in paragraph (d) above, by his nearest relative, and

ii. in the cases mentioned in paragraphs (g) and (h) above, by his nearest relative.

2. In sub-section (1) above "the relevant period" means -

(a) in the case mentioned in paragraph (a) of that sub-section, 14 days beginning with the day on which the patient is admitted as so mentioned;

(b) in the case mentioned in paragraph (b) of that sub-section, 6 months beginning with the day on which the patient is admitted as so mentioned;

(c) in the case mentioned in paragraph (c) of that sub-section, 6 months beginning with the day on which the application is accepted;

(d) in the cases mentioned in paragraphs (d) and (g) of that sub-section, 28 days beginning with the day on which the applicant is informed that the report has been furnished;

(e) in the case mentioned in paragraph (e) of that sub-section, 6 months beginning with the day on which the patient is transferred;

(f) in the case mentioned in paragraph (f) of that sub-section, the period for which authority for the patient's detention or guardianship is renewed by virtue of the report;

(g) in the case mentioned in paragraph (h) of that sub-section, 12 months beginning with the date of the order, and in any subsequent period of 12 months during which the order continues in force.

3. Section 32 above shall apply for the purposes of this Section as it applies for the purposes of Part II of this Act.

Section 69: Applications to Tribunals concerning patients subject to hospital and guardianship orders

1. Without prejudice to any provision of Section 66(1) above as applied by Section 40(4) above, an application to a Mental Health Review Tribunal may also be made -

(a) in respect of a patient admitted to a hospital in pursuance of a hospital order, by the nearest relative of the patient in the period between expiration of 6 months and the expiration of 12 months beginning with the date of the order, and in any subsequent period of 12 months; and

(b) in respect of a patient placed under guardianship by a guardianship order -

i. by the patient, within the period of 6 months beginning with the date of the order;

ii. by the nearest relative of the patient, within the period of 12 months beginning with the date of the order and in any subsequent period of 12 months.

2. Where a person detained in a hospital -

(a) is treated as subject to a hospital order or a transfer direction by virtue of Section 41(5) above, 82(2) or 85(2) below, [Section 77(2) of the Mental Health (Scotland) Act 1984] or Section 5(1) of the Criminal Procedure (Insanity) Act 1964; or

(b) is subject to a direction having the same effect as a hospital order by virtue of Section 40(3), 47(3) or 48(3) above, then, without prejudice to any provision of Part II of this Act as applied by Section 40 above, that person may make an application to a Mental Health Review Tribunal in the period of 6 months beginning with the date of the order or direction mentioned in paragraph (a) above or, as the case may be, at the date of the direction mentioned in paragraph (b) above.

Section 70: Applications to Tribunals concerning restricted patients

1. A patient who is restricted patient within the meaning of section 79 below and is detained in a hospital may apply to a Mental Health Review Tribunal -

(a) in the period between the expiration of six months and the expiration of 12 months beginning with the date of the relevant hospital order or transfer direction; and

(b) in any subsequent period of 12 months.

Section 72: Powers of Tribunals

1. Where application is made to a Mental Health Review Tribunal by or in respect of a patient who is liable to be detained under this Act, the Tribunal may in any case direct that the patient be discharged, and -

   (a) the Tribunal shall direct the discharge of a patient liable to be detained under Section 2 above if they are satisfied -

      i. that he is not then suffering from mental disorder or from mental disorder of a nature or degree which warrants his detention in a hospital for assessment (or for assessment followed by a medical treatment) for at least a limited period; or

      ii. that his detention as aforesaid is not justified in the interests of his own health or safety or with a view to the protection of other persons;

   (b) the Tribunal shall direct the discharge of a patient liable to be detained otherwise than under Section 2 above if they are satisfied -

      i. that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or

      ii. it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment; or

      iii. in the case of an application by virtue of paragraph (g) of Section 66(i) above, that the patient, if released, would not be likely to act in a manner dangerous to other persons or to himself.

2. In determining whether to direct the discharge of a patient detained otherwise than under Section 2 above in a case not falling within paragraph (b) of sub-section (1) above, the Tribunal shall have regard -

   (a) to the likelihood of medical treatment alleviating or preventing a deterioration of the patient's condition; and

   (b) in the case of a patient suffering from mental illness or severe mental impairment, to the likelihood of the patient, if discharged, being able to care for himself, to obtain the care he needs or to guard himself against serious exploitation;

3. A Tribunal may under sub-section (1) above direct the discharge of a patient on a future date specified in the Directions; and where a Tribunal do not direct the discharge of a patient under that sub-section the Tribunal may -

(a) with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence of transferred to another hospital or into guardianship; and

(b) further consider his case in the event of any such recommendation not being complied with.

4. Where an application is made to a Mental Health Review Tribunal by or in respect of a patient who is subject to guardianship under this Act, the Tribunal may in any case direct that the patient be discharged, and so direct if they are satisfied

(a) that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment; or

(b) that it is not necessary in the interests of the welfare of the patient, or for the protection of other persons, that the patient should remain under such guardianship.

5. Where application is made to a Mental Health Review Tribunal under any provision of this Act by or in respect of a patient and the Tribunal do not direct that the patient be discharged, the Tribunal may, if satisfied that the patient is suffering from a form of mental disorder other than the form specified in the application, order all Direction relating to him direct that that application, order or Direction be amended by substituting for the form of mental disorder specified in it such other form of mental disorder as appears to the Tribunal to be appropriate.

6. Sub-sections (1) to (5) above apply in relation to references to a Mental Health Review Tribunal as they apply in relation to applications made to such a Tribunal by or in respect of a patient.

7. Sub-section (1) above shall not apply in the case of a restricted patient except as provided in Sections 73 and 74 below.

Section 117: After-Care

1. This section applies to persons who are detained under Section 3 above or admitted to a hospital in pursuance of a hospital order made under Section 37 above, or transferred to a hospital in pursuance of a transfer direction made under Section 47 or 48 above, and then ceased to be detained and leave hospital.

2. It shall be the duty of the District Health Authority under the local Social Services Authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the District Health Authority and the local Social Services Authority are satisfied that the person concerned is no longer in need of such services.

3. In this section "the District Health Authority" means the District Health Authority for the district, and "the local Social Services Authority" means the local or Social Services Authority for the area in which the person concerned is resident or to which he is sent on discharge by the hospital in which he was detained.

MENTAL HEALTH REVIEW TRIBUNAL RULES 1983

Rule 2: Interpretation

1. In these Rules, unless the context otherwise requires-

"The Act" means the Mental Health Act 1983 - - -

"Assessment application" means an application by a patient who is detained for assessment and entitled to apply under Section 66(1)(a) of the Act or who, being so entitled, has applied; ....

"Party" means the applicant, the patient, the responsible Authority any other person to whom a Notice under Rule 7 or Rule 31(c) is sent or who is added as a party by direction of the Tribunal; ...

"Responsible Authority" means -

(a) in relation to a patient liable to be detained under the Act in a hospital or mental nursing home, the managers of the hospital or home as defined in Section 145(1) of the Act.

Rule 16: Adjournment

1. The Tribunal may at any time adjourn a hearing for the purpose of obtaining further information or for such other purposes as it may think appropriate.

2. Before adjourning any hearing, the Tribunal may give such directions as it thinks fit for ensuring the prompt consideration of the application at an adjourned hearing.

3. Where the applicant or the patient (where he is not the applicant) or the responsible Authority request that a hearing adjourned in accordance with this rule be resumed, the hearing shall be resumed provided that the Tribunal is satisfied that resumption would be in the interests of the patient.

4. Before the Tribunal resumes any hearing which has been adjourned without a further hearing date being fixed it shall give to all parties and, in the case of a restricted patient, the Secretary of State, not less than 14 days notice (or such shorter notice as all parties may consent to) of the date, time and place of the resumed hearing.

Rule 20: Notice of Hearing

1. The Tribunal shall give at least 14 days notice of the date, time and place fixed for the hearing (or such shorter notice as all parties may consent to), to all parties and, in the case of a restricted patient, the Secretary of State.

Rule 22: Hearing Procedure

1. The Tribunal may conduct the hearing in such a manner as it considers most suitable bearing in mind the health and interests of the patient and it shall, so far as appears to it appropriate, seek to avoid formality in its proceedings.

2. At any time before the application is determined, the Tribunal or any one or more of its members may interview the patient, and shall interview him if he so requests, and the interview may, and shall if the patient so requests, take place in the absence of any other person.

3. At the beginning of the hearing the President shall explain the manner of proceeding which the Tribunal proposes to adopt.

4. Subject to Rule 21(4), any party and, with the permission of the Tribunal, any other person, may appear at the hearing and take such part in the proceedings as the Tribunal thinks proper; and the Tribunal shall in particular hear and take evidence from the applicant, the patient (where he is not the applicant) and the responsible Authority who may hear each other's evidence, put questions to each other, call witnesses and put questions to any witness or other person appearing before the Tribunal.

5. After all the evidence has been given, the applicant and (where he is not the applicant) the patient shall be given a further opportunity to address the Tribunal.

Rule 31: Appointment of a Tribunal and Hearing Date

1. On receipt of an assessment application the Tribunal shall:

(a) fix a date for the hearing, being not later than 7 days from the date on which the application was received, and the time and place for the hearing;

(b) give notice of the date, time and place fixed for the hearing to the patient;

(c) give notice of the application and of the date, time and place fixed for the hearing to the responsible Authority, the nearest relative (where practicable) and any other person who, in the opinion of the Tribunal, should have an opportunity of being heard;

and the Chairman shall appoint the members of the Tribunal to deal with the case in accordance with Rule 8.

DISCUSSION IN RELATION TO THE MENTAL HEALTH ACT 1983

Kenneth Grey was transferred to Hackney Hospital under Section 47 of the Mental Health Act. A direction made under this section (a "transfer direction") has the same effect as a hospital order made without restrictions under Section 37.

In almost all cases where prisoners are transferred from prison to hospital under the Mental Health Act, he/she will be transferred under Section 49 which gives the Home Secretary power to impose restrictions so that the patient cannot be transferred to another hospital, be absent on leave or discharged without the consent of the Home Secretary.

The reason that Kenneth Grey was transferred under Section 47, is that he was extremely close to the end of his sentence (his earliest date of release (EDR) being 25.11.94) and Section 47 is used on such occasions. Otherwise, if he is due to be released say within the next month, a prisoner may feel that a transfer with restrictions under Section 49 is a means of prolonging his sentence, since the consent of the Home Secretary is required before he can be discharged, transferred or given leave of absence from the hospital. Also a restricted patient cannot apply to a Mental Health Review Tribunal for the first 6 months of the duration of the hospital order or a transfer direction.

In the case of a prisoner transferred under Section 49, the restriction direction will automatically lift on the expiry of his sentence (allowing for remission) i.e. his EDR and thereafter he is considered as remaining in hospital under a hospital order under Section 37 without restriction.

We can see how the confusion arose in the case of Kenneth Grey, given that it was more usual for transfer to the hospital from prison to be under Section 49 rather than under Section 47 which is without any restriction. But even if that mistake is understandable, there was a further mistake made on behalf of all the hospital staff concerned, in that they believed that the section itself and therefore the right to detain the patient expired on the date of the prisoner's EDR. This is not correct. What expires on the EDR is any restriction direction. The transfer direction remains in force until discharge and has the same effect as a hospital order.

Given that Kenneth Grey was transferred under Section 47, the hospital should have treated him as subject to a hospital order and therefore had the right to detain him for assessment and treatment until such time as he was considered to be suitable for discharge by the responsible medical officer, by the managers or by his nearest relative (but the nearest relative could not apply for his discharge within the first 6 months).

There was therefore no need for an application for an order under Section 2 of the Mental Health Act. Under Section 2, a patient or his nearest relative has the right to apply to a Mental Health Tribunal within the first 14 days of the making of the order, and under the provisions of the Mental Health Tribunal Rules, a hearing must be held within 7 days of receipt of the application. Although under Section 47, Kenneth Grey had the right to appeal to a Mental Health Tribunal, that application could be made at any time within the first 6 months of his detention and the Tribunal only had to give 14 days notice of any hearing. It is quite clear therefore that the decision to replace his Section 47 detention order by a Section 2 order led to a Tribunal Hearing being set up at a much earlier stage.

It is also clear from the Mental Health Tribunal Rules, that the Tribunal could have heard evidence from any member of the medical or nursing staff who had been involved with Kenneth Grey and that they could have adjourned any hearing of his appeal if they felt that further information was needed or if they felt that there was any other good reason to do so.

It is the opinion of the Panel that the misinterpretation of the various provisions of the Mental Health Act and the Mental Health Review Tribunal Rules, contributed to Kenneth Grey's premature discharge from compulsory detention under the Mental Health Act. Had this not occurred and a proper assessment been carried out with appropriate treatment, his mother's murder might have been prevented.

LIST OF WITNESSES/INTERVIEWEES

NAME	TITLE
I. Afrin	Prison Officer - H.M.P. Pentonville
Dr Indrani Anthony	H.M.P. Pentonville
Dr Carole Barnes	House Officer, City & Hackney Community Services
Paul Beard	Director of Nursing & Specialist Services; Tower Hamlets Healthcare *At the time of the incident: Project Manager/Director of Nursing: City & East London Family and Community Health Services*
Vestna Bennett	Approved Social Worker, London Borough of Hackney
Dr N Boast	Consultant Forensic Psychiatrist, City & Hackney Community Services
Eddie Davies	Lead Practitioner - North West Locality Team, City & Hackney Community Services
Mike Fox	Chief Executive, City & Hackney Community Services
Dorithe Goode	Probation Service Assistant - Middlesex Probation Services
Nand Gopaul	Senior Nurse Manager - Mental Health Services, City & Hackney Community Services
Martin Green	CPA Manager - City & Hackney Community Services
Kenneth Grey	Subject of the Report
Dr Henry Kennedy	Consultant Forensic Psychiatrist, Camlet Lodge, Secure Unit, Chase Farm and Royal Free Hospitals
Jim Keown	General Manager, Mental Health Services, City & Hackney Community Services
Dr Danny Mooney	House Officer, City & Hackney Community Services
Dinah Morley	Assistant Director, Social Services, London Borough of Hackney
Dr J O'Neill	Senior Registrar, Goodmayes Hospital

NAME	TITLE
David Panter	Director of Corporate Affairs, Deputy General Manager; East London & The City Health Authority
Dr P Pierzchniak	H.M.P. Pentonville
Yuyha Roogee	Staff Nurse - Brett Ward
Lyn Sambani	Named Nurse - PICU
Anton Weekakone	Night Nurse - Brett Ward
Dr Yisa	H.M.P. Pentonville

CHRONOLOGICAL LIST OF PANEL MEETINGS

DATES OF MEETINGS

12 July 1995

2 August 1995

15 August 1995

16 August 1995

17 August 1995

21 August 1995

22 August 1995

23 August 1995

15 September 1995

18 September 1995

20 September 1995

2 October 1995

19 October 1995

27 October 1995

LIST OF BACKGROUND READING

City & Hackney Mental Health Services Casefiles on Kenneth Grey

City & Hackney Mental Health Services including the North West Locality Mental Health Team, policies and procedures

City & Hackney Mental Health Services Memo from Dr T. Turner, Consultant Psychiatrist re: Leave of Absence and RMO Function *July 1994*

East London and The City Health Authority Specification for Adult Mental Health Service 1995

H.M.P. Pentonville Prison Healthcare Records - Kenneth Grey

Record of Kenneth Grey's Criminal Antecedents provided by the Middlesex Probation Service

Reports prepared for the Trial proceedings - Kenneth Grey at The Central Criminal Court, Old Bailey, London *24 July 1995*

The Care Programme Approach for People with a Mental Illness referred to the Specialist Psychiatric Services. Health & Local Authorities Circular 1990.

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community. NHS Executive HSG(94)27

Medical responsibility in NHS hospital and community services for mentally ill and mentally handicapped people DoH PL/CMO(89)1

Code of Practice pursuant to Section 118 of the Mental Health Act 1983 *August 1993*

Statutory Instrument No. 942 (Information relating to patients other than conditionally discharged patients) *1983*

Report of the Panel of Inquiry appointed to investigate the case of Kim Kirkman. West Midlands Regional Health Authority *1993*

The Report of the Inquiry into the Care & Treatment of Christopher Clunis presented to the Chairman of North East Thames & South East Thames Regional Health Authorities *February 1994*

The Report of the Independent Panel of the Inquiry examining the case of Michael Buchanan. North West London Mental Health NHS Trust *November 1994*

The Falling Shadow "One Patient's Mental Health Care" Duckworth *1995*

Report of the Inquiry into the circumstances leading to the death of Jonathan Newby Oxfordshire Health Authority *1995*

The Woodley Team Report: Report of the Independent Review Panel to East London and The City Health Authority and Newham Council, following a homicide in July 1994 by a person suffering with a severe mental illness. *September 1995*

Learning the Lessons. Mental Health Inquiry Reports published in England and Wales between 1969 and 1994 and their recommendations Zito Trust *January 1994*

Risk Taking in Mental Disorder - Analysis, Policies & Practical Strategies Ed. David Carson S.L.E. Publications *1990*

A Preliminary Report on Homicide. Confidential Inquiry into Homicides & Suicides by Mentally Ill people. Steering Committee *1994*

A promise of better things to come. C Heginbottom and Nick Bosanquet. Health Service Journal, vol 105 no. 5463 *July 1995*

GLOSSARY OF TERMS

E D R	earliest date of release
P I C U	psychiatric intensive care unit
M H A	mental health act mental health administrator
A C R	automatic conditional release
N W L M H T	north west locality mental health team
M H R T	mental health review tribunal
C P S	crown prosecution service
A S W	approved social worker
R M O	responsible medical officer
W R	ward round
P O	prison officer
P P O	principal prison officer
S N	staff nurse
A W O L	absent without leave
S S D	social services department
C E L F A C S	city and east london family and community health services
E L C H A	east london and the city health authority
L M H T	locality mental health team
E E G	electro encephelo gram