Report of the Independent Inquiry into The Care and Treatment of WM

July 2000

LONDON BOROUGH
OF HARROW

Brent & Harrow
Health Authority

NHS

REPORT OF THE INDEPENDENT INQUIRY INTO

THE CARE AND TREATMENT OF WM

JULY 2000

PRESENTED TO

BRENT & HARROW HEALTH AUTHORITY
AND
LONDON BOROUGH OF HARROW

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- Mr Bob McDonald on behalf Brent & Harrow Health Authority
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CONTENTS

EXECUTIVE SUMMARY

1. On 12 January 1998 at the Central Criminal Court, WM pleaded guilty to the murder of an elderly lady of 91 years whilst committing burglary. He was sentenced to life imprisonment. WM had been known to the mental health services in Harrow since 1986 and he was receiving medical treatment at the time of the homicide. In accordance with Department of Health guidance (Circular HSG (94)27), Brent & Harrow Health Authority and Harrow Council Social Services appointed an independent inquiry to examine the adequacy of his care and treatment, and to recommend any changes to current practice.

Family and background

2. WM was born in Birmingham on 11 November 1962 into a family of Irish travellers who had settled in England. He was the witness to and victim of violence in his childhood, and his mother left his father and stepfather as a consequence of domestic violence. Criminal records on WM show offences of burglary from the age of 12, disorderly conduct and numerous motoring offences. He left school at 16 years with no qualifications. When aged 18 he received a six-month prison sentence and, a year later, he was sentenced to five years imprisonment for assault with intent to rob, and offences of burglary.

Contact with mental health services

3. In 1986 he moved to Harrow where his relatives lived. He physically assaulted his grandfather. He was referred by the court for psychiatric assessment and admitted informally to hospital. The consultant psychiatrist's view was that this offence was committed as a direct result of psychotic illness, of which he was then showing quite florid manifestations. He was diagnosed as suffering from schizophrenia. Subsequent after-care plans for residential care were disrupted by his movements and subsequent offending, culminating in imprisonment for aggravated burglary.

4. Following WM's release in 1992, he returned to Harrow and relatives provided him with temporary accommodation. He made an application for housing as a homeless person. During this time, he was treated by the specialist medical team as an outpatient and referred to the community mental health team for the Care Programme Approach. After six months residence with his relatives, he was offered bed and breakfast accommodation. His family sought his urgent admission to hospital, but a visiting psychiatrist and approved social worker found no grounds for admission. After four weeks he was re-housed and presented himself to the community team as not seeking further help. They closed his case. He found it difficult to manage on his own and moved to live with his mother.

5. His second admission to hospital was in July 1993, when it is first recorded that he had been misusing alcohol and drugs (cannabis), and he had thoughts that his family was conspiring against him. He was discharged after three weeks with a programme at the day hospital. His Social Landlord accepted his need for a housing transfer. Referrals to the community mental health team for assistance with financial and accommodation issues were dealt with on a duty service basis.

6. He referred himself for a third hospital admission in February 1994, reporting that he had been drinking heavily and taking illicit drugs (crack cocaine, LSD

and marijuana), and having thoughts of self-harm. He was discharged after 10 days to his mother's address despite her opposition to his discharge. The clinical notes stated that there was no objective evidence of mental illness or alcohol withdrawal. He was referred to the community drug and Alcohol Service but did not keep an appointment.

7. In March 1994 he was remanded in custody in Wormwood Scrubs Prison on a charge of burglary, and his mother contacted the community mental health services. A co-ordinator for Harrow's mentally disordered offender scheme allocated WM to herself and liased with agencies. He was diverted from custody to a secure hospital under s47/9 of the Mental Health Act 1983 and remained under a hospital order for six weeks. A probation officer referred him for assessment by the community drug and Alcohol Service for admission to a residential rehabilitation unit. He was deemed unsuitable. In June he was made the subject of a twelve month probation order.

8. WM presented himself with his mother requesting a fifth admission to hospital in August 1994. His mother felt she could not cope. WM complained of auditory hallucinations and the primary diagnosis was drug-induced psychosis. WM was discharged after seven days to his mother's address and referrals were made to the community Drug and Alcohol Service and community mental health team. Within five weeks of discharge WM's mother was phoning to arrange readmission which was refused. WM did not attend subsequent appointments offered by the Drug and Alcohol Service.

9. Health and Social Services had a duty to provide after-care services to WM (s117 of the Mental Health Act). A review meeting was held on 26 January 1995. The decisions taken were that Social Services had no role to perform in his care and supervision, and his probation officer would liase with the health services.

10. In March 1995, he was charged with burglary jointly with his brother, and remanded in prison. His mother sought diversion to hospital. There was little evidence that the offence was related to WM's current mental health state, and he remained on remand and received treatment from the prison healthcare service. In May 1995, charges against him were dropped and he was released. In June, his probation order ended.

11. In the months that followed, he visited his GP but failed to keep outpatient appointments and did not always attend for depot injections. In October 1995, his consultant psychiatrist requested a review with the community mental health team but before action progressed, WM was again charged with offences (handling stolen goods). From 9 November to 20 December 1995 he was in prison.

12. In January 1996 he was again remanded, on this occasion for motoring offences. In February, his consultant psychiatrist saw him in prison and found minimal symptoms. of his mental illness. WM stated he had had no misuse (alcohol or drugs) for the past four months. WM was sentenced to a probation order combined with a Community Service Order. In April, he was arrested for driving whilst disqualified. A forensic psychiatrist assessed that WM's symptoms. of mental illness had not increased in intensity in the last few weeks and there was no reason to divert him to hospital. WM was bailed but later arrested in Birmingham. He was remanded in Wormwood Scrubs Prison and all outstanding charges, including breach of his probation order, were dealt with

by courts during May and June 1996. The Probation order was ended by the court. The prison healthcare service notified the date of his release as 1 August 1996, and requested follow-up in the community by Harrow mental health services.

13. WM's consultant psychiatrist saw him as an outpatient in October 1996. He was receiving regular depot injections at a local clinic and he denied any current illicit drug misuse.

14. WM's mother became unwell and went to live with one of her children. WM's sister moved to live and care for him in his flat. In January 1997, his sister wrote to the housing service to identify herself as his carer and, because it was only a one-bedroom flat, requested his transfer to larger accommodation so that she could look after him. The housing service made enquiries and believed that WM was not living in the flat. On 10 February, the housing service issued WM with a Notice to Quit because of his sub-letting of the flat, and failure to use it as his principle residence.

15. WM's mother sought to prevent the eviction, explaining that she had been in hospital and he had used her accommodation to be near a telephone. On 18 February, the housing service contacted the mental health service and spoke to the community nurse who reported that she had no knowledge of WM's personal circumstances. WM was informed that the housing service did not regard his sister as his main carer and that he had overcrowded his property. At this time, one of his brothers was also staying in the flat.

16. On Wednesday, 26 February 1997, WM and his mother sought his admission to hospital. WM reported taking an overdose of tablets two days earlier, feeling fed-up and depressed, hearing a voice telling him to kill himself, and violence towards his sister. The hospital doctor noted that WM told him he had not been taking drugs for weeks. The doctor's impression was that WM did not have acute symptoms. of mental illness at the time of interview. WM's mother demanded admission but the doctor informed them that he did not find the case urgent enough, and that WM should see his consultant psychiatrist at his next outpatient appointment which was due in three working days. The doctor recorded that WM was unhappy with his consultant, and noted that he had no social worker.

17. WM and his mother sought help at his GP's surgery. A GP contacted the community mental health team who contacted the hospital. The community team did not intervene. His GP decided to monitor WM's condition, saw him at the surgery the next day and noted little change. The following day (Friday) his mother rang the GP to cancel the appointment. WM did not attend for his outpatient appointment with his consultant psychiatrist due on 3 March 1997.

18. On 19 March 1997 the police arrested WM on charge of burglary by artifice. The community mental health services (Extended Hours Service) was contacted and a need for an 'appropriate adult' to be present during police interview was confirmed. He was given police bail. He received his depot injection on 20 March 1997. On 22 March 1997 there was a police surveillance operation on WM and his brother during targeted times of the day. They were observed to enter blocks of flats and police enquiries revealed that some elderly residents had been burglarised. However, the police stated (at the time of this inquiry) that there was insufficient forensic evidence to secure arrests and prosecution.

19. After the police surveillance had ended, at about 6 a.m. on 23 March 1997, WM entered the flat of an elderly frail lady on a pretence. He brutally assaulted her. Neighbours were alerted to noise, detained him and called for the police. WM was arrested. When interviewed in the police station by mental health professionals, no significant change in the symptoms. of his mental illness were found, but WM admitted to consuming crack cocaine and alcohol on the evening prior to the assault. Following the death of the victim, WM was charged with murder. On 12 January 1998, WM received a life sentence following a plea of guilty to murder. He also pleaded guilty to three burglaries between 22 and 23 March 1997.

MAIN FINDINGS AND RECOMMENDATIONS

Medical care and treatment

20. For the most part, his GP, consultant psychiatrist and a community nurse who administered his depot injections managed WM's health care needs. Although there were four hospital admissions within the period of twelve months (1993 - 1994), the medical focus was on increasing evidence of substance misuse as the primary factor. Clinicians knew that WM had returned to live with his mother and that she was reporting increased difficulty in coping.

21. Thereafter, despite requests from WM and his mother, hospital admission was not considered appropriate to meet his health needs. For the periods he lived in the community or was in prison, he was treated with neuroleptic medication by depot injection and there is evidence that this had the effect of stabilising his mental condition. Despite reports of occasional self-harm and a voice that disturbed him over many years which urged him to kill himself, the only evidence that consideration was given to prescribing an anti-depressant is in 1993 by his second consultant psychiatrist. It would appear that the medical staff failed to address this aspect of his difficulty.

22. His medical treatment, although proper for the management of schizophrenia was rarely reviewed and the changes in medication were between Depixol and Clopixol with very little other 'anti-psychotic' treatment offered. In February 1995, WM complained of side effects from his medication and this was not fully addressed. It does not appear that an adequate medication review was undertaken.

23. The only multi-disciplinary review that took place was convened at the instigation of WM's consultant psychiatrist for purposes of s117 of the Mental Health Act 1983 in January 1995. There is evidence that the consultant sought further reviews with the community psychiatric nurse and community mental health team. In August 1996 WM was released from prison with no provision for after-care from the criminal justice services. The prison appropriately notified his consultant and community nurse of the release, but no action was taken by either to ensure a comprehensive review of his health and social care needs. The sole focus was on medical arrangements for the treatment of his mental illness (i.e. to reinstate his fortnightly depot injections and to offer two to three monthly outpatient appointments).

24. His last hospital admission was in 1994, and despite the continual drug taking, evidence of some hallucinations and his continued anti-social behaviour, no further hospital admissions were suggested, in spite of the subsequent downward trend and the requests by WM himself and his mother. He had been referred to the community Drug and Alcohol Services, and there was on going encouragement to attend. Medical assessments for Court reports found little change in his symptoms. and concluded that offences were unrelated to his mental illness. There is evidence that on 26 February 1997, he took an overdose and was seen at the GP's surgery threatening to kill himself and reporting that he had been violent towards his sister who was staying with him. However, it was felt that no hospital admission was necessary. We are concerned that the decision was taken by a senior house officer, without prior consultation with the consultant psychiatrist, and without ensuring that a follow-up enquiry into the social circumstances was undertaken by a social worker.

We recommend that:

a. ***Whenever a medical member of a clinical team assesses a person at their and their carer's urgent request for psychiatric hospital admission, (a) a consultant psychiatrist is consulted before a decision not to admit is taken, and (b) there is follow-up action to ensure that a community care assessment is undertaken by a community mental health team.***
b. ***Peer review (i.e. request for review by another consultant) should be considered in cases of protracted unresponsive patients – particularly those (like WM) who have escalating levels of antisocial/disorganised behaviour in the community.***

Risk of violence

25. Criminal records prior to 1986 show some convictions for violent behaviour prior to the onset of WM's mental illness. An assault on his grandfather took place in 1986 that was attributed to active mental illness. We found no reports of violent incidents from 1991 to 1997 in the records from all the agencies involved in his care. Following diagnosis in 1986, treatment may have influenced patterns of behaviour.

26. During hospital admissions in 1994, he reported preoccupations that his family was conspiring against him. When he sought admission in February 1997, he informed the hospital doctor that he had been violent towards his sister. He was assessed as not displaying signs of serious active mental illness and he denied drug misuse. Given the lapse of ten years from the last reported incident of violence, the threshold for concern was reasonable.

27. WM had shown a fixed and unremitting pattern of criminal and antisocial behaviour, latterly in association with drug and alcohol abuse. It was therefore absolutely clear that unless there was significant change in his personal and social circumstances and way of life, this pattern of behaviour would continue. In some respects the risk of harm to others should have been formally indicated because the nature of alcohol and drug abuse is such that it renders individuals capable of committing unpredictable crimes. Although there is evidence that risk to WM's own health and well being from substance misuse was discussed with him, it is not recorded that risk of harm to others was addressed.

28. We have considered whether the mental health services were in possession of information about WM that should have been passed to the Police (s115 of the Crime and Disorder Act) in order to prevent an offence. In our view, there was no significant information that was not already available from court reports that preceded the homicide.

We recommend that Harrow & Hillingdon Healthcare NHS Trust and Harrow Social Services ensure that any history of alcohol and/or drug misuse is included in all risk assessment processes.

Role of the community mental health team

29. The Care Programme Approach and Care Management had been incorporated into local guidelines in 1991 but not supported by additional resources. Restrictive criteria applied. Guidance was updated in 1996 following the issue of a revised operational policy, and staffing has improved.

30. Towards the end of 1994, WM's circumstances were such that he met the Harrow criteria for the Care Programme Approach/Care Management. However, no comprehensive assessment of his health and social care needs and history was undertaken. A day activity programme was arranged for WM by clinicians and he attended a day hospital for four months. This was the only programme offered by the mental health services throughout the ten-year period of our purview. No agency undertook a full assessment of his capabilities.

31. It was known that WM had an exclusive social network with emotional dependency on family members. There is no evidence that the psychosocial dimensions of WM's needs, the family context and social circumstances were addressed at the s117 review meeting in January 1995. Clinical notes show clear signs of his mother's need for respite and WM's inability to manage alone. Neither her nor WM's emotional needs came into focus.

32. It seems. that the probation service's involvement influenced the decision of the MDO co-ordinator to close the case in June 1995, and the allocated social worker's perception of her responsibilities. Whilst we accept that the probation officer was WM's social supervisor and she undertook to liase with health services, the review meeting had been convened under the provisions of s117 of the Mental Health Act 1983. For that purpose, we would have expected the mental health social worker to have personally interviewed WM and his mother, to be satisfied that he was not in need of social services.

33. The letter to WM and his mother informing them of the review meeting was a poor standard of written communication. Neither attended. A difference in understanding between the consultant psychiatrist and the community nurse about the nurse's role in respect of CPA was not subsequently clarified. In outcome, when the twelve-month probation order finished, WM had no key worker (as defined under CPA guidance) from the community mental health services.

34. Up to April 1996, attempts were made to review care arrangements for WM following the one multi-disciplinary review meeting (January 1995). Action by community team staff was disrupted by WM's remands in custody and imprisonment - for which diversion was not sought in psychiatric reports. In August 1996, WM was released from prison with no provision for after-care from the criminal justice services. The prison appropriately notified his consultant and community nurse of the release but it does not appear that action was taken by either to instigate a comprehensive review of his health and social care needs. The sole focus was on medical arrangements for the treatment of his mental illness.

35. There was sufficient evidence to show that WM had complex needs and that, under the local revised CPA guidance (1996), he should have had an allocated key worker from the community team. Knowledge of the mental health crisis

experienced by WM and his family in February 1997 should have been a trigger for a multi-disciplinary response, not just a medical one.

36. Although the Extended Hours Service had a role to intervene and assess the social and personal circumstances which led to the demand for hospital admission, no contact was sought by them with either WM or his mother. WM's mother was unwell at this time and concerned about his lack of self-care and vulnerability. It is evident that specialist mental health practitioners relied on the GP to monitor the situation until the outpatient appointment (due in a few days time). WM's non-attendance to see Dr.. D, about whom he had reported unhappiness, did not lead to any outreach visits to check on his or family members' well being.

37. WM and his family believe that the mental health services were unresponsive to their needs at a point of crisis, and that no one from the mental health services really listened to them. His mother described the responses as "going round in circles". There was certainly no evidence of change in the professional predisposition towards him and his family. No member of the community team sought to make further enquiries.

38. We find that operational guidance and procedures based on good practice were not adhered to in response to the crisis referral in February 1997.

39. In 1999, the Government published a National Framework for Standards in Mental Health Services, and the Department of Health issued revised guidance on the Care Programme Approach. If this guidance is adhered to, people with multiple needs will receive an enhanced care programme with a named care co-ordinator. In evidence to us, both WM and his mother believe that a named key worker to whom they could have turned for support would have made a difference.

We recommend that:

a. ***Brent and Harrow Health Authority and Harrow Council review their joint guidance on the implementation of their duties under Section 117 of the Mental Health Act 1983***
   and
b. ***they should ensure that adequate resources (staffing levels, training and information systems) are made available to support the Modernised Care Programme Approach national policy guidance, and significantly improve implementation performance compared to 1991***
c. ***Harrow & Hillingdon Healthcare Trust and Harrow Social Services should monitor the implementation of National Standards for Mental Health for service users with a serious mental disorder who are substance misusers***
d. ***Harrow & Hillingdon Healthcare Trust should review the provision of clinics for depot medication in the light of the findings from this Inquiry.***

We also recommend that:

Individuals who have co-morbidity problems. (i.e. mental illness, substance misuse and criminal behaviour), should receive an enhanced care programme which is based on multi-disciplinary and multi-agency assessment; and care co-ordinators should ensure that joint reviews are undertaken, at least six monthly.

Needs of informal carers

44. Under the provisions of the Disabled Persons (Services, Consultation and Representation) Act 1986, which was in force when WM and his mother came to Harrow, and under the Carers (Recognition and Services) Act 1995, which came into force on 1 April 1996, social services had a duty to take into account and assess the needs of informal carers. Multi-agency Drug Action Teams. were established from 1995 in local authority areas. Local performance indicators required by Government had to include measures of availability of support services for families, partners and friends of individual Drug misuers.

45. WM had considerable support from many members of his family, in spite of their individual personal problems. The support included accommodation, provision of meals, laundry, assistance with completing DSS forms., financial management, ensuring he took his medicine and reminding him about appointments. At various times he stayed at his aunt's house and at his grandmother's house, and even after he had obtained a tenancy in an unfurnished flat, he still spent considerable time staying at his mother's place for company and support.

46. The records show that on many occasions, it was his mother who brought him to the hospital seeking admission - and following admission, attempted to delay the discharge until she felt that he was well enough to come out of hospital. It was also his mother who was concerned about the effects of imprisonment on his mental illness, and who contacted the mental health services to seek his diversion from custody. On many occasions she expressed her concern regarding his Drug abuse to professionals. The records show that whilst living with her, WM occasionally talked to himself, displayed periods of disturbed sleep patterns, had depressed moods, and exhibited behaviour which sometimes frightened her.

47. WM's mother was entitled to have her needs as WM's informal carer assessed. There is no evidence that she was advised of this entitlement and no assessment ever took place.

We recommend that:

Harrow & Hillingdon Healthcare Trust and Harrow Social Services should ensure that quality assurance monitoring is in place and that the statutory provisions relating to the needs of carers, and standards set under the National Standards Framework for Mental Health are properly implemented.

Role of community Drug and Alcohol Services

48. In January 1993, the Department of Health issued guidance (LAC(93)2) to local authorities on the provision within community care of services for adults who misuse alcohol and/or drugs. As a priority, authorities were urged to ensure that the special circumstances of Drug and alcohol misusers were recognised and reflected in procedures for assessment and care management. It was recognised that people with serious and urgent alcohol and/or Drug problems. are likely to need a rapid response because of crisis and to capture fluctuating motivation. Serious deterioration, which may carry social, legal and care implications, might ensue if there was delay before assessment or if assessment procedures were prolonged.

49. From 1993, the records show clear concern by health, probation and his mother over WM's use of drugs. Our findings showed the unsuitability of the Community Drug and Alcohol Service as then constituted to deal with clients with the complex needs of WM. Whilst they accepted referrals for assessment, they were unable to offer any significant assistance to WM and offered no recommendations to others involved in his care or supervision. Residential rehabilitation services were seen as an option by WM's consultant and a probation officer, who requested such services. The Drug service considered that he was not suitable for them on grounds of a history of violence and, in particular, the fact that he was on prescription medication.

50. There is no evidence that a representative of the Drug service was invited to attend the s117 meeting in January 1995, even though drugs were known to be one of the major issues in his care.

51. At the time, the service placed heavy reliance upon patients being far more organised than WM was, in terms of confirming appointments and attending at set times. In October 1995 WM himself telephoned the Drug and Alcohol Service requesting help with his alcohol problem. He was given an appointment for the third week but he failed to attend. A new appointment was sent but he failed to confirm that he would attend and it was cancelled. The onus was left with him to contact them again which he never did.

52. We are concerned that central guidance had a limited impact on the approach taken by the community Drug and Alcohol Service. We have reviewed changes that have taken place since WM had contact. The practice improvements include closer working relationships with community mental health teams. and assertive outreach. The new powers in the Drug and Treatment Testing Order (1998) should enable drugs counsellors and probation officers to deal more appropriately with clients such as WM.

53. Given the increase in substance misuse in recent years, and findings from the National Inquiry into Suicide and Homicides (1999), we are disappointed that the National Standards Framework on Mental Health and the Modernised Care Programme Approach policy guidance (issued in 1999 by the NHS Executive) pays limited attention to the role of community Drug and Alcohol Services

We recommend that Harrow & Hillingdon Healthcare Trust and Harrow Social Services:

a. ***ensure that Department of Health Circular LAC(93)2 and subsequent central guidance on Drug and alcohol misuse issues relating to community care assessments and service provision are being fully implemented, and that past barriers to service provision identified in this Inquiry have been removed;***
b. ***ensure that all staff working in specialist mental health services and community Drug and Alcohol Services have access to regular evidence-based training on substance misuse and risk assessment;***
c. ***put in place monitoring of the use of the new powers to deal with Drug offenders;***
d. ***develop joint strategies in conjunction with primary care and voluntary agencies to overcome the cycle of short-term in-patient admissions followed by a return to Drug and/or alcohol misuse for certain individuals like WM.***

We recommend that the Department of Health should consider the preparation of national guidance on the care of those mentally disordered offenders who abuse substances.

Probation Service

54. Probation was the most significant social work contact with WM between June 1994 and July 1995. There was good liaison and communication between the probation officer and the health services. There was also contact between the probation officer and WM's mother when she was concerned about his Drug taking or council tax debts that had accrued. The probation officer persisted in her attempts to engage the Community Drug and Alcohol Services in dealing with WM's Drug misuse but such efforts were of no avail given their operational policies at the time.

55. In 1996, for a further offence, the probation officer recommended a probation order combined with a Community Service Order of 100 hours for unpaid work. After one hour of community service WM produced a sickness certificate on grounds of his mental illness. There is no evidence that consultation with the mental health services took place before or after the making of a Community Service Order. WM committed further criminal offences and breached his probation order which was subsequently revoked by the court, and WM was imprisoned.

56. The records kept by the probation officer are exemplary in their clarity, comprehensiveness and systematic reviews of the supervision plan.

We recommend that Middlesex Probation Service ensure that its staff only propose to Courts the making of a Community Service Order for a person suffering with a mental disorder after consultation with the appropriate specialist medical staff from the mental health services.

Housing Service

57. Although Housing and Community Care Circular 10/92 had been issued, arrangements for joint assessment between housing, health and social services had not been developed during the time WM had accommodation problems. It took six months for him to be provided with bed and breakfast accommodation when living in overcrowded conditions with relatives. He was nominated for an unfurnished flat. The allocation was in an unsuitable locality, nuisance was caused to neighbours, and the placement failed. His Social Landlord (Housing Association) accepted WM's need for housing transfer. He experienced difficulties living alone and returned to stay with his mother.

58. In 1993, there was pressure for his hospital discharge when neither his first tenancy, nor a second flat under consideration of offer was habitable for basic comfort. He was discharged to his mother who sought to organise affairs.

59. WM stayed with his mother for a significant time. The Housing Association appeared to be ignorant about his dates of hospitalisation, imprisonment or family network. WM made several applications for housing transfer to be nearer to his mother, whom he regarded as his main carer but was accorded

low priority. There was an almost non-existent contact between mental health services and housing.

60. In February 1997, WM was under notice of eviction on grounds that he had not used his flat as his principle residence and had sub-let it. The Housing Association did not accept an application from his sister to be recognised as his carer and who informed them of her residence with him. This was during a period when his mother was unwell. His brother was also staying at the flat. Whilst we accept the need for Housing Services to prevent unlawful occupation, we are concerned at the implications of unilateral action without regard to inter-agency working arrangements.

We recommend that:

a. ***Harrow Council ensure that its Housing Department and all local Social Landlords consult with the mental health services prior to issuing a Notice to Quit to a tenant who has complex needs;***
b. ***Harrow Housing and Social Services, and Harrow & Hillingdon Healthcare Trust take into account the findings of this Inquiry when producing a joint local Charter for people in need of on-going support and their carers;***
c. ***Harrow Social Services and Harrow & Hillingdon Healthcare Trust ensure that housing representation is considered by staff for care programme review meetings.***

Inter-agency issues

63. We have reviewed the local Health Improvement Plan and Community Care Plan in Harrow for 1999-2000. The direction and service developments are commendable and are indicative of shortfalls that existed in provision during the period of our Inquiry. They may have made a significant difference, had they been available sooner, in the care and treatment of WM and support to his main informal carer.

64. There were local voluntary agency services relevant to the needs of WM. There was no evidence that the family were referred to them. Health and social services authorities are required under s117 of the Mental Health Act 1983 to provide services in co-operation with relevant voluntary agencies.

We recommend that:

Brent & Harrow Health Authority and Harrow Social Services review operations to ensure that the co-operation of voluntary agencies with a contribution to make towards people with mental health needs who misuse drugs and alcohol is being sought pursuant to s117 of the Mental Health Act 1983.

Ethnic and cultural issues

65. The panel believes that WM's particular ethnic and cultural background i.e. Irish Travellers -"Gypsies" - played a role which influenced the manner in which he and his mother presented their problems, and how his behaviour was perceived and responded to by professionals. The coping strategies that individuals and families develop are influenced by cultural, social and economic factors including any experiences of discrimination from belonging to a

particular minority group. The strength of relationships and the efforts made by family members to protect and sustain WM's health were never analysed by professionals. In contrast, there was a tendency on the part of some professionals to suspect ulterior motives and manipulations when looking at reasons for referrals from him and his mother. For an individual with complex needs – enduring mental illness, substance misuse, long term unemployment, inexperience of managing alone, family ill health - the interventions provided to WM by health and social services were disproportionately low in degree. Some research findings indicate that this is a shared experience among some Irish mental health service users.

We recommend that:

a. ***Brent & Harrow Health Authority require forensic psychiatric service providers to use the same methods for denoting ethnicity as used by community mental health service providers;***
b. ***Harrow Council, Brent & Harrow Health Authority, and Harrow and Hillingdon Healthcare Trust include evidence from Irish studies in staff training programmes; and***
c. ***that quality assurance monitoring reports include analysis of the number of Care Programmes by ethnic classification of service users.***

Records and record keeping

66. Hospital and Community staff working under considerable pressure need to be supported by reliable comprehensive record keeping and information systems. In this instance, the task was made more difficult because the patient was part of a large family with similar names and frequently moved. Continuity of care and awareness of issues arising with other agencies can be improved with better sharing and access to other record keeping systems. Our investigations showed that there were shortcomings in the standards of records and record keeping including defects in identifying the correct patient, missing records and lost notes. For instance, for a year after WM's transfer to a new GP, letters from his consultant were still being sent to the former practice. There was no integrated recording system across all health and social services sites.

We recommend that:

a. Harrow Council and Brent & Harrow Health Authority give priority to the development of an integrated record and information system across all mental health service sites;
b. Harrow Council and Harrow & Hillingdon Healthcare Trust ensure that service user consent is encouraged for information sharing between the mental health services and housing services, particularly to facilitate notification of change of personal circumstances;
c. ensure that standards for record keeping are set and that management systems are in place for audit purposes, and
d. ensure that a quality assurance system is in place for correspondence addresses, particularly appointment letters to service users and reports to GPs.

Conclusions from this Inquiry

67. WM did not plead diminished responsibility at his trial, and all the psychiatrists who examined him after the offence have been in agreement that his mental illness was not a direct cause of the homicide. It is more likely that his substance abuse played a major part in his attack on the victim.

68. The appointment of this Independent Inquiry was in accordance with Health Department requirements under Circular HSG(94)27. We have concluded that there were failings in the provision of services to WM and his main carer, his mother, and that central and local guidance was not always followed in his care and treatment. Since WM's mental illness was not the cause of the homicidal behaviour, it cannot be said that had these shortfalls in service delivery not occurred, the crime would have been prevented. However, the fact remains that the interventions from health and social services, and from the criminal justice agencies, were ineffective - a holistic and collectively strategic approach may have had greater impact. Our recommendations aim to ensure a better quality of service delivery to people suffering from mental illness who may misuse alcohol and/or drugs, and to their carers.

INTRODUCTION

69. On 12 January 1998, at the Old Bailey Central Criminal Court, WM was sentenced to life imprisonment for the murder of Miss Beatrice Hughes, an elderly lady of 91 years. WM was also sentenced to six years imprisonment for three offences of burglary to run concurrently with the life sentence. He had pleaded guilty to all charges. In his sentencing remarks, Judge Boal stated:

> "WM, you have pleaded guilty to the most horrendous murder. In the course of your third burglary within 24 hours you inflicted terrible injuries upon a defenceless lady in her 90s all to steal from her relatively valueless but no doubt to her priceless possessions. The fact that you may have committed this appalling crime whilst under the influence of crack-cocaine, cannabis or alcohol or even all three does not in any way absolve you from responsibility for this cowardly crime. You knew what you were doing."

70. WM had been known to the mental health services in Harrow since 1986, and he had been diagnosed as suffering with schizophrenia. Medical reports after the offence stated that personality factors associated with primary and secondary problems of drug abuse (rather than mental illness) were more likely to play a determining role in precipitation of his aggressive behaviour. There was therefore no plea of diminished responsibility. The Inquiry Panel would wish to sympathise with the friends and acquaintances of the victim of his appalling crime, and we have asked that they should be provided with support and counselling should they so wish.

71. In accordance with Department of Health guidance (Circular HSG(94)27), this independent inquiry was commissioned by Brent and Harrow Health Authority and the London Borough of Harrow, and a panel appointed: Professor Bridgit Dimond was to be chairman, and Dr. Ruth Seifert and Mr. Ken Dixon members. The Inquiry began in February 1999.

72. WM had multiple needs which brought him into contact with the mental health services, Drug and Alcohol Services, criminal justice and housing agencies.

73. The *Report of the Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (1999) found that for the majority of perpetrators of homicide who had a history of mental disorder, the primary diagnosis was alcohol or Drug dependence or personality disorder, rather than schizophrenia or affective disorder. Of the smaller group (22%) who were under the care of the mental health services at the time of the offence or who had been in recent contact, there were high rates of alcohol and drug misuse, and 42% of the sample were known to be misusing both alcohol and drugs. Over half had a history of self-harm. As reflected in national criminal statistics produced by the Home Office, the killing of strangers is a rare occurrence.

74. This Inquiry has therefore sought a holistic approach in evaluating the effectiveness of interventions by different agencies, the degree of inter-agency co-ordination, and what lessons may be learnt.

PART ONE: CHRONOLOGY

BACKGROUND

Personal history

75. WM was born on 11 November 1962 in Birmingham into a family of Irish travellers. His mother confirmed that it was a normal delivery with normal milestones and no early problems. His parents separated in 1974 and his mother attributed this to the father's violence. She subsequently remarried, only to face the same circumstances, and left her second husband in 1981. She described how she had had to take the children to refuges to avoid violence. WM not only witnessed domestic violence at a young age; he was himself the victim of it, being hit over the head by his stepfather. The Probation officer's report states that:

> "Having lived with his parents until the age of eleven, he and his siblings were received into the care of the local authority when his mother separated from his father following years of violent abuse. The children were returned to their mother after two months. During this time WM attended special school where he experienced problems. culminating in his exclusion for fighting."

76. He was also educated in a Roman Catholic school and this may have been the origin of the black shadows and nuns which featured in his later hallucinations. He left school at 16 years with no qualifications and worked as a porter in a fish market for about a month.

77. He formed a relationship with a girl when he was 18 years. She became pregnant and a son was born in March 1982. The girl and son both still live in Birmingham. In 1987 he was reported as still having periodic contact with them but the probation report in October 1987 states that there had been no further contact. In May 1994 he told the Drug and Alcohol Service that he last saw his son 3 years before.

Early medical history

78. WM had a normal childhood in terms. of medical care other than the fact that at quite a young age he was noted to be losing weight. The cause is unclear. At about 8 years old, he suffered a head injury and was unconscious. There are many different versions of what happened. WM himself in a statement to the police following the homicide said that when he was six years old his head was battered with a brick and he was admitted to the Birmingham Accident Hospital under his mother's name. He said that he spent some six months in hospital getting over this. His mother told the panel that when WM was going on seven he had been hit by a brick when he was playing with a couple of boys and he ended up in Selly Oak Hospital for six weeks. His mother gave evidence that she felt that there was a change in his general disposition following the head injury but she could not be specific.

Family History

79. He was the eldest of seven siblings, (five by his mother's first marriage, two by her second marriage). His father was described as a violent and difficult man. The family described themselves as Irish Travellers but had settled for at least thirty years in permanent housing in England. His step-father died five years

ago of a myocardial infarction and had served time in prison for burglary. Two of his brothers were in prison in 1996. His mother suffered from depression with intermittent hospital admissions and has also been WM's main carer. She has mental illness in her family. One brother who apparently had a psychotic illness committed suicide, and a second brother who suffered from chronic schizophrenia died five years ago of a cerebral vascular accident.

80. The family has clear evidence of serious mental disorder on the mother's side and history of criminal behaviour from the father which continued into the next generation

Criminal Record

81. His offending started at an early age. Aged 12, he was arrested for burglary and seen at Birmingham Juvenile Court. A year later he was again arrested for burglary and sentenced to 12 hours at an Attendance Centre. At 14 he was arrested and charged with actual bodily harm and disorderly conduct. The Birmingham Juvenile Court sentenced him to a supervision order for two years and conditional discharge for one year. When 16 years old he was convicted of driving offences, including driving whilst disqualified by age, no insurance, no test certificate, false name and address and breach of conditional discharge. He was given a twelve-month supervision order and an attendance centre order (24 hours). In March 1980, he was fined for failure to comply with the attendance centre order, and in June 1980 he was fined for violent behaviour in a police station (he had assaulted a police officer).

82. When aged 18 years, he appeared before Birmingham Magistrates Court and was convicted of failure to surrender to bail, motoring offences and giving false personal details. He was sentenced to a Community Service Order (200 hours) and fined. In November 1981, at Hampstead Magistrates Court, he received prison sentences of up to six months for assault occasioning actual bodily harm, failure to surrender to bail and motoring offences. He was later fined for breach of a Community Service Order. On 15 September 1982, he was sentenced at Cardiff Crown Court for offences of burglary, theft and assault with intent to rob, and given sentences of up to five years. Two months later, aged 21, he was also convicted at Harrow Magistrates Court for driving whilst unfit through Drink or drugs, and received a fourteen day concurrent prison sentence. The date of release was May 1986. He served the sentence in Dartmoor Prison.

FIRST CARE EPISODE IN HARROW 1986

83. During her visit to WM in Dartmoor Prison, his mother noticed that WM was not his usual self. She told the panel that she went to see him and could not believe the state he was in. "He wasn't the same person." She recognised from his symptoms, signs that she had seen in her brother who had been diagnosed with schizophrenia.

84. Following his release from Dartmoor, WM came to stay with his relatives in London. In July 1986 he attacked his grandfather. He believed that his grandfather was attempting to force him to be a Muslim. On 17 July 1986, he was remanded on bail to appear on 14 August 1986 for probation and psychiatric reports.

85. The Middlesex Probation officer requested an assessment on WM from a Consultant Psychiatrist at Northwick Park Hospital. The probation officer wrote:

> "In the past year WM's mother has complained that her son is mentally ill. She has approached the Social Services Department about this. She also has been to the Housing Department asking for an immediate transfer, saying the attack by her son on his grandfather has exacerbated family tensions and she is afraid her son may be attacked by her brothers and sisters who also live in the locality.
>
> When seen WM denied he was mentally ill. He did however show signs of incongruity of affect, in that he was giggling and smiling for no apparent reason. He also wandered around the office building.
>
> His mother claims that at home he sleeps a lot. She appeared uncertain as to whether he talked to himself. She stated however she has to have him with her most of the time."

Admission to psychiatric hospital

86. WM was interviewed in the outpatient clinic on 30 July 1986 by a consultant psychiatrist, Dr.. C-O. The consultant was sufficiently concerned about WM to arrange his immediate hospital admission as an informal patient. The assessment by the consultant stated that:

> "It is my definite opinion that the offence with which he stands charged was committed as a direct result of his psychiatric illness of which he is showing quite florid manifestations."

87. In August 1986 the consultant psychiatrist wrote to the probation officer, sending a copy to a social worker in a community team in Harrow stating that:

> "what he seeks more than anything is help with accommodation. It is possible that he might qualify with his past history of schizophrenia and his current vulnerability."

88. WM was to have appeared before the Magistrates on 14 August 1986, but the matter was adjourned in his absence to 11 September 1986. An EEG reading was taken on 18 August 1986. The comment was "normal reading". He was

taking part in a double blind trial consisting of Lithium and Pimozide and in September 1986, he was referred to a specialist because of a rash on the upper half of his body.

89. On 19 September the clinical records note that he was pestered by a female patient and left the ward and was with his mother. The nurse attempted to contact his aunt, since she was the only family member on the phone but there was no reply. The doctor spoke to his probation officer who was to visit him and try to persuade him to return. WM eventually returned to the ward of his own accord accompanied by his mother.

Magistrates' Court hearing

90. On 9 October 1986 WM appeared in the Magistrates Court and was given a conditional discharge for two years. The Probation Report to the court noted that:

> This is the type of illness with a recurring pattern, however, and there could be difficulties in future particularly if WM did not take his medication. For this reason may I with respect suggest WM be dealt with in such a way as to enable him to continue treatment. I do not suggest probation involvement and he is known to the Social Services. This is the appropriate agency for the mentally ill with the powers of sectioning etc. which the Probation Service do not have.

91. Whilst still an in-patient a referral was made to Harrow Social Services for an application to be made to their rehabilitation hostel for mentally ill people (Tanglewood Hostel). The reason was so that the residential care staff could assess his independent living skills and help him improve with a view to him living independently in his own accommodation. WM viewed it as a stepping stone. The application form to the hostel noted that WM qualified as a bricklayer whilst in prison but was unemployed. Past physical violence to people and property was noted, but in response to the question about a history of Drug addition - the answer was "No".

92. He was given a week's home leave on 16 October 1986 and was to return to the ward the following Thursday whilst awaiting the hostel's decision. He remained as an in-patient for a further two weeks. On 30 October 1986 the case summary forwarded to the GP by the hospital noted:

> Management - after starting on neuroleptics, his condition improved dramatically and his delusions quickly receded into the background. He said that he thought that all his previous thoughts were because he was under stress following his release from prison, and he now thinks that all this thoughts about his grandfather were a `lot of rubbish'. Whilst on the ward he had to attend court over the assault on his grandfather and received a suspended sentence for this. He was discharged home on 30 October to stay with his mother temporarily and we are awaiting a place at Tanglewood, a hostel for young people.

93. He was seen at the outpatient department on 27 November 1986 and a senior house officer to the consultant reported that he:

> "feels very well and thinks that this must be because of the needles. He is attending Tanglewood Hostel for interviews with a view to being placed there. His mother is moving to Kilburn. Taking depots and procyclidine. To be seen in 6 weeks time."

He forgot his appointment on 7 January 1987 and came up to the ward on 26 January 1987. The medical records note:

> "...Living with mother in Kilburn. "I get browned off" Getting fed up waiting for hostel (Tanglewood), but hopes he'll be turned down. There's one in Kilburn that's nearer. ... Suggest decrease depixol to 40 3/12. Try to get accommodation sorted out (? if he can get LA hostel place in Kilburn area. Send F/U "

94. The consultant psychiatrist wrote to WM's GP:

> "There is no doubt in my mind that WM suffered a schizophrenic illness, undoubtedly beginning whilst still in the prison and extending following his discharge. He had been unwell for some months by the time he came to see us and I have no doubt that the assault with which he was charged last year was a direct result of his delusional beliefs.
>
> W was with us for some weeks and was extremely bizarre. He was a rather withdrawn solitary individual who `did his own thing' but his behaviour was at times most bizarre. He would clearly talk to himself and gesture in a bizarre fashion and, on some occasions, would strip to the waist and dive head long into bushes outside the department. Eventually, I am pleased to say that W settled very satisfactorily on neuroleptics... .
>
> He is clearly living a very restricted social life and only goes out rarely. He is almost entirely in the company of his family... .
>
> At interview I was very impressed indeed. W is not a sophisticated lad, being rather inarticulate and under-educated but, when I saw him, he was very pleasant, smartly turned out and presented himself in a very amiable and likeable fashion. Indeed, he was quite jokey in an appropriate fashion and, for him, I would have considered his mental state to be more or less within normal limits.
>
> ...I am also going to try, via the social workers, to switch his application for hostel accommodation from Harrow to Brent. This is sometimes a rather bureaucratic procedure but we will try and push as much as possible.
>
> In the long term I certainly would be more than delighted to follow W up, though obviously, there may be practical problems with him living so far away. He was a part of one of our MRC sponsored trials of treatment in functional psychosis and, on that basis, I would be delighted to keep an eye on things. If, however, you think that it would be more appropriate to seek local psychiatric support, I would quite understand. Although he has done extremely well I think we must view his prognosis as guarded. He has a very bad family history and I think his early history of behavioural problems and delinquency fits in very well with what we know about those schizophrenic patients who tend to do badly in the long term. Nonetheless, I think his chances of relapse can be greatly militated against if he stays on medication.

Transfer between Social Services Authorities

95. Harrow Social Services referred him to Brent Social Services on 5 February 1987 to make an application:

"for admission to one of your mental health after-care hostels. His mother is moving house, and she and WM wish to remain in close proximity to each other because Mr M values his mother's support. The consultant who is involved with Mr M is concerned that he should spend as little time as possible in this difficult family environment in order to prevent a relapse."

96. At this juncture, since Harrow Social Services were no longer the relevant authority because of his change of ordinary residence - his mother having moved South - they closed the case on 13 March 1987. A letter from the probation service in October 1997 to WM's consultant psychiatrist shows his address as still being in Brent.

Out of catchment area of Northwick Park Hospital

97. The medical records in 1987 show evidence of his non-attendance at outpatients: from 12.03.87- 03.12.87, seven appointments were missed. For some of these missed appointments he may have been in prison. The consultant psychiatrist had in his letter to the GP suggested an option of referring WM for local psychiatric help, though he gave the medical research trials as a reason for retaining him on his case load. Dr. C.O.'s letter to a solicitor on 13 December 1988 referred to Northwick Park Hospital's attempt to keep contact with WM although out-of-catchment area from the community psychiatric nursing service. WM told us that he recalled an Irish male nurse visiting him at home every 2 weeks to give injections which were then taken over by local GP.

Offending, living in the Midlands and imprisonment (1987 – 1992)

98. From January 1987 there is a gap in the available records to October 1987, when WM again appeared in court. On 22 October he was due in court for offences of carrying offensive weapons, driving whilst disqualified/ no number plates, no insurance etc. and breach of conditional discharge. The probation officer wrote to the consultant psychiatrist, Dr. C-O, stating that WM had been remanded on bail and he was asked to send a report to the probation officer. Subsequently his continued offending led to his detention in police cells in Nottingham from where he wrote to Dr. C-O in 1988. His letter, dated 9 October 1988, reads as follows:

"Dear Dr. O
Just a line to let you that I am in Custody in Nottingham and am up in Court on the, well I don't know the date as it hasn't been fixed yet, I'm on Remand for trial in inner London Crown Court, the reason I didn't turn up for the reports is because I took one of my turns and just disappeared to Ireland to clear my head and came back and got caught for drink-driving and I got in gate arrest in Birmingham and brought up here for these other charges, at the moment I'm feeling the same way I did when I was admitted to hospital, I have seen the doctor and explained my case to him and they will be treating me with Dipixol [*sic*]so I would be most grateful if you could set out my Reports for the Court. My Charges are one attempted Burglary and two burglaries plus I'm on a 18 month suspended sentence and have a Court Case in Harrow Wealdstone for a offensive weapon and driving charges so I'll sign off for now so take care. all the best. from W"

99. In November 1988 WM wrote a letter instructing solicitors. On 13 December the consultant psychiatrist wrote to WM's solicitors for the court hearing as follows:

> "I only managed to see him once in January 1987 as he defaulted on 5 subsequent appointments. He did manage to come up to the department once 'on spec.' as it were and attended the outpatient clinic in January though not for an arranged appointment. He simply wandered in.
> ...My own advice was that he continue with long term anti-psychotic medication and, in this regard, his care was transferred to the local psychiatric service in an attempt to try and ensure better compliance though WM said that he preferred to come to our department for follow-up and this was agreed.
> I fear his prognosis must be guarded, partly because of features relating to his illnesses but also because of his compliance and rather disorganised lifestyle."

100. In March 1989 WM appeared before Harrow Magistrates on a charge of possessing an offensive weapon in public places. He was imprisoned for 28 days. The records next note his appearance on 20 March 1991 at Birmingham Crown Court on a charge of aggravated burglary. He was imprisoned for 18 months. The aggravation related to the existence of a 6-inch bladed combat knife. During these years from 1989 to 1992 there is no evidence of contact between WM and health and social services in London. WM's account to his solicitor of these missing years is as follows:

> "In or about 1987 at Woolwich Crown Court I received custodial sentences totalling about thirty-three months for three offences of Burglary Artifice. After I had served twenty-five months of the sentence I was released on parole, but then arrested for another offence of Burglary for which I was convicted on 20 February 1991 at Birmingham Crown Court. I was given a sentence of eighteen months imprisonment and then had to serve the remainder of the prison sentence imposed on me at Woolwich four years earlier.
>
> When I was serving the five year sentence, before I became ill, I learned bricklaying and passed my City and Guilds. When I was released in 1992, I started to work for my uncle. I did not work consistently through the period."

RETURN TO HARROW IN 1992

101. WM was released from prison in May 1992. At the end of August 1992, he came back to Harrow seeking temporary accommodation with his Aunt. She referred him to the community mental health team on 8 September 1992. She was concerned about his welfare because he had nowhere to live. She had two small children and could not put him up indefinitely. The record of referral notes that:

> "William is refusing to return to B'Ham - he has been treated previously at NPH. Wants to stay in this area. When Aunt rang yesterday 7.9.92 she was advised to take WM to the GP. this she did and ???? her to take him to Homeless Persons Unit (HPU). The HPU has said that it will take 10 days to process this application. In the meanwhile WM has no where to live. She has tried hostels but they are all full up."

102. Two months later, in November, his GP wrote to the hospital referring WM for re-assessment: A consultant psychiatrist, Dr. H, subsequently saw WM and reported on 30 December 1992 to the GP as follows:

> "He said he has kept mentally pretty well on Depixol since he was discharged from Northwick Park Hospital in 1986.
> He is one of the C family, that has been much afflicted with schizophrenia.
> At interview he came across as a warm, composed, cheerful young man with no evidence of delusions, hallucinations, ideas of reference, incongruity or thought disorder. He was not depressed nor suicidal. The main symptom is difficulty in sleeping without Temazepan. It is not easy to withdraw patients from Temazepan...probably whilst things are unsettled it is best to continue.
> I am sending a copy of this letter to my social work colleagues as what he seeks more than anything is help with accommodation."

103. Following the referral the community mental health team's duty worker offering WM an appointment. He did not keep two appointments. On 2 February 1993 WM visited the community team offices. He had been told by the housing department to obtain a letter from his consultant psychiatrist. He informed a duty worker that he was waiting for an outpatient appointment letter to be sent to him. A duty worker recorded:

> "He said he could no longer stay with his aunt who suffered with her 'nerves'. He demanded I telephone Dr. H. today to write the letter. I informed him that it could not be done immediately. He then said he was going to NPH this pm. I detected alcohol."

The duty worker informed Dr. H's secretary that WM was on his way. Dr.H rang back and the duty worker noted:

> "Dr. H wants to know if it was likely he would be accepted for re-housing and were we going to follow it up. I indicated he would not be seen as a priority, but that I had suggested client could contact us if needed further help or advice."

The consultant noted in his records:

> "If pt. does attend here I can give him letter of ref. to Housing Dept."

104. A week later WM's aunt rang the community team wanting to know whether her nephew had an appointment with the consultant. She was advised to ring his secretary at Northwick Park Hospital. WM attended an outpatient clinic on 16 February and the consultant reported as follows to his GP:

> "Today our patient told me that for about a week before his fortnightly injections he feels more depressed with headaches and loss of appetite. I am not happy about increasing depixol because of extra-pyramidal side effects. suggests adding an anti-depressant. Gave him a hand-written letter for Homeless Persons Unit.
> I was able to give him a letter stating that he has a history of schizophrenia and by virtue of his current mental state and lack of finances."

Referral for Care Programme Approach

105. On 18 February 1993 the consultant psychiatrist, Dr. H, referred WM for assessment for support under the Care Programme Approach giving the reason as serious mental disorder and homelessness. WM was allocated for assessment to a social worker. The social worker wrote to him on 23 February 1993 suggesting an interview on 10 March 1993, and explaining that:

> "this was a programme aimed at providing a co-ordinated service to patients who are regarded as vulnerable in the community."

106. On 26 February 1993 WM went to the community team offices and it was noted in the records:

> "problems at his Aunt's are getting worse. He has been to HPU and given them a letter from Dr. H and was asking us for a letter of support so that he could take it to HPU today. Explained what I could say was limited as no assessment made as yet but did get a letter typed from him to take - see asf. He agreed to come for a full assessment 10 March."

107. On 1 March 1993 a visit was made to WM at the request of the family, for an assessment with a view to hospital admission under the Mental Health Act 1983. The records of the circumstances for the visit by a psychiatrist, Dr. B, state:

> "disturbed but was told simply to call an ambulance - tried Social Services for home assessment."

108. Dr. B's written account of the outcome to the GP states:

> "been staying with grandmother nearby. Also stays with aunt .. his mother is homeless and is staying with the same aunt....she (mother) is unable to look after WM due to her nerves... WM told us he would like to live on his own...at this point both his aunt and mother interrupted and insisted that what he really wanted and needed was observation in hospital and they both insisted that he was too unwell to manage in B&B though equally they both felt he probably only needed to be in hospital a day or two.
> Overall I could find no clear grounds for admission to hospital, even on an informal basis. Nevertheless, I do feel his mental state should be kept under regular review.
> Having called us urgently for an assessment, they appeared to be unwilling to give us any clear reason for the assessment or what the actual cause for concern

was. They did present us with a list of immediate demands including both WM's immediate transferral to hospital for observation and also an immediate solution to his housing problems. ... I will let Dr. H know and also make a referral to the CPNs to try and assess the situation further."

In his clinical notes, Dr B. also wrote:

"Note: Mother and Aunt appear to have limited perception of the role of medical and social services – both were unwilling to give any details of W's current problems, also unwilling to let him give his own account, or even to limit the number of spectators in the room or turn TV off. Therefore assessment rests largely on cross-sectional interview."

The approved social worker's notes of the visit state:

"Accommodation problems are the major issues with this family. WM has been offered bed and breakfast accommodation. Unfortunately at this stage both Dr. B and myself were ordered from the house by the Aunt. Reason given was that she did not consider we were being helpful or that we were any good - She would not accept that WM did not need admission to hospital - we left the house.
Recommendations Dr. B will liase with Dr. H over WM's medication; MR *allocated social worker)* should liase with HPU to check whether accommodation has been taken up; WM will keep his outpatient appointment for next week to see Dr. H.
Alternatives to admission "To take up accommodation offered by HPU."

109. The approved social worker wrote on 3 March 1993 to WM's aunt giving her written feedback.

"W did not require admission to the Psychiatric Ward at NPH. It was our understanding that W had been offered Bed and Breakfast accommodation, an arrangement which we felt he should take up as soon as possible as we believed the lack of somewhere to live was his main problem. We were unable to complete the assessment requested by you, however at the time of leaving we were quite satisfied that W did not require admission to hospital. I hope that W will liase closely with his Social Worker, MR, who can be contacted at Atkins House."

110. On 8 March 1993, Dr. B referred WM to community nursing services with the request that WM's mental state be kept under review - "possible impending relapse following Drop in depixol - also moving problems.". WM was allocated to a community nurse.

111. WM did not attend for his CPA assessment interview on 10 March 1993. The following day the community nurse noted:

"Telephone call to HPU to discover address of B&B. Reported to have moved in 2.3.93. Another appointment offer to attend office for assessment and be seen by myself and his allocated social worker due to concerns re personal safety. To liase with GP re depot compliance and Dr. H re psychiatric assessment."

112. A letter from the community nurse was sent to WM offering an appointment for 31 March 1993 to discuss any difficulties he may be having. On 15 March, the community nurse noted in the file:

"Discussed with Dr. H (consultant psychiatrist). Does not really see need for CPN. Attended GP regularly for depot and appointments to see Dr. H. Homelessness problem now solved."

WM did not keep the appointment with the community nurse and his allocated social worker on 31 March. The nurse wrote that day to WM's consultant psychiatrist:

"As expected, this gentleman did not arrive for the appointment which had been offered to him, probably, as you suggested, because his accommodation problem has now resolved. As we previously discussed...there does not appear to be a role for a CPN at present. I will therefore be closing the case. Should the situation change in future, please do not hesitate to re-refer to this department." (copy to GP).

The community team file also shows an entry on a CPA assessment feedback form by the allocated social worker:

"Not suitable for CPA.
Reason: problem of homelessness resolved, now in bed and breakfast awaiting single tenancy - Refused any more contact with social services by ignoring appointments made."

113. On 20 April 1993 the social worker from the community team wrote to the consultant psychiatrist (CPA refusal pro forma):

"Your patient WM has been assessed for the Care Programme Approach but was not found to be suitable for the following reason:
has been accepted as homeless by HPU and placed in Bed and Breakfast.
Not wanting contact."

2nd HOSPITAL ADMISSION 1993

114. After a month of B&B accommodation, WM was allocated a flat by Network Housing Association and he moved to his unfurnished tenancy in April 1993. However within a few months he had moved back to live with his mother. On 17 May 1993 he failed to attend for an outpatients appointment.

115. On 13 July 1993, a report from an Accident and Emergency Department notes that he fell down 3-4 steps. The next day he was admitted to Farrington Ward at Northwick Park Hospital. A hospital discharge summary provides a concise account of reasons for the hospital admission:

> "WM is an unemployed young man with a 7 year history of schizophrenic illness, well maintained on depot injections - Depixol 40 mgs i.m. two weekly - that he stopped taking 5 months ago. He has been complaining of strange thoughts coming back to his mind, more centred around his religious beliefs. These thoughts were making him feel restless and agitated during the day and sleepless at night. He was blaming Depixol for his moodiness and aggressiveness while being in prison one year ago. He was released in May 1992.
> He had been drinking a lot for the last three weeks prior to his admission - 15 pints of lager every night. Also he took 20 tablets of Kemadrin in one go three months ago, went light-headed and could not remember details. He has been smoking cannabis every night for the past four months; he takes it (to) relax and says that he has not had any for the past six days. His appetite was alright.
> He also hears whispering, a woman's voice; he cannot make out what is being said. He also says that he sees shadows, ?ghosts, on an off, "out of the corner of my eyes". He denies any recent trouble with the Law.
> He has been living in a one-bedroomed flat for four months but moved recently to stay with his mother temporarily in her own house because he could not cope on his own in his flat. He has been there for two weeks."

116. On admission to hospital the doctor noted that:

> "Own flat is uninhabitable, has water but no cooker + no furnishings
> Given loan from Social Fund, mother does not know what he did with it
> He wants to leave his flat because he says he is the only young person living in the block."

117. His medication was increased. On 22 July he was receiving 200 mgs Depixol fortnightly. His behaviour settled down with no outbursts of aggression, feeling calmer in himself. A CT scan was carried out on 22 July and was assessed as normal.

Referral to community mental health team for social work assistance

118. On 26 July 1993 the ward referred WM's situation to both a community mental health team social worker and the Housing Association with a request for advice on accommodation and finance issues. WM was interviewed on the ward by a social worker on 30 July.

> "WM was admitted to hospital after jumping out of the lift of his mother's flat between 1 and 2 weeks ago. He says he was high at the time on a mixture of alcohol and cannabis. He denies any deliberate intention of hurting himself. Both his ankles were badly strained and he now walks with crutches. He had not taken any medication over the previous six months.

Refused offer of studio flat because too small and too far from Harrow,
- housing assistant in Network Housing to look for something else.
On financial issues: WM believes he should have had a grant not a loan; feels that arrears are due on disability premium; Mother is dealing with this with DSS; WM wondered if we could influence matters favourable with DSS.
As the matter was clearly being investigated already, there was no need for social services intervention. WM appeared satisfied and thanked me for talking with him.
However in view of recent incident leading to hospitalisation, I would recommend follow up by CPN."

119. The case was confirmed closed on 10 August 1993. The hand-written words "Passed to CPN service" has line through it.

120. A print-out from the community mental health team's computerised records of a systematic assessment show the perceived profile of WM's health and social care needs at this time:

> "No difficulties with medical, personal or physical care. Minor difficulties with daily living activities (laundry and cooking) and accommodation, finding it difficult to manage on level of income, socially isolated and needs to develop relationships, partial absence of social stimulation. Frequent access to informal carer and able to access primary care and other agencies. Self-doubt, forgetful, frequent problems with thought, some difficulty over sleeping and waking early."

Self-assessment

121. WM was discharged from hospital on 2 August 1993 to his mother's address, and referred to the day hospital for follow up. His key worker in the day hospital was identified from nursing staff, and he was referred for occupational therapy assessment - the short term goals being (a) to improve his concentration, (b) to introduce structure by engaging him in purposeful activity and (c) to assess his level of functioning.

122. WM completed his own self-assessment for the day hospital:

> "Medical "I don't help myself because I do take hard drugs and alcohol - but I would like to try to help myself"
> Social situations "depends on people's attitudes". "I am paranoid at times." "I have an aggressive nature" "I feel more isolated than lonely." Doesn't socialise - "fights occur"
> Leisure: "time spent at home doing nothing or in pub + smoking of drugs. I know it is not good for me, I will try and change my life-style."
> Work "never had chance to work because I have been in prison a total of 10 years - think I can't hold a job because of my violent nature, I don't provoke but it just happens." "I enjoy using my hands - I am a bricklayer I would like to use skills I learnt in prison.
> Finance -"v. poor, I get £50 per week and it's hardly sufficient to pay the bills and rent."
> Domestic "My mother does the cooking for me. I can't cook.""

Requests for practical assistance

123. Soon after WM's hospital discharge his mother was phoning the community mental health team offices to complain. The duty officer report for 5 August 1993 is:

> T/C Mrs L very angry. WM moved into new tenancy and has no furniture; angry given loan not grant; Only has a bed - no other furniture. Mother also concerned about WM's medication; "Mother expected WM to be given a social worker on his discharge 2.8.93 - very angry and abusive. WM was referred to CPN service on 28.7.93 - no allocation as yet.

124. A phone call to Network Housing Association confirmed that they had offered WM accommodation at a different address and also confirmed that he seemed to lack the basic furnishing to actually move in. On 9 August 1993 a joint telephone call was made to WM with the social worker and community psychiatric nurse. The records note that he said that

> "he had been upset that he had not been allocated a social worker when he left hospital. I informed him that we do not automatically allocate social workers to everyone and that he had been seen at NPH prior to discharge - he acknowledged this and said that at present things were in hand and he did not want our help. I asked him to talk to his mother about our conversation to avoid future confusion..... I also informed him of how to use the duty system should he require future contact."

Following this telephone call, a letter was sent to WM on 10 August 1993 from the community team saying the case was now closed.

> "You also said that you did not require a service from his team. As I explained when I spoke to you, we will now close the case, but should you wish to contact us in the future please telephone the above office."

125. On 8 September 1993 the community mental health team file notes that a duty telephone call was received from WM's mother asking for a letter for a 'community furnishing project' to get furniture for his flat. The duty officer telephoned the project and WM's mother was put in direct contact with them.

> "4.15pm WM telephoned to say that he was told by someone at the Day Hospital that M R was his allocated social worker, however he has been told by the department that he has no allocated social worker. He feels he needs an allocated social worker because he is a sick man. He then asked if we can apply for a bus pass he has no money to spend on transport apparently the CAB are dealing with the DSS grant for his community furniture and does not need any further assistance with this matter."

An appointment was made with WM to see the duty officer on the 10 September 1993 at 1.00pm. A registration form was completed and he was issued a concessionary bus pass under the provisions of the Chronically Sick & Disabled Persons Act.

Occupational Therapist's review

126. On 10 September 1993, a record of review was completed by his occupational therapist at the day hospital:

"Physical: W complains of sore feet (from an accident previously) and pain following his depot injection. Otherwise he appears fit.
Interpersonal: W related to OT and other clients articulately, although sometimes unpredictably and inappropriately interrupting conversations with irrelevant questions. He reports having no friends outside the family and does not see this changing. He has a large Irish family and a close relationship with his mother.
Intrapersonal: He is almost overly self-confident with little insight into his assets and weaknesses. He has a tendency to blame everything on his "schizophrenia" rather than work on problems himself. His attendance is erratic and blames this on misinformation from staff.
Cognitive: Concentration is hindered at times by impatience and restlessness.
Self-maintenance: Lives alone in his flat but has no furniture. He is taking steps to obtain furniture. When not in day hospital he spends the day at his mothers. She cooks all his meals.
Productivity: He does not think he will ever be able to keep a job because he describes himself as "violent". His short-term objectives of attending the day hospital seem realistic.
Leisure: He appears involved with his church. He wishes to make contact with his 11 yr. old son and is contacting solicitors for this.
Main identified problems:
1. lack of insight and willingness to take responsibility for his problems (alcohol has been a problem in the past)
2. concentration and impatience
3. unrealistic long term objectives

Client's expectations:
Short-term objective of making furniture in woodwork is realistic.
He is very motivated to do this and says he wants to work on his unpredictable/impatient behaviour.
Objectives/recommendations
To engage W in activities in which he is motivated such as woodwork and pottery. Require him to make commitment to attendance at the day hospital and to finishing projects started to build on his concentration and encourage responsibility."

127. WM described his main problem as

> "can't concentrate, can't read a book, used to read 6 a week. Can watch a bit of TV but not much. Cannot touch electrical things as Brain gets a shock."

Self referral to community mental health team

128. On 27 September 1993, WM inquired through the community mental health team about his social security benefits which were in arrears. The duty worker's record of response was:

> "Client has been to the CAB who are dealing with his case, however he has not heard anything from them for 6 weeks. He tells me that he has been in prison a few times since 1986 and currently has been give a loan from DSS which he is paying back at £10 per week from his benefit. T/c to CAB not available. "advised client of days and times of opening and telephone number. Suggested that he contacts them himself as they are already dealing with his case. He agreed."

Visit to Accident and Emergency Department

129. On 3 October 1993 he attended the A&E Department. The report notes

> "Slept on floor 2/7 days ago (after drink) since the c/o pain in R side of chest worse on inspiration."

Self-referral to Community Mental Health Team

130. On 10 November 1993 WM turned up at community team office asking to see duty worker:

> "He is due to appear at a DSS tribunal and wanted someone to represent him there...Advised WM to go to CAB and ask for help. He attends day hospital daily."

131. On 18 January 1994, at the request of the community nurse who administered WM's deport injections at a local clinic, the manager of the Day Unit was asked if WM could receive his depot injections in the Day Hospital. Between 20 January 1994 and 21 February 1994 the Day Hospital records show that he attended on three occasions and received his depot injections there.

3rd HOSPITAL ADMISSION 1994

132. On 22 February 1994 WM went to the Hospital A&E Department, and he was referred to the Day Hospital. In the Day Hospital he reported (1) that he would like to be admitted and (2) Drug abuse and (3) voices. He was admitted informally at 3.30 p.m. to hospital. The reason for admission was stated as:

> "Heavy consumption of alcohol (10-12 pints lager daily & illicit drugs– crack + LSD). Having thoughts of self-harm and therefore seeking help."

133. He was placed on Eastlake Ward at Northwick Park Hospital, which had a designated bed and staffing for detoxification from alcohol and/or drugs. WM signed a "treatment agreement" with the multi-disciplinary team. On admission the nursing assessment identified auditory hallucinations and ideas of self harm as the needs related problems and defined the nursing intervention as:

> "1 Nurse to spend time with WM to develop nurse/patient relationship
> 2 WM should inform staff when he is leaving the ward and where he is going
> 3 Assess mental state on a daily basis."

WM's perception of his needs was:

> "Drinking heavily and taking illicit substances. Having thoughts of self-harm and is upset because he has been refused access to his 12 year old son for the last 3 years."

The nurse's perception of his needs was:

> "?heavy alcohol and illicit Drug consumption, unclear previous diagnosis of schizophrenia?? Forensic history and need to be given clear boundaries and limits. ?Personality Disorder."

The clinical notes state:

> "No objective evidence of mental illness (or alcohol withdrawal) There may be a ? reason for wanting admission but it has not emerged."

134. On 24 February, a charge nurse contacted the Community Drug and Alcohol Service seeking an appointment for WM. The service noted that he had reported as having been using crack/cocaine and Drinking10-12 pints larger daily. An appointment was offered for 3 March. On 28 February 1994 WM's mother appeared wanting to see his consultant psychiatrist, Dr. W. She was told she could see him the next day. WM was seen by a doctor on 1 March 1994 and was anxious for discharge, which was planned for the next day.

> "Note: Phone call from mother this evening. Mother feels that it will be too early for W to come home as she feels he is not ready to do so."

135. In spite of the mother's concern WM was discharged on 2 March. He did not attend the Drug & Alcohol Service and they wrote to him (addressed to his flat) saying if he required further help, he could contact them.

CUSTODY DIVERSION TO HOSPITAL 1994

136. Two weeks following his hospital discharge, on 16 March 1994, his mother contacted the community mental health team because WM was in custody at Wormwood Scrubs Prison. The referral was responded to by the co-ordinator of Harrow's Mentally Disordered Offenders (MDO) scheme, who made a hand-written note:

> "Currently attends Caryl Thomas Clinic - depot every 2/52 weeks. That is his only input. To open to me to co-ordinate through MDO scheme."

He was remanded in custody in prison on a charge of burglary and his mother telephoned the MDO co-ordinator to express her concerns. The co-ordinator advised the prison of his medication, and reassured his mother that he was as well as could be expected, and that the medical staff and prison probation would be monitoring him.

137. A psychiatrist, Dr. M, from the local forensic mental health service was asked to assess WM. He obtained information from the medical records department at Northwick Park Hospital. A file note on 21 March 1994 by the MDO co-ordinator reads:

> "WM seen in court, quite well seen by Dr. M in prison who says he is suffering from Psychotic features which are exacerbated by custody - if he does not get bail today he will review for admission to Bentham; Comprehensive bail application made but even with guaranteed increase in supervision it was rejected; contacted Dr. M to inform him WM is returning to prison he will see him and get back to me. To write to Dr. A to inform him."

The local catchment area consultant psychiatrist from Northwick Park Hospital had changed to Dr. D who took responsibility for WM. On 28 March, the co-ordinator spoke to Dr. D. and explained the full position.

138. On 31 March 1994 WM was transferred to the Bentham Unit, a secure hospital unit, under section 48/49 of the Mental Health Act 1983. He appeared in Harrow Magistrates Court on 18 April 1994 charged with burglary and of being found in an enclosed area for an unlawful purpose - namely theft contrary to section 4 of the Vagrancy Act 1824. He was then transferred to the Bentham Unit until 16 May 1994 under an interim hospital order (Section 38 of the Mental Health Act 1983). Dr. D's assessment of WM for the adjourned court hearing stated:

> "From my assessment I did not see a clear relationship between his illness and the offences charged. I think that he is prone to criminal activity which is independent of his illness. Indeed, it is likely the need to obtain money to fund his substance abuse, plays a significant role in his current behaviour.
> Given that he is now currently stable from a psychiatric point of view, I do not see the need for any further in-patient treatment and, if he does not receive a custodial sentence, we undertake to offer him out-patient follow-up. It might also be considered by the Court whether addressing his substance misuse would be included in a probation order, as this is more likely to play a role in his offending than any schizophrenic illness."

139. The MDO co-ordinator saw WM at the Bentham Unit on 11 May 1994 and noted that he appeared well, "no disturbances or thoughts – says he no longer

hears voices." He was discharged from the Bentham Unit on 16 May 1994 to his home address and the discharge summary noted that WM had displayed a marked improvement within a few days of admission, saying that the intensity and frequency of his auditory hallucinations had decreased. A copy of the report was sent to his GP.

140. On 16 May 1994 reports for sentencing were presented and his probation officer requested an adjournment for three weeks to allow WM time to make contact with Drug rehabilitation services. Dr. D had made it clear that WM did not need to be an in-patient any longer. The court granted conditional bail to WM. On 19 May 1994 he was seen by the MDO co-ordinator at the Probation offices:

> "Not sleeping well but apart from that. OK. Spoke with Bentham Unit re medication - on 200mg CPZ nocte - contacted GP and informed them of same. Re-referred Caryl Thomas Clinic for depot."

141. The co-ordinator learned that WM had been considered by the Drug & Alcohol Service as unsuitable for attendance at any rehabilitation centre. On 3 June she discussed the situation with the Drug service and in response they wrote to WM on 7 June offering him an appointment for 15 June.

142. On 6 June 1994 WM was seen by Dr. D at outpatients. Dr. D wrote to the GP advising of the position and offering a further appointment in two months. (The letter was addressed to WM's former GP - the mistake was corrected the following month). The community nurse record of the 10 June 1994 notes the receipt of a copy of this letter and that Depot has been renewed. On 13 June 1994 the MDO co-ordinator notes:

> "WM sentenced; 12 month probation order with encouragement by the magistrates to comply with mental health and Drug and Alcohol Services. Dr. D informed. Agreed no further role for myself. I will now close the case. CPN will continue contact with WM via the clinic and he will be followed up at out patient's by Dr. D."

143. The MDO co-ordinator ceased her involvement on 14 June 1994, and in a case closure document stated:

> "Sentenced on 13.6.94. Now under probation; Caryl Thomas Clinic for Depot; No role for MDO Co-ordinator; Support from probation; to receive Support/counselling from drugs/alcohol; To remain open to CPN - depot only."

144. On 15 June 1994, WM kept his appointment with the Drug and Alcohol Service. He informed them that he had not used any illicit drugs for three months and had no inclination to do so, and that he did not need to attend the service again. The duty worker who interviewed him considered this reasonable. The MDO scheme co-ordinator was informed.

HEALTH AND SOCIAL SERVICES' DUTY TO PROVIDE AFTER-CARE SERVICES

145. A letter was sent on 6 July 1994 from a social worker at the Bentham Unit to the community mental health team manager. It stated that WM had been detained at Bentham Unit under S.48/9 and discharged to his home address:

> "As the enclosed summary explains, his ongoing support was from Dr. D at NPH and from Ms.. C M at the Harrow Probation Office. Since WM has a right to services under S.117 of the MHA 1983 and also since his problems are ongoing and may bring him to attention again, I thought that I should write and inform you of the situation. I apologise for the delay in doing this."

Enclosed with the letter was a transfer form dated 22.6.94 from Bentham Unit.

146. Following receipt of this letter WM was allocated a social worker in the community team on 12 July 1994. A hand-written note on back of a form states:

> "Please see letter from social worker, Bentham Unit. WM was an in-patient there under S48/49 from 31/4/94 - 16/5/94. Now on probation; regularly sees probation officer. Request is for involvement under S. 117
> Decision: Joint assessment with P N (CPN). Case allocated to C H-R."

A mental health filter form for an initial community care assessment was not completed.

147. WM failed to attend his outpatient appointment on 1 August 1994 and a further appointment was arranged. On 16 August 1994 his consultant psychiatrist, Dr. D, wrote to the community nurse, PN

> "WM failed to keep his recent appointment. Can you let me know if he is continuing to take his Depot if not can we discuss it? I have of course sent him another outpatient appointment."

5th hospital admission 1994

148. Before any action had been taken by the community nurse, WM was admitted to Northwick Park Hospital on 23 August 1994.

> "Presented complaining of auditory hallucinations.. female voice saying kill yourself. ... thoughts are being controlled by a thin black nun. "it became apparent that these symptoms that he experiences, seem to be directly related to his recent use of illegal. During his admission it also came to light that he had received a Summons for non payment of Council tax on the day of his admission to Farrington Ward. W. claims this to be completely coincidental."

The clinical notes of 23 August state

> "Presented here with Mum; auditory hallucinations 10 years getting worse voice telling him to kill himself. ...Stays with Mum most of the time 3 nights ago he started banging on Mum's bathroom door...she feels she cannot cope - worried that he would harm. Not violent...Mum wants William to be admitted to hospital today. ... ? beds. G G contacted; shortage of beds ? element of manipulation in this case would discuss with Dr. M."

149. The next day the clinical notes stated that he had been using crack cannabis LSD and alcohol over the last 2 weeks

> "Plan urine Drug screen; continue anti-psychotic medication; d/w Dr. D tomorrow; discrete obs. R B SHO"

150. The primary diagnosis was Drug-induced psychosis. He was seen on 25 August by Dr. D. The senior house officer spoke to his mother on 26 August:-

> "She says he's been bad for 3 weeks. Talking to himself, talking of hurting himself.....She feels he's not well and will not leave him on his own for fear of him trying to hurt himself. She denies that he's been in any trouble with police or criminal behaviour recently. She says he's been using drugs recently ? crack Does not want him home yet because she feels he is too ill. Plan for r/v by Dr. D on Tuesday."

Mother's opposition to early discharge

151. The Clinical notes of a senior house officer on 30 August state:

> "plan discharge on 2.9.94; CPA referral, Drug rehab referral."

However on 31 August WM was seen with his mother

> "Mother is very concerned that WM is too ill to return home and would like him to stay in for a couple of weeks. I've spoken with one of the probation officers who says WM received a summons for his council tax non-payment. However they are under the impression that this has been sorted out.
> Plan R/W Dr. D re ready to discharge tomorrow. Drug rehab appt. made for 8.9.94 at 9.30am."

The Drug & Alcohol Service's record of contact from the senior house officer is dated 1 September. The hospital records for 2 September note that WM agreed that the voices were no worse and on 5 September that he was feeling well:

> "Plan Drug rehab Thurs (note added FAILED TO ATTEND) Home today, mother informed, OPA 4/52"

152. He was discharged on 5th September. He did not attend the appointment on the 8th with the Drugs and Alcohol Service. His next outpatient appointment was 10 October. On this day, A note by the senior house officer states:

> "10.10.94
> Mother rang me this morning to say that she wanted WM to be seen urgently - She failed to tell me that she had an appt at 3.15pm today!
> Mother says that he's been walking around the house talking to himself. Frightened to leave the house alone. According to his mother he was smoking crack 2 days after his last discharge. He failed to attend Drug rehab....
> Mother demanding admission. Denies any contact with police
> Plan r/v by Dr. D in OPD as planned.
> Contact with probation officer - she is not aware of any recent contact with the police."

153. He was not admitted but the clinical records state that he is "To see Drug unit; OPD 6/52". Two days later, on 12 October 1994, the consultant psychiatrist, Dr. D, wrote to the GP following his review of WM in outpatients on 10 October 1994. However, the letter was again mistakenly addressed to WM's former GP (with whom he was no longer registered):

> "William was accompanied by his mother who had been concerned about his unusual behaviour over the last few weeks. This consisted of her feeling afraid of the way he appeared, and feeling that he was more withdrawn than usual.
> WM had been taking drugs. Failed to keep his appointment with Drug Counselling. Advised to make contact with Drug service as clearly this is the root of a lot of his difficulties. To see again in six weeks."

154. On 11 November 1994 a doctor at Northwick Park Hospital saw him. The clinical note states that:

> "Self-referral to reception. c/o. Has been hearing voices since his discharge from hospital. Heard them on discharge. They increase and decrease....Not taking his depot – missed 5 injections ?. Stopped abusing drugs since 5 weeks completely ? Gets ideas that others, especially family, are against him but this may be himself, not held firmly, apprehensive, non-specific feeling rather than fixed delusional ideas. Voices sometimes tell him to kill himself but he does not listen to them at present, they upset him but not very distressing..."

The doctor referred him to his consultant psychiatrist, Dr.. D. who noted his condition. The depot clinic nurse reported on 13 November to Dr. D:

> "WM has missed his depot on three occasions. Reminder sent on each occasion, but has not responded.
> I will arrange to visit him at home at the end of the week. I will inform you of any new developments."

The community nurse attempted a home visit to WM's flat on 30 November. There was no reply. The nurse wrote to Dr. D on 2 December 1994:

> "WM has consistently not attended the Caryl Thomas Clinic even though two letters have been sent and I have visited his home address and left a note for him. He last had Depot 80 mgs on 6 October 1994 at the clinic."

In response, Dr. D telephoned the community nurse to inform her that WM stays with his mother and gave the mother's address.

155. On 5 December 1994 Dr. D again wrote mistakenly to the former GP, following his review of WM in the outpatients department on 14 November 1994:

> "I had seen him a couple of days previously when he showed up on the ward. Basically he has been missing his depot on the last couple of occasions, he is also drinking very heavily and abusing drugs. He has failed to keep his appointment with the Drug clinic. On mental state examination there are no active psychotic features. WM has once again agreed to start attending the Drug clinic and to resume his previous medication.
>
> I think that his recent presentation is also related to the fact that his mother is away on holiday and she has tended to keep an eye on him in the past, even to

the extent of looking after most of his basic needs such as food and clothing etc. We shall review the situation again in the outpatient's in a couple of weeks." Copy to:MDO co-ordinator and community psychiatric nurse."

156. The community nurse visited his mother's house on 7 December 1994 and was told by his mother that she had just missed him, but that she would bring him to the clinic tomorrow. WM did not attend the depot clinic. He also failed to keep his outpatient appointment on 12 December 1994 and Dr. D wrote to his community nurse:

> "WM failed to keep his appointment today We are sending him another appointment, though given past experience no doubt he will fail to keep this also. Can we discuss this at the community mental health team meeting.
> (copy to the MDO co-ordinator)"

The community nurse's notes of the next day record:

> "Spoke to MDO Co-ordinator who gave me date of WM's next probation meeting and phoned probation office. Will attend that on Thursday 15.12.94. WM attended clinic on 15 December 1994 and was given his injection. He was also given an appointment card; Nothing much said by him about his non-attendance. Phoned probation officer and reported that he had had his depot."

157. On 21 December 1994 the community nurse notes state:

> "Phoned probation officer; WM did not turn up on Monday for appt. But did come this afternoon, saying that as uncle was ill and his mother was caring for him at home. Admitted not having injection for a long time. But thought he should have it when he felt he was unwell. Has been given a bloc of Appts. by probation officer who is saying that she will take him back to court if he misses one of these. She thought he looked very unwell. Will phone her when I have spoken to Dr. D."

The next day 22 December 1994 she noted:

> "Phoned probation officer. Drug rehab was an option she wanted for WM. But was refused because he was in psychiatric care and on medication. But possibly Dr. D could get a better result by writing to them. Conference will be called."

The community nurse assumed responsibility for liaison with WM and his mother about a review meeting.

158. WM had made application to his Housing service to be transferred closer to his mother and he had been advised on 7 December that he was low priority. On 28 December 1994 the GP wrote to Network Housing Association to support WM's request for housing transfer:

> "as his mother has an intricate role in managing his medical problems it is definitely in WM's best interest for medical reasons to be transferred to a place near his mother's new home".

Multi-disciplinary review meeting 1995

159. On 12 January 1995 the community nurse administered WM's injection and recorded that she informed him of the new date for the conference. A few days later, she sent the following letter addressed to WM and his mother at the address where there were both staying:

> "16 January 1995
>
> Dear Mr.W,
> There will be a Section 117 Review at the Honeypot Lane Centre on Thursday 26th January at 10.30am concerning your care.
>
> Included in this meeting will be Dr. D, social worker Ms. C-H, probation officer Ms. C and myself.
>
> Yours sincerely,
> Ms. S – Community Psychiatric Nurse"

160. Dr. D's written entry (in clinical records) of the review meeting was:-

> "26/1/95 – Section 117 meeting.
> Patient/relative did not attend.
> Probation (Ms. C) – reporting regularly – no condition on probation order. Doesn't want to attend Drug unit. Told by Drug unit that not able to offer counselling as he was on psychiatric medication.
> Case manager – CPN Ms. S – Maintaining depot. No concerns.
>
> Dr. D – Has been seen when discontinued meds with change in symptoms – agrees to resume same (Nov. last) – Also continues to drink heavily and suggestion of intermittent Drug misuse.
> Plan - To continue depot
> To try to engage in Drug treatment – CPN – Probation
> Encourage to attend opd *(i.e. out patient department)*"

161. The community nurse's written record of the meeting (in the community mental health team file) is:

> "117 meeting with C M Dr. D C H R and myself. No message from WM or his mother. Taken off 117. Medication could be reduced if WM agreeable and sees Dr. D."

The social worker from the community team made no record of the meeting. In evidence to us she recalled that the consensus was that there was no role for Social Services, and she closed the case.

162. The probation officer's record of the meeting (in probation service file) is:

> "Attended S117 review meeting. WM not present. Concern expressed at WM's continued Drug use... Is receiving depixol medication fortnightly. No longer receiving injections due to failure to attend clinics. Had major relapse in 1987 – medication to prevent possible relapse. However, doctor's feeling is that WM

perhaps invents symptoms. Feeling by all that family are efficient in manipulating benefit system. WM currently receives disability allowance – concern expressed in view of Drug abuse." (26.1.95)."

163. At her next meeting with WM, on 2 February 1995, the probation officer discussed the outcome of the S117 review meeting with him. Her records note that:

> "W resistant to attending Drug Concern at present... explained failed to attend hospital appointments as due to dislike of physical side effects of medication."

164. On 9 February 1995 WM was seen by the community nurse:

> "Looking well and seems to be coping. Asking that I ring his mother tomorrow about the house.
>
> Rang Mrs L who had to go out of bed to answer my call -- complaints about washing and trip to launderette
> I said that it can be difficult without a washing machine. She said that she couldn't afford one. I said that WM was young enough to do his own washing. She seemed to think that I wasn't being very fair and put the phone down on me."

165. WM failed to attend the next outpatient appointment but Dr. D noted that he was taking depot regularly. On 17 February 1995 WM attended the GP surgery:

> Stabbed in L leg 2/52 at pub in Hammersmith - 3 sutures each in 2 separate wounds at back of thigh healed well ROS X 6

On 24 February 1995 Dr. D wrote to the community nurse:

> "WM failed to keep his appointment with us yet again on 13 February. I know from a recent review that he's been taking his depot regularly though I wonder has he yet complied with attending the Drug clinic. Could I ask that further reviews be carried out in Honeypot Lane *(community mental health team offices)* and if you could arrange this please and I will suspend his list on the outpatients services for the moment."

Dr. D quoted a different address for WM and this is changed on a copy of the same letter in handwriting to WM's flat provided by the Housing Association.

Request from mother for custody diversion

166. On 16 March 1995, a co-ordinator for Harrow mentally disordered offenders' scheme, responded to a telephone call from WM's mother:

> "WM's mother had been told by her daughter that her two sons were in Magistrates Court today and they had been sent to Wormwood Scrubs. Telephoned Magistrates Court. WM charged with burglary jointly with his brother D L Both were remanded in custody. WM remanded to W Scrubs until 23.3.95. Mrs M is requesting that WM be transferred to Bentham Unit. I said we would investigate for her."

The co-ordinator then telephoned WM's probation officer, but found that she was not available until 20 March 1995. The Bentham Unit was contacted and on 29 March 1995 a report by a psychiatrist of the Bentham Unit was sent to

the Prison Medical Officer Wormwood Scrubs. The psychiatrist had been asked to see WM by the joint co-ordinator (CS, who had former involvement with WM). The psychiatrist concluded that:

> "There is little evidence that the current alleged offence is in any way related to Mr M's current mental state. I do not feel that it is appropriate at the current time to transfer him to the Bentham Unit. If WM is convicted of the alleged offence and his mental state gives cause for concern then we will of course be more than happy to liase with the local service regarding appropriate treatment."

167. A copy of this report was sent to the co-ordinator and WM's consultant psychiatrist, Dr. D. On 17 May 1995 the co-ordinator recorded that:

> "WM released from custody by Harrow Mags. because Crown Prosecution Service withdrew charges; WM had been maintained on depot injection while on remand at Wormwood Scrubs. He had remained stable throughout the period. He had been monitored weekly by court diversion scheme when appearing at Harrow Mags. Court."

The co-ordinator spoke to WM at court that day, and then closed the case. He told us that he would have informally notified Dr. D of the court outcome.

168. The term of WM's probation order ended on 14 June 1995, and his probation officer closed the case.

Release from criminal justice system and requests for care review

169. Little is known about WM following his release from the criminal justice system. WM requested his GP to support his application for a housing transfer and he gave the following reasons:

> "upstairs flat, no fire escape, full of dampness, - very awkward for me to travel up and down the stairs as I get an injection, my hip is sore and painful most of the times - need to be near my mother who is my carer."

On 16 August 1995 the GP wrote to the Housing Department

> "His main carer is his mother who has recently been moved to Wealdstone. It would be in WM best interest to be living near to his mother for these reasons and I would be grateful if consideration could be given to providing him with new accommodation."

On 19 September 1995 WM visited his GP who noted that he was:

> "Not too bad until a week ago when he began to hear voices again. Feeling nausea in the morning. Seeing black shadow again. Feels in control for approx. 50% of the time. has not continued F/U with Dr. D Sees CPN 1X every 2/52 for Depixol 80gMs.. Next appt. 2/7. Urged to keep this."

170. On 25 October 1995 the office manager of the outpatients department wrote to WM's consultant psychiatrist stating that WM had failed to keep three appointments and no further appointment had been given. The consultant, Dr. D, wrote a hand-written note on this memo:

> "This patient is not to be discharged."

Following this Dr. D wrote to the community nurse referring to the letter he had sent in February:

> "this is to remind you that the above needs a review as he doesn't attend the outpatient clinic. Can you also confirm whether he is attending the Drug clinic."

A copy of this was sent to the community mental health team manager. A hand-written note on this stated:

> "Subsequently discussed at team meeting – DS *(community nurse)* having difficulty contacting him at this address - advised to contact mother."

The manager had also written on his letter:

> "AC *(MDO scheme co-ordinator)* Can you discuss with DS *(community nurse)* and make possible assessment. Thanks. 9.11.95"

RE-ENTRY INTO CRIMINAL JUSTICE SYSTEM 1995

171. The same day as arrangements were being made in the community mental health team to re-assess WM (9 November 1995) he was charged with the offence of handling stolen goods. He was found by the police sitting in a graveyard holding a handbag, which had been stolen in a burglary. He spent six weeks in custody and was released from Wormwood Scrubs on 20 December 1995 and was to appear for sentencing at Hendon Magistrates Court on 17 January 1996. Two days after his release he is recorded as visiting his GP complaining of a long history of recurring headaches. It is noted that these had been previously investigated ten years before "CT Scan 1986 – no abnormalities detected". Additionally, it was noted that he "saw CPN yesterday for injection".

172. WM was also to appear before Harrow Magistrates Court on 11 January 1996 on charges of motoring offences. The probation officer prepared a report recommending a combined probation order and Community Service Order. In her pre-sentence report, the probation officer stated:

> "As his supervising officer for the period of probation between June 1994 and June 1995, I had extensive liaison with the mental health services regarding WM's care and treatment. During his period some doubt was expressed about the schizophrenic label and on the occasion of WM's admission to hospital in 1994, Dr. D's assessment was that his mental illness was Drug induced. Indeed WM has a history of serious Drug and alcohol misuse and at the time his probation order was imposed, admitted to daily use of crack cocaine over several years.
>
> During the period of statutory supervision 13 June 1994 to 12 June 1995, WM was considered unsuitable for treatment according to Harrow Drug Service's policy because he was receiving psychiatric medication. He continued to use drugs during this period although less regularly....
>
> WM has several previous convictions for the same offence. He appears not to recognise the seriousness of his actions and has expressed little regret for them. Therefore he would appear to be at significant risk of re-offending."

173. Following his court appearance on 17 January, the probation officer reported to the consultant psychiatrist, Dr. D, that WM was remanded until 28 February 1996 and the Court had requested a psychiatric report from him. The consultant wrote to WM offering an appointment on 2 February - two letters were sent to different addresses in order to reach him. On 9 February Dr. D interviewed WM at Wormwood Scrubs Prison. In the consultant psychiatrist's view, there were minimal symptoms of WM's psychiatric illness, though WM heard voices on occasions. There was Drug and alcohol misuse, though WM said not for the past four months. Dr. D sent a copy of this report to both the community nurse and to the probation officer. On 16 February 1996 Dr. D reported to the court:

> "It is clear that WM suffers a severe psychiatric illness although this does not seem to have any relationship to the offence with which he is charged."

Dr. D was not prepared to make any recommendations to the court.

174. On 3 April, WM was arrested for driving whilst disqualified and breach of bail, and appeared in court the following day. A psychiatrist attached to Brent Court Liaison Scheme wrote to Dr. D for more information about WM. At this time it was stated that WM was living with his mother and two brothers in Wealdstone. The psychiatrist's letter to Dr. D stated:

> "I spoke to WM's mother by telephone and she is obviously concerned regarding the Drug abuse by W. She also said his sleep pattern is quite disturbed and he occasionally talks to himself. There have been no incidents of violence or aggression in the home, and his mother confirmed the fact that he had missed his two most recent depot injections. She is anxious for further psychiatric help with regard to her son W.
>
> It was our impression, when we examined WM on 4 April 1996, that his offences were not related to his mental illness and while he continues to have a complaint of auditory hallucinations, this symptom has not increased in intensity in the last number of weeks. We therefore felt that there was no indication to divert him at this stage but felt he would benefit from further assessment by his sector team, who are familiar with his history and his current treatments."

A footnote was added to the letter stating that following WM's appearance in court on 4 April 1996, he was due to have a further assessment on 23 April 1996 by the writer and Dr. D at the request of the court and as a condition of bail. A copy of this letter was sent to staff at the Bentham Unit. WM failed to keep the appointment for 23 April 1996 and Dr. D suggested to the community nurse, (who is described as the key worker):

> "As we discussed previously, I think it will be helpful if we have a joint review meeting."

However, a hand-written note by Dr. D states that he discussed the matter with a member of staff subsequently, and ascertained that WM was in custody.

175. By May 1996 WM was being held on remand from Birmingham Magistrates Court. A note of a telephone call to the solicitors by the MDO scheme co-ordinator suggested that WM was at Brimstone Young offenders Institution, but this was probably the wrong place according to evidence given to the panel at interview. WM had outstanding court cases in Birmingham, Hendon, Harrow and Brent. The plan was to remit all the cases to Brent Magistrates Court so that they could be dealt with on 16 May 1996.

176. WM appeared in court and was remanded in custody at Wormwood Scrubs till 13 June 1996. Dr. D was asked by Probation to provide another court report. Dr. D saw WM on 11 June 1996 and reported to the Clerk of Justices at Brent Magistrates:

> "He informed me that he had had missed his medication in the past five to six weeks before the incidents and so at the time had had a recurrence of thoughts that others were against him and might harm him and also a recurrence of hearing voices. He said he had been eating and sleeping poorly...and had lost a stone in weight. He also said that he had been abusing crack cocaine, taking this on approximately two days a week over a four to five week period around February/March 1996.

He told me that since he had resumed his medication in April this year his symptoms had resolved rapidly and he denied their presence over the last couple of weeks.

There is no evidence that any of his offences relate to his mental illness and there are no symptoms of current mental illness. Accordingly I cannot give any specific recommendations to the court concerning treatment of his mental illness other than to state that following his release from prison we will undertake to continue to provide treatment in the community.
(Copies to: CM, probation officer and DS, community psychiatric nurse)."

Release from prison and follow-up

177. On 31 July 1996 the Prison Medical officer at Wormwood Scrubs wrote to Dr. D that WM was to be released on 1 August 1996 and gave details of medication and when it was next due. He also asked if arrangements could be made for follow up in the community. The Prison Medical Officer sent a copy of this letter to the community psychiatric nurse, DS.

178. He was seen at his GP surgery on 13 August 1996 and the GP noted that he had been in prison for three months. It was also noted he had not had his depot injection and that there was a need to contact the local depot clinic and community nurse to check that he was on the list for treatment.

179. The clinical notes of his out patient appointment on 14 October 1996 stated that WM was seeing DS "the keyworker" every 2 weeks for injections, heard the voice occasionally at end of his depot medication cycle, denied any current Drug misuse and minimal alcohol, had no court charges pending and appeared to be in good spirits. In his report of this review to the GP, Dr. D added:

> "Complains of police harassment following release from prison in August. To see again in 2 months time."

A copy of the letter was sent to the community nurse, DS. WM failed to attend an outpatient appointment for 1 December 1996 and a further appointment was sent. He continued to receive his fortnightly injections from the community nurse.

REQUEST FOR HOSPITAL ADMISSION IN FEBRUARY 1997

180. On 12 February 1997 WM visited his GP and was seen in surgery as an urgent extra. He had run out of medication, he felt well and did not complain of any particular problems. He was given a prescription for Chlorpromazine 100mg 2 at night, 60 tablets. Co-Codamol 100 tablets and vitamin BPC 84 capsules. He confirmed that he was having regular Depot medication. He was given a sick note for 6 months because of his schizophrenia. The following day he received his depot injection from the community nurse.

181. He did not attend the appointment booked for 24 February 1997 with the GP. However two days later he was seen as an extra by another GP, Dr. K, at the surgery. His GP, Dr .T, told the panel:

> *"WM told Dr. K that he had apparently taken 15-20 tablets of Kemadrin 2 days previously. He felt fed up and depressed. He had previously spoken to Dr. K on that day when he was advised to attend hospital. He had done so but had been advised admission was unnecessary and to see his GP. Apparently he felt confused because he was being refused help. He did have an appointment already to see Dr. D on 3 March 1997. He complained of hearing voices telling him to kill himself. He was seen on the following day by myself. He confirmed that he was having Depixol 80mg every 2 weeks and taking his Chlorpromazine. There was little change since the day before though he was very calm. He was due for his Depixol that day. He was asked to come in and see me the following day and, if he felt that there was still a problem, he would be re-referred to the psychiatrist to be seen sooner than his appointment the following week."*

The community mental health team file for 26 February 1997 has the following entry:

> "T/C from Dr. K WM's GP at 4.30pm WM had presented himself at surgery, threatening to kill himself. Apparently he had taken an overdose earlier in the day. Was seen at NPH out-patient's today, but was not admitted, instead was redirected to his GP. As it was late in the day I redirected Dr. K to EHT *(Extended Hours Team)*."

The next entry reads as follows:

> "T/C from RW EHT *(Extended Hours Team)*. Informed me that WM had spent several hours at outpatients and was seen and assessed by psychiatrist. Psychiatrist will liase with GP to discuss best course of action as WM wants to be admitted to NPH as an in-patient."

The records of the Emergency Hours Duty Team for 26 February 1997 (written as 26.2.96 but clearly wrong) are:

> "Assessed in A&E by duty psychiatrist and offered follow up appt. next week. EHT contacted by GP Dr. K who had pt in surgery and was worried about him ? suicidal intent. Agreed that he would be further assessed in A&E but he DNA. ? possible link of recent symptoms to fraud investigations."

182. The duty doctor who interviewed WM at Northwick Park Hospital on 26 February was a locum senior house officer to Dr. D. The locum doctor noted that WM had no social worker and that WM was not happy to see Dr. D. His

report of his interview with WM is given in a letter he sent to the GP (dated 7 March 1997):

> "The above patient *(WM)* was brought by his mother to hospital on 26/2/97 demanding admission. She told me that his GP had advised her by telephone to see Dr. D. WM was casually dressed, in the beginning of the interview relaxed but became agitated as the interview progressed.
>
> He told me that he took an overdose of Procyclidine last Monday night, and was very violent towards his sister with whom he lived now for the last 8 months. She is 17 years old. At first he said he did not know why he took the overdose and later he told me that it was because a voice from a woman was telling him to do that. She told him to kill himself.
>
> He says he has heard this voice for years, 24 hours a day, and even now during the interview!!". This is in contrast to what he told Dr. D in the outpatients clinic on 14 October 96. Objectively his speech was normal in volume and rate; his speech was of normal variation; there was good eye contact. The flow of speech was coherent; there was no loosening of associations; thought block or any signs to suggest an acute psychosis. He told me that he has not been taking drugs for weeks now.
>
> Because of the voice he feels depressed. He sleeps only for a few hours a night and wakes up at about 4 o'clock in the morning. His appetite is poor for years and his mum told me that he has lost 2 stones in 9 months time. He spends the whole day sitting at home. He told me that he was compliant with his medication.
>
> My impression was that this man did not have any acute symptoms at the time of the interview. He has got an outpatient appointment to see Dr. D this Monday, but is not happy about seeing him. He and his mother were demanding admission now and I told them that I did not find his case urgent enough.
>
> As planned we will see him in the outpatient clinic on Monday.
> Copy to DS, community psychiatric nurse, Honeypot Lane."

183. Dr. D's note on WM's clinical records, dated 27 February 1997, is:

> "Discussed at team meeting.
> Recent presentation to duty Dr.. NPH (?where are notes)
> Felt to be unchanged from previously.
> Taking meds.
> ?In difficulties with police.
> See OPD/Dept clinic."

184. On 27 February, WM returned to see his GP who noted that there was little change and that he was due to receive Depixol that day. When we interviewed WM, he recalled that he discussed with his GP whether she could get him admitted to hospital and whether he could change his consultant psychiatrist, Dr. D. WM later attended the local clinic to receive his depot injection. At the community team meeting on 27 February, WM was discussed and the minutes note WM:

> "Arrived with mother in A&E. He had taken on OD and jumped through a window; hanging around the unit. Not clear whether criminal investigations. Want to be admitted. Duty follow-up. In prison in August".

The following day, 28 February, his mother called to cancel the appointment with his GP. WM was not seen in surgery again. The surgery received the letter from Northwick Park Hospital on 7 March relating to WM's visit there on 26 February.

185. WM did not attend the outpatient appointment on 3 March 1997 to see Dr. D nor did he attend for his next depot injection, which was due on 13 March 1997.

186. On 19 March 1997 the police arrested WM on a charge of burglary by artifice; his solicitor was called to the police station. The Harrow Extended Hours Team was contacted. The Extended Hours Team Activity Log states:

"Caller:	Police
Reason:	mentally ill ?
Client name/address:	WM (*address of WM's flat shown)*
Gender	F
Open CMHT ?	Yes.
Client group	MH
Response time	30 minutes
Action/outcome	confirming need for appropriate adult."

The police station was in the neighbouring borough of Barnet, and our understanding is that local arrangements for an Appropriate Adult (to attend the police interviews of vulnerable persons) involved a voluntary helper scheme. Following the police interview with WM, he was granted police bail until 27 March 1997, for re-bail to Kilburn ID suite.

187. The following day (20th) he did attend the local clinic for his depot injection. On this occasion he saw a member of the nursing staff, MA, who was covering in the absence of the community nurse, DS. MA told the Inquiry Panel that when he saw WM, the nurse had knowledge of recent events. MA recalled that WM mentioned his attempt to be admitted to hospital and that he had seen doctors, but on that day he reported to the nurse that he was feeling okay. The nurse told us that WM did not appear distressed.

188. On 21 March 1997 WM attended the A&E Department where it is recorded that:

> "No history of trauma, sudden onset of pain in Rt side of ribs (Bone not ?) past 2/7, pain (increases?) when coughs. 17.20 time of examination 17.30 no answer DNA"

WM did not wait for a full examination. This was the last contact WM had with either Health or Social Services prior to the fatal offence on 23 March 1997.

THE OFFENCE ON 23 MARCH 1997

Police surveillance

188. On 22 March 1997 there was a police surveillance operation on WM and his brother. Two police officers kept static observation on WM's address and a team of ten officers with vehicles conducted mobile surveillance on the two brothers. They watched the brothers leave WM's flat and were seen to go to various areas in Sudbury, Greenford and Northholt. They were seen to enter a flat and were out of sight for 6 or 7 minutes. They were then seen to return to their car and drive away. Some officers continued to follow them whilst another two visited the property they had entered to make sure nothing untoward had happened. They spoke to the occupant who told the police that a young man said he had lost his ball in her back garden and went with him to look for it. When asked by the police, she discovered that she had been burglarised. The stolen property included £605 of cash and two rings.

189. In evidence to us, the Metropolitan Police Service's senior representative stated that there was insufficient forensic evidence for arrest with successful prosecution on 22 March 1997. Both brothers subsequently pleaded guilty to the offence of burglary in respect of this property, none of which was recovered.

190. The police surveillance continued and later in the early hours of the following morning of the 23 March 1997, the police watched WM enter the communal front door to a block of flats. It was subsequently learnt that he had pretended to the occupants that he was a neighbour from upstairs and was worried about a flood which could be coming through their ceiling. She let him in and he asked the occupant and her husband to run water in the kitchen and bathroom, he stole items from the living room and left the flat. He was subsequently identified by the husband in an identification parade.

191. Five hours later at about 6.00am he entered another block of flats where the offence occurred. The times of the police surveillance operation had been targeted to patterns of crime, and had ended before WM's entry into the block of flats where the homicide occurred.

The homicidal offence

191. In his address to the court before sentencing on 12 January 1998, Counsel for the Prosecution Mr Sweeney described the details of the homicide as follows:

> "(The accused admits) that a few hours after he had committed a burglary (the subject of count 2 of the indictment) he committed a further burglary alone at the flat of a 91 year old lady called Beatrice Hughes, again gaining entry by pretending to be an upstairs neighbour, and then having gained entry he carried out a vicious attack on Miss Hughes including stamping on her face and head rendering her unconscious and causing her other severe injuries. Having incapacitated her he began to search her flat for valuables. However his entry and attack were heard by neighbours who found the defendant in the flat, and after a fierce struggle with these neighbours he was detained by them until the arrival of the police. Miss Hughes never regained consciousness and finally died from her injuries on the 13 April 1997.

The defendant has a history of both mental illness and Drug abuse, and it is clear that certainly prior to Counts 3 and 4 he had taken both cocaine and cannabis. Though it is equally clear he had his wits about him.
In interview he claimed alibi, obviously now abandoned and that he could not recall the events."

192. The police arrested WM and at 7.30 a.m. of 23 March 1997, WM's solicitor was telephoned and given details of the offence and that he would be asked to attend the police station. The police telephoned again at 15.50 asking him to attend.

Mental health assessments after the offence on 23 March 1997

193. A mental state examination was carried out on 23 March 1997 by Dr. O, a specialist doctor approved under s12 of the Mental Health Act 1983. His conclusion was that:

> "Currently no signs or symptoms of an acute mental illness which indicate admission to hospital is needed at this point. I believe he is currently fit to be interviewed."

WM's consultant psychiatrist also made an assessment the same day, Dr. D. The hand-written record notes:

> "No evidence on this assessment of any recent change in symptoms that would warrant hospitalisation. In my opinion there does not appear to be any connection between his long-standing illness and the alleged offence. Fit to plead."

The typed copy gives a slightly different conclusion:

> "I consider that he should be processed through the judicial system and his behaviour concerning the alleged offence is not illness derived.
> (copy to DS, *community nurse*)"

194. A referral was made to Harrows Extended Hours Service and an approved social worker interviewed WM at the police station with a view to assessment under the Mental Health Act 1983. His conclusion was that:

> "Fit to be interviewed with an appropriate adult for the alleged offence. To be followed up under the Mentally Disordered Offenders scheme. RA, team leader, notified of conclusions by telephone."

195. A medical examination was also carried out on 23 March 1997 by another S12 approved doctor, Dr. S. In his report he states:

> "Denies any memory of offence. Does not claim offence occurred as a result of these voices.
> In my view his personality factors associated with primary and secondary problems of Drug abuse (rather than mental illness are more likely to play determining role in precipitation of his aggressive behaviour. Based on this conclusion and because of serious nature of the offence and likely risk for others in community, WM case should be dealt by usual criminal procedure by the court."

196. The mentally disordered offenders scheme co-ordinator was notified of the offence and detention, and the case was allocated. A CPA referral form was completed on 24 March 1997, and a critical incident form was completed by the community mental health team manager the same day. The team manager's interim report on 25 March 1997 noted that against "Keyworker" "none". However this was deleted in handwriting and DS *(community nurse)* added. Also recorded was:

> Follow up status: 1 Open to team (East) for Depot Only - Fortnightly Caryl Thomas Clinic, CPN - DS.

197. On 25 March 1997 WM appeared at Harrow Magistrates Court for attempted murder. He was remanded to Wormwood Scrubs Prison to be assessed by a consultant forensic psychiatrist from the Bentham Unit. On 27 March 1997 Dr. D wrote to the prison giving details of medication. The same day the police requested from Dr. D a statement/report, especially on any history of blackouts and the likelihood of illness causing prolonged blackouts. On 2 April 1997 WM made a second court appearance and was remanded in custody till 30 April 1997. The next day WM gave consent for the consultant forensic psychiatrist to access his records.

198. On 14 April 1997 the clinical notes record that the victim had died. On 30 April the community mental health team file notes that WM was charged with murder at Harrow and that he was to return to court in 4 weeks time. The side effects of medication were detailed as was action to liase with medical staff at Wormwood Scrubs Prison. On 27 August 1997 a psychiatric report was prepared by a S12 approved doctor at the request of WM's solicitor. His conclusions were:

> "In summary, I agree with Dr. D that his behaviour related to the alleged offence was not illness related and the facts of the matter may be safely left for a jury to consider."

199. The Central Criminal Court requested a report from another specialist medical practitioner who interviewed WM on 15 November 1997. This specialist's report, dated 17 December 1997, stated:

> "4)...Though there is no doubt that schizophrenia would constitute an abnormality of mind, in this particular case, I do not believe that there is evidence that it substantially impaired his mental responsibility for his acts and omissions in doing or being party to a killing. I am therefore of the opinion that he does not meet the criteria for "diminished responsibility" within the meaning of the Homicide Act 1957.
> 5) I am of the opinion that he is fit to plead.
> 6) Were he to be convicted of murder and given a mandatory life sentence, it might be that during the course of his imprisonment he would require admission to hospital under the provisions of Section 47 of the Mental Health Act 1983. Given the nature of his index offence, I believe that he could only be treated within the confines of a Special Hospital."

200. On 12 January 1998 WM received a life sentence. In his plea of mitigation, WM's defence counsel had little to say other than that:

> "He has pleaded guilty. That really is the mitigation that is available to him...

Only two days before these offences he had been to the psychiatric services and received his injection from the psychiatric nurse. He had been with his mother and my instructions are, and it seems to be supported by this report, he wanted to be admitted to hospital* as he felt that he was not well and expressed a concern that if he were not admitted he might do something that he would afterwards regret. That has happened. ... It does show, perhaps to a limited degree, that he knew then that he had got problems, his attempted cry for help failed and we are now here today."

* Counsel is probably referring to the request for admission made on 26 February 1997, more than three weeks before the offence.)

ACTION TAKEN BY THE NHS TRUST FOLLOWING THE OFFENCE

201. After receiving the critical incident report and a preliminary investigation, the Harrow and Hillingdon Healthcare NHS Trust indicated that it wished a full review of the clinical management of WM. An external Consultant Forensic Psychiatrist, Dr. Hamilton, was asked to review the medical records, notes and correspondence held by the Trust, together with records of social workers in the community mental health team. Social work notes were seen with the permission of the London Borough of Harrow, Social Services Department.

202. Dr. Hamilton provided his report on 23 May 1997 on the care and treatment of WM. It was put before the Trust Board on 4 July 1997 by their Director for Mental Health Services together with a review of the findings and the follow up action. Certain areas were identified for further investigations and are set out in the Trust Board's papers for 4 July 1997 as follows:

> **"1. Care Programme Approach:**
> The Director of Elderly Care and Mental Health will put in place a full review of the Care Programme Approach which will look at the present policy and procedures in order to establish the appropriateness of those policies and whether the information flow, which is critical to the CPA, is effective. The review will also, in conjunction with Social Service colleagues and the Community Mental Health Teams., examine the process of discharge from CPA/case closures and who holds responsibility. The review will also identify whether the role of a CPA Co-ordinator (new post) would improve the overall functioning of the CPA.
> **The review will be conducted by a senior manager and be completed by 1st October 1997. An update report on this action will go to the November Trust Board.**
>
> **2. Role of key worker in depot clinic;**
> The report highlighted the ambiguity regarding the Community Psychiatric Nurses' role in the depot clinic versus the key worker role for their own personal caseloads. We have already undertaken a review of these issues and action has been taken to make sure that every patient, whether attending depot clinic or not has an identified key worker.
> **Completed**
>
> **3. Hospital number/patient identifier.**
> The mis-filing of clinical notes has been highlighted by this incident and it is quite clear that many pieces of clinical information do not contain the patient identifier or a date of birth. This obviously causes a problem when filing clerks attempt to cross reference clinical notes with other pieces of information that require filing.
> **The Director of Elderly Care and Mental Health will arrange for a review of the frequency by which patient identified and date of birth appear regularly on clinical documents. The results of the review will be published and the Management Team and Division of Psychiatry will agree a protocol for the use of patient identifier/date of birth by all members of staff writing in clinical notes.**
>
> **To be completed and implemented by 1st September 1997."**

PART TWO: FINDINGS

MEDICAL CARE AND TREATMENT

Medical history

203. It appears that WM had a normal childhood in terms of medical care other than the fact that at quite a young age he was noted to be losing weight. The cause is unclear. At approximately 8 years of age, he had a serious head injury which required that he remain in Hospital for a period of six weeks. At the time he was rendered unconscious. His mother gave evidence to us that she felt there was a change in his general disposition following his head injury. She could not be specific, but felt that it might have affected him.

204. At the age of 12 or 13, he was seen by a Consultant Urologist concerning difficulties, possibly with his kidneys. There seems to be no firm diagnosis and no serious illness was attached to this. Other than this WM has been physically fit and well. For approximately ten years prior to the homicide he drank heavily up to 18 units a day (acceptable intake for men 21 units a week) and he was also known to abuse drugs on a regular basis for at least five years prior to the homicide, including LSD, crack cocaine and other street drugs.

205. Since his sentence, he has been diagnosed as suffering from a pituitary tumour for which he is receiving treatment at the Hammersmith Hospital. This tumour was not diagnosed previously.

Psychiatric care episodes

206. The evidence gathered indicates that WM first developed mental illness while serving a sentence in Dartmoor Prison. He was released in May 1986. A psychiatric assessment was instigated by a probation officer in July 1986 following an assault on his grandfather. It appears he was reluctant to be seen by the psychiatric services and attended an outpatient clinic at the insistence of his mother. The consultant psychiatrist was sufficiently concerned to arrange his immediate admission to Northwick Park Hospital. On admission to Hospital he showed clear evidence of delusional thinking. He denied at the time that he had been drinking alcohol. The Consultant who admitted him at the time, Dr. C-O, concluded that WM was suffering from a major psychiatric illness. He felt that it had been apparent in Dartmoor Prison over the last eight to ten months and he registered his concern that this was not picked up by the Prison Authorities at the time.

207. Dr. C-O continued to look after WM from that admission until December 1987 when his care was handed over. At the time an EEG was performed which was noted to be normal. Prior to that admission, it had been noted in March 1984 that he had taken an overdose in response to a female voice. It is possible that the decision to allow WM to remain a patient of Northwick Park Hospital led to less contact with services, notably outpatients, because of geographical distance (it was known that he had moved with his mother outside the catchment area, from Harrow to Brent). Initially, he received depot injections from the community nursing service at home, and by February 1987 administration of the three-weekly injections had been assumed by his new GP.

208. When he returned to Harrow in 1992, he was referred by his GP to Dr. H, consultant psychiatrist, who saw him as an outpatient and who subsequently referred him to the community mental health team for the Care Programme Approach. The consultant was informed that his case had been closed to both social work and the community psychiatric nursing service.

209. His second admission to Northwick Park Hospital was in July 1993 when he came under the care of a different consultant, Dr. C. It was noted then that he had difficulty living independently and had gone back to live with his mother. He was having strange thoughts, again about Muslims.. There is then the first report of him hearing a woman's voice talking to him in his head. This voice apparently continues over the next few years. It was noted that he had failed to take his medication for several months, was smoking a considerable amount of cannabis and that he had jumped from his mother's flat. There are various accounts, one saying that he fell down some steps or that he jumped and that he was high on drugs or alcohol. He remained in Hospital for three weeks and then attended the Day Hospital. Over the next few months he continued to complain of hearing a female voice.

210. His third admission was on 22 February 1994, when he presented himself complaining again of the female voice, which was telling him to kill himself. He admitted on that occasion that he had taken crack cocaine and LSD, and he was admitted to a ward providing detoxification. He was discharged on 2 March 1994 with "no objective evidence of mental illness".

211. It is interesting to note that on this occasion, despite the fact that he was hallucinated, the conclusion was that there was no mental illness present. One must assume that the hallucinations were felt to be in relation to drugs, although previous history of this hallucination would indicate that the hallucination is separate from his Drug taking. Following discharge he was soon arrested for burglary, suspected of having stolen a handbag from a 87 year old lady, and he was remanded to Wormwood Scrubs Prison.

212. Following an assessment in prison, he was transferred on 31 March 1994 under Section 48 of the Mental Health Act 1983 to the Bentham Unit, a secure hospital facility. He was noted to be psychotic with thought withdrawal and broadcast. He had passivity of control and of thoughts. Again, the female voice telling him to kill himself was present. While an in-patient he was assessed by Dr. D, who by this time was the Consultant responsible for this catchment area. Dr. D recommended regular follow-up at his outpatient clinic and WM was discharged from that admission on 16 May 1994. He was seen as an outpatient in June 1994 but failed his two monthly appointment on 1 August 1994.

213. Both the hospital clinical team and community mental health team were aware that WM's compulsory admission to the Bentham Unit brought him under the statutory after-care provisions of S117 of the Mental Health Act 1983.

214. His fifth admission was on 23 August 1994 when he came with his mother complaining of auditory hallucinations. His mother indicated that she could not cope and she was requesting admission. Again he had thoughts of control and passivity and it was also noted that he was using crack cocaine, LSD, cannabis and a considerable quantity of alcohol. He was discharged on 2 September 1994 to his home address. Appointments were made for the Drug and Alcohol Service but at that time he did not attend. There is also some evidence that a

referral for the Care Programme Approach was intended, according to the record of a junior doctor. However, there is no detail of the referral nor evidence of contact with the Community Mental Health Team. Notably, the hospital discharge summary sent to WM's GP was not copied to the community team.

215. This was WM's final hospital admission, and from 1994 until 1997 he was treated as an out-patient on medication. Following the last hospital discharge, there is evidence that he was unwell for the rest of the year, that the voice was continuing to plague him, that he was drinking heavily and taking drugs and that he was missing his injections. For instance, in October 1994, it is reported that he was accompanied to the outpatient's clinic by his mother who had been concerned about his unusual behaviour over the past few weeks. This consisted of feeling afraid of the way he appeared and feeling he was more withdrawn than usual. It transpired during the interview that he had been using drugs- initially crack cocaine following hospital discharge, and most recently cannabis and possibly other drugs- and that he had failed to keep his appointment with the Drug and Alcohol Service. The only complaint in respect of his psychotic symptoms was of hearing a voice like a whisper occurring once a week for a couple of minutes and it was noted that he was continuing to receive his depot injections. WM was again advised by his consultant psychiatrist to make contact with the drugs Service. He failed to attend his next outpatient appointment and Dr.. D requested discussion at the community team meeting.

216. In January 1995 a meeting took place to review WM's after-care under Section 117 of the Mental Health Act 1983. The health care plan was that WM continue to receive regular medication by depot injections at a local clinic, attend two monthly out-patient appointments to see Dr. D, and be encouraged to attend the Drug and Alcohol Service.

217. In February 1995, Dr. D notified the community psychiatric nurse that WM had failed to attend an outpatient appointment, queried whether he was attending the Drug and Alcohol Service and requested a review by the community team. However, on 13 March 1995, WM was arrested and remanded to Prison where a Forensic Psychiatrist, Dr. L, assessed him. It appeared at the time that WM was still symptomatic even though he had been receiving regular neuroleptic medication (relief from symptoms is not always absolute with medication). No recommendation was made for hospital admission. In May 1995, all criminal charges against him were dropped.

218. In October 1995, Dr. D wrote to the community psychiatric nurse to remind her that a review was outstanding as WM was not attending outpatient appointments. It is noted that the matter was subsequently discussed at a community team meeting and that the nurse had difficulty contacting WM at the address shown on records. She was advised by Dr. D to contact his mother.

219. In January 1996, WM was arrested for handling stolen goods and he was interviewed by Dr. D on 9 February 1996. At the time WM complained of minimal symptoms from his psychiatric illness, and stated that at the time of the offence, he had consumed six cans of larger. In April 1996, he was arrested and sentenced to imprisonment. The Prison Medical Officer notified Dr. D of WM's release date (1 August 1996) and provided detail of medical treatment he had received whilst in prison.

220. Dr. D saw WM at an outpatient appointment in October 1996. WM reported no current psychotic symptoms and said that he heard voices occasionally at the end of his depot cycle (he was receiving medication on a regular basis). He missed an outpatient appointment in December 1996, although he continued to attend the local clinic for depot injections.

221. Despite the continual Drug taking, evidence of some hallucinations and WM's continued anti-social behaviour, no further hospital admissions were suggested, despite the downward trend. Although he attended the Drug Service on at least one occasion, this was for assessment and he did not return for treatment on a regular basis.

222. There is evidence that on 26 February 1997 he took an overdose and was seen at the GP's surgery threatening to kill himself. Despite this it, was felt that no hospital admission was necessary.

223. It appears from 1993 onwards that there are various and sporadic mentions of housing problems, referral for CPA and need for discussions with the community team. It is clear that WM's Drug and alcohol use were escalating during this period, and that he continued to show evidence of mental illness. Between 1994 and the homicide in March 1997, there was no suggestion of hospital admission. It is difficult to understand why - with an escalation of offending behaviour, Drug taking and evidence of mental illness - an admission was not sought during this two-and-a half year period.

224. The evidence from clinical notes is that much of his relapse in behaviour was caused by non-adherence to health care plans and illicit Drug taking. This is also outlined in a letter on 13 April 1994 to Dr. D from the Bentham Unit.

Medication

225. From his first admission in 1986, WM was prescribed long-acting intra-muscular neuroleptics for which he attended a local clinic. It appears that his only contact on any regular basis was through the Depot Clinic but he failed to attend on numerous occasions. Evidence provided to the Inquiry by a family member indicates that he often told his family that he was going for his injection, but in fact did not attend. There were times when family members would make sure that he did attend. His Depot medication varied between Clopixol and Depixol, both of which are long-acting neuroleptics. The dose of these drugs varied during the course of his contact with Northwick Park Hospital.

226. In May 1994, he was discharged from hospital on Depixol 40 mg IM weekly, Chlorpromazine 200 mg at night and Procyclidine 5 to 10 mg three times a day. This medication apparently continued with minor variations on the dose. At the time of the homicide, his medication was Depixol 80 mg IM fortnightly, Chlorpromazine 200 mg at night and Procyclidine 5 mg three times a day. He had received his Depot three days before the homicide.

227. WM's hospital admission in 1993 indicates that he was on Clopixol 200 mg IM every two weeks and Chlorpromazine 75 mg at night. In March 1994 he was on Clopixol 300 mg every two weeks and this had clearly been changed by May of the that year to the Depixol outlined above.

228. WM's medication remained very similar with minor variations from 1992 until the time of the homicide. Despite a female voice that affected him over many years, urging him to kill himself, only Dr. H who looked after him in 1993 considered it worth trying an antidepressant with the neuroleptic medication. From then on, WM had no antidepressant medication despite evidence of a single voice urging him to kill himself. There was also evidence that he had overdosed previously, and that on one occasion, he had jumped out of his mother's window. (This latter event was in association with drugs and alcohol). Whether this would have made any significant difference is doubtful, but it was not considered or discussed in any of the medical notes seen by the Inquiry.

Events preceding the homicide on 23 March 1997

229. In the month prior to the homicide, WM attended his GP on 12 February 1997. At that time, he said he was feeling well and simply needed a repeat prescription for his Chlorpromazine. He failed to attend an appointment on 24 February, but on 26th February he visited his GP and was then seen by Dr. K. The evidence from the GP notes indicate that WM had taken an overdose a day or so prior to the appointment. He indicated that he felt depressed and fed up, and he was advised by the GP to attend the Hospital. He had done so but admission was felt to be unnecessary and he was referred back to his GP. He felt confused because he was being refused help and yet complained of hearing the woman's voice telling him to kill himself. He was nonetheless taking his Depixol injections on a fortnightly basis.

230. Although the GP offered to see him on the following day, which was 28 February, his mother cancelled the appointment and he was not seen again prior to the homicide. Despite the fact that the Locality Team at Northwick Park Hospital apparently noted that he had taken an overdose and was threatening to kill himself, they took no particular action and he was referred back to his GP. There is evidence to indicate that at this stage, his mother was becoming increasingly concerned and was asking for hospital admission.

231. The clinical note reflects that the case was not thought to be urgent enough for WM to require admission or any other form of intervention and that he should be seen in the out-patient clinic as previously arranged on 3 March by Dr. D. This decision was taken by a locum Senior House Officer to Dr. D. The case was not discussed with Dr.. D at the time. It seems that WM was sent from one agency to another - his mother was asking for help and there was no practical response. It had also been noted on 22 February 1997 that WM had been violent towards his sister at the urging of the woman's voice. Even so, no admission was thought to be necessary. He did, however, attend for his injections on 27 February and two days prior to the homicide.

232. The next contact he had with the Psychiatric Services was on the day of his arrest on 23 March 1997. He was seen by an Approved Social Worker and a Locum Consultant Psychiatrist, as well as Dr. D. The conclusion was that WM had not committed the crime in relation to his psychiatric disorder and that his symptom of hearing voices did not fulfil the criteria of true hallucinations as he had insight into it. Dr. D's opinion was that personality factors associated with primary and secondary problems of Drug abuse were more likely to have been causal in the assault on the elderly lady, which eventually led to her death.

Review of prison medical records

234. Medical notes obtained from Wormwood Scrubs Prison reveal that WM was first seen in 1994, where it is noted on 14 March 1994 that he had a history of schizophrenia going back seven years and he was being treated with Clopixol 300 mg intra-muscular every two weeks. Four days later on 18 March, he is noted to have mild persistent psychotic symptoms, and on 29 March complained of a woman's voice which was telling him to kill himself. This latter symptom is consistent with what is noted in medical notes in hospital and the out-patient department.

235. It is interesting that medical staff noted this persistent voice and yet it was not gone into in any detail, nor was it addressed in terms of psychological interventions in the management of his illness or treatment.

236. In the following year, prison medical notes (March 1995) indicate that WM was now on Depixol 80 mg, and in April of that year, that he returned to Court and was said to have "no medical problems".

237. A year later, in May 1996, there is a note indicating that he is much the same as he had been before, continued to be treated with Depixol and in July 1996 again a note saying that he had returned from Court and was considered to be "fit and well".

238. Following the fatal assault, there is a note of 28 March 1997, which makes reference to the fact that WM had last seen a psychiatrist six months prior to this time in custody. It also notes that he feels that his injections are not working and that his voices are worse - one voice continues to tell him to kill himself. However, very soon after that note is made, he is considered to be recovered, not suicidal, not depressed and feeling well. There is some disparity between the examination of Dr. D on 23 March 1997, after WM had committed the offence, and the note in Prison five days later revealing that he is complaining of a voice. Nonetheless, this soon dissipated and the complaints were very short lived.

239. The prison medical records reveal that in May 1998, WM was noted to be pale, suffering from hair loss and his voice deepening. Investigations were carried out, and, in July he had a CT scan which revealed a large suprasellar mass. He was seen by endocrinologists in September 1998 when he was considered to be suffering from hypopituitarism and a prolactinoma. He was receiving ongoing treatment for this at the time of this Inquiry. Previous scans had not revealed any abnormality. There is no mention made - in prison medical notes, or from the Hospital where he had been seen by specialists - of any link between his previous behaviour and his current organic state. There is no evidence to show that his pituitary tumour is a relevant factor in his behavioural or psychotic problems, nor is it linked in any way to his Drug abuse.

240. It is apparent from the above evidence that WM is an individual who had a considerable number of problems. These included schizophrenia comprised of delusional ideas from time to time and auditory hallucinations, continual criminal activity and a history of Drug and alcohol. He also had a history of a serious head injury.

241. Evidence from the medical staff from 1992 onwards indicates that the consistent opinion was that WM's offending behaviour was not directly related

to his mental illness. It was felt that his criminal behaviour was separate and that his antisocial personality with the taking of known stimulant drugs, was causal in his criminal behaviour. In support of this, there is evidence to show that WM was offending many years before the onset of his schizophrenia, and that following his use of drugs, he was committing burglaries in order to obtain money to fund his Drug habit. Criminal behaviour was part of his family culture, and other male individuals in the family who were also criminal in their behaviour did not show evidence of mental illness. It seems therefore that criminality, both at a family and cultural level, was separate from the fact that he had mental illness.

Could medical intervention programmes have been more effective?

242. WM was treated by the neuroleptic group of drugs for the illness of schizophrenia. However, his particular Drug treatment was rarely reviewed and the changes in medication were between Depixol and Clopixol, with very little or other anti-psychotic treatment offered. Early on in his contact with Northwick Park Hospital, he had been seen by Dr. H who considered that there was a depressive element to his difficulties. WM's continued mention of headaches and of the woman's voice persistently telling him to kill himself were intermittently present throughout his contact with Northwick Park Hospital, and indeed at times when he was in Wormwood Scrubs Prison. These two symptoms would be consistent with depression, which had previously been raised and he had been previously treated with Imipramine. Patients with psychosis commonly suffer from depression, particularly when in remission from their major psychotic delusions. It is not uncommon that an anti-depressant would be used with neuroleptic drugs to beneficial effect, particularly if individuals have evidence of depressive hallucinations such as described by WM. In our opinion, therefore, the medical staff failed to address this aspect of his illness.

243. In February 1995, WM complained of side effects from his medication and it does not appear that this was fully addressed. We do not consider that an adequate medication review was undertaken - WM was simply continued on neuroleptic medication by injection, and occasionally by mouth in the form of Chlorpromazine. In our view the detail of WM's difficulties was less vigorously pursued than it could have been. We do appreciate the difficulty of effective medication in individuals who are drinking alcohol in large quantities and taking mind-altering drugs. However, this issue calls into question medical management arrangements.

244. Whilst it is clear that WM was seen at regular intervals by medical staff and personally by the Consultant, his care programme was extremely limited for someone with multiple needs. Whilst living in the community, for the most part WM remained on a simple care programme i.e. attendance for depot medication at a local clinic, attendance at outpatients to see a psychiatrist and encouragement to attend the Drug and Alcohol Service. Responses by the community mental health team to referrals from the hospital clinical team are examined in the next section to our Report.

245. The reluctance by medical staff to admit WM to hospital, despite the evidence of ever increasing antisocial behaviour and history of Drug misuse, is questionable. There was no hospital admission for the two-and-a half years prior to the fatal offence, despite good evidence to show that his behaviour was

deteriorating. Considering the level of difficulty and complex needs of this particular individual, this may be considered a poor response. On the other hand, we do acknowledge the fact that Dr.. D was consistent in ensuring that follow-up action was taken when WM defaulted on appointments at the outpatients department, and at the Depot Clinic. There is also evidence that when he presented himself, he was seen by medical staff, and as far as his mental state was concerned, it was documented that there was no evidence of significant relapse.

246. In a broader context however, it was known by medical staff that he was going in and out of prison, that he was committing minor offences and that he had been violent on several previous occasions. It was known that he was someone who had a history of misusing alcohol and illicit drugs and that he had a dependency on his mother who was finding it increasingly difficult to cope. When his mother sought his hospital admission a month before the fatal offence, it was known that he had no allocated social worker from the community mental health team or probation service. The question arises as to the extent to which these factors should have been addressed in conjunction with the medical management of his mental illness.

247. Of all the service providers involved with WM, the locality medical team had a fuller picture of WM's background and circumstances It was becoming increasingly apparent that medical and social interventions had limited impact on his quality of life and pattern of antisocial behaviour. One option could have been to consider the merits of a long hospital admission. Such an option would have facilitated re-assessment of his psychotic illness, a Drug review, review of his psychological and social support needs, review of his family circumstances and a review of his addiction problems to both illicit drugs and alcohol. A sustained period of stability, followed by a co-ordinated after-care plan may have achieved necessary change. However, this solution was never addressed by the professionals involved.

248. The role of the Community Drugs and Alcohol Service in WM's care and treatment is examined below.

Was WM's violent behaviour predictable?

249. There is little evidence to support the fact that people who suffer from schizophrenia are more likely to indulge in criminal behaviour. The conclusion of medical staff that the cause of his offending was Drug taking and antisocial behaviour would be reasonable. It is unlikely that his early head injury contributed to either his schizophrenia or his criminal behaviour. Both schizophrenia and criminal behaviour were part of WM's family history and it is likely that WM would have developed in the way he had even without a head injury. Although head injuries are implicated in the generation of schizophrenia, where there is a strong family history, as there is in WM's family, it is unlikely that the head injury would have been causal and it is more likely that the family history is important.

250. It is highly probable that WM's motivation to buy and consume illicit drugs and to misuse alcohol, significantly contributed to anti-social behaviour prior to the homicide, both in criminality and his disorganisation. It is also likely that the fatal offence and the brutality of that offence were exacerbated by his substance misuse. It is highly unlikely that schizophrenia alone would have

caused him to obtain access to an individual's house, appearing to be normal and plausible, and then to carry out a serious assault.

251. What was certainly predictable was that WM would continue to offend. Social and demographic background factors indicated that he was someone at high risk of reoffending. His probation officer had concluded by 1996 that supervision under a probation order was insufficient as a preventive measure. The most reliable predictor of behaviour is previous behaviour, and WM had shown a fixed and unremitting pattern of criminal and antisocial behaviour in association with Drug abuse. It was therefore clear that, unless there was significant change in his personal and social circumstances, his behaviour pattern would continue in that way.

252. Whether the violence of the particular offence could have been predicted is doubtful. WM had some early convictions as a young person for assault, and he had been admitted to hospital following an assault on his grandfather. It is important to note that the previous violence was prior to his diagnosis of schizophrenia, and following diagnosis with treatment, patterns of behaviour possibly could change. The Panel found no reports of violent incidents from 1991 to 1997 in the records from all the agencies that contributed to this Inquiry. In some respects the risk of harm to others should have been formally indicated because the nature of alcohol and Drug abuse is such that it renders individuals capable of committing unpredictable crimes. Although there is evidence that risk to WM's own health and well-being from substance misuse was discussed with him, it does not seem that risk of harm to others was addressed.

253. We have considered whether the mental health services were in possession of information about WM that should have been passed to the Police (s115 of the Crime and Disorder Act) in order to prevent an offence. In our view, there was no significant information that was not already available from court reports which preceded the homicide.

We recommend that:

a. **Whenever a medical member of a clinical team assesses a person at their and their carer's urgent request for psychiatric hospital admission, (a) a consultant psychiatrist is consulted before a decision not to admit is taken, and (b) there is follow-up action to ensure that a community care assessment is undertaken by a community mental health team.**

b. **Harrow and Hillingdon Healthcare Trust and Harrow Social Services should ensure that any history of alcohol and/or Drug misuse is included in all risk assessment processes.**

c. **Peer review (i.e. request for review by another consultant) should be considered in cases of protracted unresponsive patients – particularly those (like WM) who have escalating levels of antisocial/disorganised behaviour in the community.**

ROLE OF THE COMMUNITY MENTAL HEALTH TEAM

Operational context

254. Harrow and Hillingdon Healthcare Trust and Harrow Social Services have operated joint community mental health teams. since 1990. Initially one team provided assessment and approved social work services and one team provided long term rehabilitation services. The Care Programme Approach (CPA) was implemented in Harrow from April 1991 in expectation that it would be managed within existing resources. A referral system was established for the community teams., and local guidance on CPA incorporated social services responsibility for community care assessment and care management.

255. It was reported that in the first six months, referrals for CPA exceeded the resource capacity and consequently the eligibility criteria was tightened. At this time, the balance of staffing in the CMHTs was 70% social workers and 30% CPNs. A local audit project was undertaken between December 1992 and May 1993. Communication problems between hospital wards and community teams. were identified. Although a comprehensive assessment of need was to be a key feature of the CPA, the audit found that no needs assessment form had been devised, and that liaison with other professionals over the assessment was seldom documented. A lack of extra administrative support and information systems to provide back-up to the CPA were seen as a major problem. The audit report concluded that additional resources would be required before the system could become fully operational for all patients referred to the mental health services.

256. In April 1993, the provisions of the NHS & Community Care Act came into force. Under Department of Health Circular LAC(93)2, Social Services were required to ensure that any criteria they developed governing eligibility for community care assessment was sensitive to the circumstances of alcohol and drug misusers. In 1993, the two community teams. combined functions and reorganised to cover the geographical areas of East and West Harrow respectively. The East team was involved with WM throughout the period of our Inquiry. This team held a weekly multi-disciplinary meeting for the purposes of assessment feedback and work allocation, which also related to the hospital clinical teams..

257. In November 1993, a Court Assessment and Diversion Scheme for Mentally Disordered Offenders was established in Harrow. The scheme aimed to identify and assess adults believed to be suffering from mental disorder and to divert them from the criminal justice system when appropriate and in both the interest of the individual concerned and the wider public. The scheme was jointly managed by Health and Social Services and staffed by a community psychiatric nurse and an approved social worker. The post holders were located with the East Harrow community mental health team.

First referral to community team

258. During WM's first admission to Northwick Park Hospital in 1986, the referral to the community team for application to a residential care unit to support him was very appropriate in the circumstances. Reports available at that time about WM's history and circumstances show factors that denoted his social vulnerability:

- domestic violence in childhood
- behavioural problems (at school and persistent youth offending)
- long periods in an institutional environment (i.e. remands/committals to prison)
- long term unemployment
- stresses from living in overcrowded conditions with his family.

259. Had the application succeeded, it would have been an important stepping stone in ensuring WM's ability to cope after years of imprisonment followed by in-patient psychiatric care. However, when WM changed his place of ordinary residence, Social Services responsibility was transferred from one local authority to another. We have no knowledge of Brent's follow-up action (it is unlikely that records in Brent Social Services were retained given their short period of involvement 12 years ago).

Referrals to community team following WM's return to Harrow

260. At the end of August 1992, following his release from prison, several referrals were made to the Community Mental Health Team in respect of his accommodation needs, and he was also referred for the Care Programme Approach by his consultant psychiatrist who he was seeing as an outpatient. Overcrowded living conditions and tensions in the family home had been a previous stress factor. Despite this, in February 1993 he was not considered to be a priority by the community team.

261. The record of the crisis intervention (3 March 1993) shows the degree of disparity between family members and professionals. The former wanted something based on personal knowledge of WM that the service was not responding to, and the latter expected a better level of articulation and sensitivity to interview surroundings. It is very likely that transcultural issues played a part.

262. WM, health and social services professionals regarded his accommodation need as the main problem. However, no assessment of his vulnerability and housing support needs took place (see para. 50 above). The decision that WM was not eligible for the Care Programme Approach was taken on grounds that the Housing Authority's provision of bed and breakfast accommodation met his social care need and his health needs were being met at the time by his GP and consultant psychiatrist. His non-attendance for appointments at the community team office for fuller assessment were taken as a sign that WM did not want contact.

262. WM was informally admitted to Northwick Park Hospital in July 1993 and hospital records show the difficulties that WM experienced with independent living to the extent that he moved back to stay with his mother. *(A detailed account from housing records is provided in the next section of this report).* The perspective of the community mental health team is captured on computer about this time. The computerised assessment shows that his difficulties with daily living, accommodation and managing on low income were viewed as minor, and it was noted that he had frequent access to an informal carer and that he was able to access primary care and other agencies himself. The team's response to subsequent referrals from WM and his mother was limited

to advice by duty workers mainly with a view to re-directing them to other agencies for assistance.

263. On 22 February 1994, WM was again admitted informally to Northwick Park Hospital. He was discharged eight days later against the wishes of his mother who felt it was too soon for him to return. No referral was made to the community mental health team on this occasion.

264. In March 1994, WM's mother contacted the community team out of concern that WM had been remanded in Prison. The matter was responded to by the co-ordinator for Harrow's Mentally Disordered Offenders Scheme. The co-ordinator ascertained that WM had no allocated worker in the community mental health team other than a community nurse who administered his depot injections at the local clinic. The co-ordinator allocated WM to herself and liased with the forensic mental health services. WM was transferred from prison to the Bentham Unit and later made the subject of an interim hospital order by the court. The MDO co-ordinator maintained liaison with his probation officer, the hospital services and the Drug and Alcohol Service. In June 1994, WM was made the subject of a probation order and the MDO co-ordinator closed his case.

Local procedures on duty of Health & Social Services to provide aftercare

265. WM had been compulsorily admitted to the Bentham Unit under s48 of the Mental Health Act 1983, and a statutory duty was placed on Health and Social Services under s117 of that Act to provide him with after-care services. An operational procedure to assist Health and Social Services in Harrow to meet their statutory obligations had been issued in 1991. The procedure was based on admissions to Northwick Park Hospital but it nevertheless embodied the principles of holding an initial case-conference with professionals and other agencies involved. It stated that if a GP was unable to attend, the GP was to be notified of the outcome. The aftercare plan was to be the subject of regular review. If a member of the case conference felt that it was appropriate to cease after-care, a review conference was to be called and both the responsible medical officer and representative from Social Services had to be in agreement. The stated aim was that, whenever possible, responsibility should be handed over to community support services once the client's situation had stabilised and informal arrangements were working satisfactorily.

266. Awareness of the provisions of s117 in respect of WM only appear to have been triggered in Harrow when a letter was sent from a social worker at the Bentham Unit in July 1994. In response, the community mental health team manager allocated WM to a social worker, Ms. H-R.

267. In August 1994, WM's mother sought WM's hospital admission and clinical notes show that she felt she could not cope. His mother reported that he had been bad for three weeks. He was talking to himself and talking about harming himself, and she was apprehensive about leaving him on his own. He was admitted for twelve days and his mother was opposed to the doctor's decision to discharge him. The discharge summary completed by a junior doctor states that he made a CPA referral, and the ward nurse keyworker indicated on a Discharge Plan form that a referral had been completed. The same document provides for a record of outcome, but it was not completed to show whether the CPA referral had been accepted or not. There is no detail of this referral in the doctor's clinical notes, nor any record in the community mental health team file.

268. After eight days his mother was reported as demanding WM's re-admission. Subsequently, on the day WM was due to attend an appointment with the Drug & Alcohol Service at a probation satellite venue, he was, instead, presenting himself at Northwick Park Hospital in mental distress. Clinical records show that his mother was trying to obtain a two bed-roomed flat so that he could stay with her. She is reported as being worried about his behaviour and this is illustrated by comments such as "No clothes on and is at home. She was afraid of how he appeared." In December, when he presented himself on the hospital ward, it was noted that he had been drinking heavily and misusing drugs at a time when it was thought his mother was away. (His mother was staying with, and caring for, WM's uncle who was ill).

269. Ms.. H-R, WM's allocated social worker, told us that she was aware that he had a probation officer and that a nurse colleague was involved. At the time, she did not see a need for action on her part. In the context of workload demands, Ms.. H-R told us that she was managing a caseload of about 50 clients. She recalled that WM was living with his mother and told us that about this time, she had a professional involvement with WM's uncle who had a disability. Ms.. H-R said she visited the uncle's home where WM's mother was caring for him, and recalled WM being around. She said the mother had needs of her own and was a 'carer' to the uncle, but Ms. H-R had no appreciation of WM's dependency on his mother, nor that WM regarded her as his primary carer. Ms. H-R told us that her role was to await the s117 review meeting and contribute "a social care perspective".

270. Ms.. H-R prepared for the meeting by reading the community team file, and recalled that WM had initially been seen about his homelessness problem, which had been resolved. She told us that the consensus at the s117 meeting was that there was no role for Social Services, and that her impression was that WM's criminal behaviour and social needs were already being addressed by his probation officer (another social work professional).

271. Ms. S, the community nurse who convened the s117, told us that she could not remember the event. When we showed her Dr. D's record of the s117 meeting, she repudiated the description of herself as a "case manager". She described her role as the depot clinic nurse as being confined to administering injections and reporting non-attendance.

272. Towards the end of 1994, WM's circumstances were such that he met the Harrow criteria for the Care Programme Approach/Care Management on any one of the following criterion (in addition to having a serious mental disorder) : -

- Repeated admissions - three or more hospital admissions within a year
- Lacks effective support system - either socially isolated or, despite involvement of professional and/or others, there is a history of failure to 'pick-up' deterioration
- Carers having difficulty in coping – as defined by carer, i.e. if carer perceives difficulty, this will not be disputed. Can also be used if carer does not identify a problem, but others feel carer is having serious difficulty in coping.

273. No comprehensive assessment of WM's health and social care needs was undertaken from July 1994. The recent hospital admissions and contacts with Northwick Park Hospital should have been a focus for social work enquiry and

robust information gathering. However, the social worker relied on the community mental health team records, which provided only a partial picture.

274. Although WM was provided with a day hospital programme based on short-term goals, the assessments by an occupational therapist were maintained separately. It does not seem that the intervention programmes undertaken in the day hospital were evaluated or discussed at the s117 multi-disciplinary review meeting. The former keyworker from the day hospital was not invited to contribute to the meeting. This was the only day activity programme offered to WM by the mental health services throughout the ten-year period of our purview. Disappointingly, there was no full assessment of his capabilities by any agency.

275. There is no evidence that the psychosocial dimensions of WM's needs, the family context and social circumstances were addressed at the multi-disciplinary meeting. It was known that WM had an exclusive social network with emotional dependency on family members. The clinical notes also show clear signs of his mother's need for respite and WM's inability to manage alone. Neither her, nor WM's emotional needs came into focus.

276. It seems that the probation service's involvement influenced the decision of the MDO co-ordinator to close his case in June 1994, and the allocated social worker's perception of responsibilities. Whilst we accept that the probation officer was WM's social supervisor and she undertook to liase with health services, the review meeting had been convened under the provisions of s117 of the Mental Health Act 1983. For that purpose, we would have expected the mental health social worker to have personally interviewed WM and his mother, preferably in their home environment, to be satisfied that he was not in need of social services.

277. The letter dated 16.1.95 to WM and his mother, is a poor standard of written communication. It neither explains the duty on health and social services, nor does it make plain that WM and his mother's contribution to the review meeting was important. Neither of them attended the meeting and reasons are not recorded. No communication was sent to the GP.

278. The difference in understanding between the consultant psychiatrist and the community nurse about the nurse's role in respect of CPA was not subsequently clarified. In outcome, when the twelve-month probation order finished, WM had no key worker (as defined under CPA guidance) from the community mental health services.

279. The limited role of a "depot clinic nurse" and practice at the time was explained to us by community psychiatric nurses from East Team, who had involvement. Responsibilities were confined to administering injections, writing reminder letters if patients did not attend on one or two occasions, and if there was non-attendance on three occasions the nurse would inform medical staff responsible for the treatment, and, if necessary, undertake a home visit. DS told us, for her subsequent contacts with WM, that:

> "He was very quiet and hardly said anything. I would greet most people at the clinic and ask them how they were. I never got a reply from him – never. ...I can remember on an occasion asking him how his mother was and getting the reply that she was all right or something of that sort...He was never very forthcoming about anything."

Another community nurse, MA, told us that at that time it was a very large clinic – up to 30 patients attended. He said:

> "Some people just come and as fast as they can, pull their trousers down, get an injection and go. But I tried to get them to sit down and to put them at ease before they go through the process. Even if there are people waiting, I get them to sit down and talk to them about various things. Then while I am doing that I am getting the injection ready, checking their cards. It can take between five and ten minutes. Some people, once you start talking to them, actually take longer because they want to tell you more about themselves. This is why people waiting outside will get annoyed because you are spending too much time with one person."

280. The practice in Harrow was not exceptional. Stanford (1996) explored literature and studies on depot clinic practice. He criticised the paucity of quantity and quality of nursing practice standards in such clinics, and also questioned whether there was value for money in the system of employing 'Grade G' Community Psychiatric Nurses to administer a treatment regime that amounts to little more than injection. Stanford's findings from a service user study showed that:

- 71% of respondents were not asked at the depot clinic about the people they lived with (despite a wealth of literature available to CPNs pertaining to expressed emotion and psycho-social intervention strategies),
- 34% of respondents reported having no contact with agencies outside depot clinics,
- only 7% saw a CPN outside the depot clinic.

Subsequent attempts to review WM

281. On 24 February 1995, Dr. D wrote to Ms. S, the community nurse, asking for a further reviews to be carried out by the community team. There is no record of a response. On 16 March 1995, a co-ordinator for Harrow Mentally Disordered Offenders' (MDO) Scheme was contacted by WM's mother to say he had been remanded in custody that day. WM remained in prison until May 1995 when he was released by Harrow Magistrates Court. The MDO co-ordinator saw WM that day and closed the case. Although this was recorded in the community team file, no review of WM was instigated. In June 1995, his Probation Order ended.

282. In October 1995 Dr. D wrote to Ms. S to remind her that a review was needed and a copy of the letter was sent to the community mental health team manager. On the day that the MDO co-ordinator was asked to undertake a joint assessment with Ms. S. (9 November 1995), WM was again remanded in custody. He was released from prison on 20 December 1995. However, in January 1996, he was remanded and during the next few months was in custody. In April 1996, Dr. D wrote to Ms. S seeking a joint review but was informed by the MDO co-ordinator that WM was in custody once more. Dr. D and Ms. S were informed of WM's release from prison on 1 August 1996 by the prison medical officer asking for follow-up in the community. There is no evidence that a review was instigated. WM kept his next outpatient appointment and regularly attended the local clinic for his depot injections from Ms. S.

283. It is evident that up to April 1996, attempts were made to review care arrangements for WM following the one multi-disciplinary review meeting in January 1995. It is also evident that action by community team staff was disrupted by WM's remands in custody and imprisonment - for which diversion was not sought in psychiatric reports.

284. In August 1996 WM was released from prison with no provision for after-care from the criminal justice services. The prison appropriately notified his consultant and community nurse of the release but it does not appear that action was taken by either to instigate a comprehensive review of his health and social care needs. The sole focus was on medical arrangements for the treatment of his mental illness (i.e. to reinstate his fortnightly depot injections and to offer two-three monthly outpatient appointments).

Operational policy changes

285. In September 1995, an Audit Commission report on mental health provision provided by Harrow and Hillingdon Healthcare Trust was produced. Among the main findings was criticism that care in the community had not been financially supported (only 13% of budget had been allocated to community services). A District Audit report on Harrow Social Services for 1994/95 also found that mental health social workers had caseloads higher than the national average. In consequence:

- CPN staffing in the community mental health teams. was increased
- The sectorisation of clinical teams in the Psychiatric Unit of Northwick Park Hospital (i.e. alignment with community mental health team areas) commenced in January 1996
- An Extended Hours Team was introduced in February 1997. The Extended Hours Team extended the service delivery hours of the community mental health teams during weekdays (16:00 to 23:00) and at weekends/bank holidays (15:00-23:00). The aim of this service was to provide a community based crisis assessment and treatment service with interventions of such a nature and degree that, where appropriate, admission to a hospital bed could be avoided.

286. In October 1996, Harrow Social Services and the Healthcare Trust issued operational procedures for community mental health teams. Procedures stated that all referrals were to be screened to identify the individual's problems and to identify whether eligibility criteria for further assessment by the community team was met. In November 1996, a revised operational policy document was also issued on the Care Programme Approach. It aimed to knit together overlapping services e.g. referrals to consultant medical teams in the Psychiatric Unit at Northwick Park Hospital, and to the Community Mental Health Teams, the Court Liaison (MDO) Scheme and the Drug and Alcohol Service. The guidelines incorporated the Carers Recognition and Service Act (with effect from April 1996) and asserted that practical support for carers should be a high priority, including carers of people who misuse drugs and alcohol.

Responses to request for hospital admission

287. The community mental health team duty officer was aware of events on Wednesday 26 February 1997; namely that WM had presented to his GP saying that he wanted to kill himself, that he had apparently taken an overdose, and that his mother sought to have him admitted to hospital but that he had been re-referred to his GP. The GP was referred to the Extended Hours Team and it appears that they, having contacted the Hospital, advised the community team duty officer that the psychiatrist would discuss with WM's GP the course of action. The community and extended hours teams took no further action.

288. The hospital doctor who saw WM noted that he was still hearing voices telling him to hurt himself, feeling depressed and having thoughts that his family were against him, but that WM displayed no acute symptoms. The doctor also noted that WM sat at home all day doing nothing and that he had no social worker. The hospital doctor's letter to the GP also shows that although WM had an outpatient appointment for the following Monday (3 March), he was not happy about seeing Dr. D. A copy of this letter, dated 7 March, was sent to Ms. S, community nurse.

289. There was sufficient evidence to show that WM had complex needs and that, under the local revised CPA guidance (1996), he should have had an allocated key worker from the community team. Knowledge of the mental health crisis experienced by WM and his family in February 1997 should have been a trigger for a multi-disciplinary response, not just a medical one.

290. Although the Extended Hours Service had a role to intervene and assess the social and personal circumstances which led to the demand for hospital admission, no contact was sought by them with either WM or his mother. (WM's mother was unwell at this time and concerned about his lack of self-care and vulnerability).

291. It is evident that specialist mental health practitioners relied on the GP to monitor the situation until the outpatient appointment (due in a few days time). WM's non-attendance to see Dr. D, about whom he had reported unhappiness, did not lead to any outreach visits to check on his or family members' well being.

292. WM and his family believed that the mental health services were unresponsive to their needs at a point of crisis, and that no one from the mental health services really listened to them. His mother described the responses as "going round in circles". There was certainly no evidence of change in service response nor the professional predisposition towards him and his family. No member of the community team sought to make further enquiries. Operational guidance and procedure was not adhered to in response to the referral in February 1997.

We recommend that:

a. **Brent & Harrow Health Authority and Harrow Council review their joint guidance on the implementation of their duties under Section 117 of the Mental Health Act 1983;**
and

b. **Ensure that adequate resources (staffing levels, training and information systems) are made available to support the**

Modernised Care Programme Approach national policy guidance and significantly improve implementation performance compared to 1991;
and

c. **Harrow & Hillingdon Healthcare Trust and Harrow Social Services should regularly monitor the implementation of National Standards for Mental Health for services users who present co-morbidity issues (mental illness, substance misuse and criminal behaviour), to ensure that joint reviews take place at least six monthly.**

d. **Harrow & Hillingdon Healthcare Trust and Harrow Social Services should regularly monitor the implementation of National Standards for Mental Health for service users with a serious mental disorder who are substance misusers**

NEEDS OF INFORMAL CARERS

Assistance from the family

293. WM had considerable support from many members of his family, in spite of their own individual personal problems. The support included accommodation, catering, assistance with completing DSS forms, tenancy transfer forms, getting him to hospital and appointments. His mother told us she cooked for him and washed his clothes and made sure he was taking his medicine. She said "I would remind him of things. If he was really sick, I would have to remind him about everything."

294. For a short time when WM came out of prison in 1986, he tried employment with his uncle who was a builder. The possibility of WM of working with him or developing the brick laying skills he had learnt in prison was not subsequently pursued by any of the agencies. WM received welfare benefits and it is reported that during the time of his probation order, his mother managed his finances. At various times he stayed at the house of his aunt and at his grandmother's house. Even after he had obtained a tenancy in an unfurnished flat he still spent considerable time staying at his mother's place. WM's housekeeping and cookery skills were almost non-existent. It was his mother who pressed the social services to assist in the provision of furniture for his unfurnished flat in 1993.

295. Records show that on many occasions it was WM's mother who brought him to the hospital seeking admission and, following admission, attempted to delay the discharge until she felt that he was well enough to come out of hospital. It was also his mother who was concerned about the effects of imprisonment on his mental illness, and who contacted the mental health services to seek his diversion from custody.

296. Even after WM's conviction and sentence to life imprisonment, it is the concerns of the mother, expressed to the solicitor and passed on to the prison, which led to the discovery that WM had a pituitary tumour.

297. Some of her experiences of living with WM's behaviour are captured in clinical records, which also record professional scepticism, for example:

- The clinical notes for 23 and 26 August 1994 read:

  "Presented here with Mum auditory hallucinations 10 years getting worse voice telling him to kill himself. ... Stays with Mum most of the time. 3 nights ago he started banging on Mum's bathroom door... she feels she cannot cope - worried that he would harm. Not violent... Mum wants W to be admitted to hospital today. ...? beds. G G contacted (a nurse) shortage of beds ? element of manipulation in this case would discuss with Dr. M.

  She says he's been bad for 3 weeks. Talking to himself, talking of hurting himself.....She feels he's not well and will not leave him on his own for fear of him trying to hurt himself. She denies that he's been in any trouble with police or criminal behaviour recently. She says he's been using drugs recently ? crack Does not want him home yet because she feels he is too ill. Plan for r/v by Dr. D. on Tuesday."

- The clinical notes for 10 October 1994, and a medical letter on 12 October 1994 read:

> "Mother rang me this morning to say that she wanted WM to be seen urgently - She failed to tell me that she had an appt at 3.15pm today!
> Mother says that he's been walking around the house talking to himself. Frightened to leave the house alone.
>
> According to his mother he was smoking crack 2 days after his last discharge. He failed to attend Drug rehab. [*rest illegible*]
> Mother demanding admission. Denies any contact with police.
> Plan r/v by Dr. D in OPD as planned."
>
> W was accompanied by his mother who had been concerned about his unusual behaviour over the last few weeks. This consisted of her feeling afraid of the way he appeared, and feeling that he was more withdrawn than usual."

298. The influence she had over WM is illustrated in a letter from Dr. D to the GP dated 5 December 1994:

> "Basically he has been missing his depot on the last couple of occasions, he is also drinking very heavily and abusing drugs. He has failed to keep his appointment with the Drug clinic. On mental state examination there are no active psychotic features...
>
> I think that his recent presentation is also related to the fact that his mother is away on holiday and she has tended to keep an eye on him in the past, even to the extent of looking after most of his basic needs such as food and clothing etc."

299. In the preceding section of this Report, we commented on the poor written communication to WM and his mother advising them of the s117 after-care review meeting in January 1995. WM's mother was at this time caring for her brother, but reasons for her non-attendance were not sought. On 9 February 1995, the community nurse noted that WM was looking well and seemed to be coping. He asked the nurse to ring his mother. The records suggest a lack of empathy between the community nurse and the family situation:

> "Rang WM's mother who had to go out of bed to answer my call -- complaints about washing and trip to launderette.
> I said that it can be difficult without a washing machine. She said that she couldn't afford one. I said that WM was young enough to do his own washing. She seemed to think that I wasn't being very fair and put the phone down on me."

300. A letter from the GP (dated 16 August 1995) to the Housing Association asking for new accommodation for WM illustrates the GP's understanding of the mother's role:

> "His main carer is his mother who has recently been moved to Wealdstone. It would be in WM's best interest to be living near to his mother for these reasons and I would be grateful if consideration could be given to providing him with new accommodation."

301. A letter from a forensic psychiatrist to Dr. D in April 1996 again shows WM's mother's caring role:

> He lives with his mother and two brothers at the address given above... I spoke to WM's mother by telephone and she is obviously concerned regarding the Drug abuse by W. She also said his sleep pattern is quite disturbed and he occasionally talks to himself. There have been no incidents of violence or aggression in the home, and his mother confirmed the fact that he had missed his two most recent depot injections. She is anxious for further psychiatric help with regard to her son W.

302. In February 1997, WM's mother, although unwell herself, made efforts to have him admitted to hospital because of family concerns about his deterioration. When his mother was ill or in hospital, WM's younger sister took on the role of carer. She had moved into his flat, cooked for him, cleaned for him and ensured that he was coping. The mother described to the panel how she ensured that WM was clean and tidy when he saw doctors, and how she believed that in February, the doctors might have wrongly perceived that WM could take care of himself.

303. In evidence to the Inquiry, family members stated that they were aware that WM took illicit drugs and they believed that hospital admissions helped him. One member told us that when he was sick and was on "crack" they would try to persuade him to go to hospital to get off the drugs. This happened a few times. They were particularly concerned that he was refused hospital admission in February 1997.

304. WM and his family felt that they would have benefited from him having a key worker who visited him at home and who would know how he was getting on.

305. WM received significant support from the female members of his family. In contrast, many of his criminal activities, notably burglary, were committed with a brother. The family had an unfavourable reputation amongst the statutory services - WM was occasionally mistaken for one of his brothers and was described as one of the "C. family" (his mother's maiden name). WM himself suffered unfavourable reaction from the extended family after he assaulted his grandfather in the summer of 1986. The impression sometimes given by the records is that WM's family was seen as aggressive, manipulative, demanding and with unrealistic expectations.

306. Health and social services in Harrow knew some of his relatives, but the panel did not seek access to their health and social services records.

Statutory provisions

307. Many of the provisions of the Disabled Persons (Services, Consultation and Representation) Act 1986 have not been brought into force, in particular the appointment of representatives of disabled persons. Section 4 places a duty upon the local authority to consider the needs of a disabled person for services under section 2 of Chronically Sick and Disabled Persons Act 1970, when requested by a disabled person or a carer. Section 8 requires an assessment of informal carers. These sections were brought into force on 1 April 1987 in England and Wales. WM was assessed and registered as disabled on 13 September 1993 by Harrow Social Services. There is no evidence however, that this affected the procedures and thinking of the social services in relation to his care and treatment, other than in determining his eligibility for a bus pass. There is no evidence that he asked for an assessment of his needs under the appropriate legislation. It is highly unlikely that he would have been aware of it.

308. The Carers (Recognition and Services) Act 1995 which came into force on 1 April 1996 places a duty on local authorities to provide for the assessment of the ability of carers to provide care and for connected purposes. The basic provisions are:

> ***1.a.*** *In any case where the LA carries out an assessment under section 47(1)(a) of the 1990 Act of the needs of a person ("the relevant person") for community care services and;*
> ***b.*** *An individual ("the carer") provides or intends to provide a substantial amount of care on a regular basis for the relevant person;*
>
> *The carer may request the local authority, before they make their decision as to whether the needs of the relevant person call for the provision of any services, to carry out an assessment of his ability to provide and to continue to provide care for the relevant person, and if he makes such a request, the local authority shall carry out such an assessment and shall take into account the results of that assessment in making that decision.*

309. Government introduced a new strategy for the period 1995 to 1998 to tackle drug misuse. Multi-agency Drug Action Teams were established in local authority areas comprising senior representatives from health, local authority and criminal justice agencies. Local performance indicators were to include measures of availability of support services for families, partners and individual friends of individual drug misusers.

310. It is highly probable that WM's relatives were not aware of these provisions. There is no evidence that they ever formally requested that an assessment of their ability to provide care for WM should be carried out. The 1995 Carers Act was not in existence on 1 March 1993 when an assessment of WM was carried out for the purposes of the Mental Health Act 1983. Even so, it is questionable whether any comprehensive assessment of WM's needs for the purposes of the Care Programme Approach (CPA), or of developing an aftercare plan for him under s117 of the Mental Health Act 1983, could have been carried out without assessing the contribution made to his care and support by his relatives - and in particular - his mother. Such an assessment or even any superficial discussion of this was lacking in the s117 meeting which took place on 26 January 1995, or at any of the times on which he was referred for a CPA assessment.

311. A comprehensive assessment of WM, including an assessment of his family context and support network, may have led to more home visits, the allocation of a key worker to WM and joint planning meetings with WM and his mother.

312. The records show that very few home visits were attempted. There is no evidence of joint planning meetings involving his mother in agreeing long-term plans for his care following discharge from hospital. On several occasions, the mother's concern at what she considered to be premature discharge were rejected.

313. WM had complex needs, with many diverse problems. His was not simply a case of dual diagnosis. There would have been considerable advantages in seeking closer co-operation with his informal carers.

314. WM's family assisted him in numerous practical ways, and ensured that he received medical treatment when they saw signs of deterioration. However, there is no evidence that an assessment, which involved the capacity of the relatives to continue this caring role, was ever carried out.

315. There is evidence that on occasions, hospital and community mental health and social services professionals found family members difficult to handle and aggressive. WM was viewed as being a member of a notorious family. This may have influenced professional attitudes over their degree of engagement.

316. There is little evidence that the health or social services professionals took advantage of the family involvement in the support of WM, for example, by drawing them into discussions on aftercare and a treatment plan. The family gave important information to the health and social services professionals which does not seem to have been acted upon, although the information was recorded:
    - WM was unable to look after himself in unsupported-accommodation;
    - WM was not always ready for hospital discharge;
    - WM's mental illness had disturbing symptoms..

317. WM's mother was entitled to have her needs as WM's informal carer assessed. There is no evidence that she was advised of this entitlement and no assessment ever took place.

We recommend that:

Harrow & Hillingdon Healthcare Trust and Harrow Social Services should ensure that quality assurance monitoring is in place and that the statutory provisions relating to the needs of carers, and standards set under the National Standards Framework for Mental Health are properly implemented.

ROLE OF COMMUNITY DRUG AND ALCOHOL SERVICE

Drug and Alcohol Services within community care

318. His health records show that from 1992, on his return to London following imprisonment in Birmingham, substance abuse figured more significantly in his behaviour and life. Medical reports note increasing concerns about his abuse of both cannabis, hard drugs and alcohol.

319. In January 1993, the Department of Health issued guidance (LAC(93)2) to local authorities on the provision within community care of services for adults who misuse alcohol and/or drugs. As a priority, authorities were urged to ensure that the special circumstances of drug and alcohol misusers were recognised and reflected in procedures for assessment and care management:

- *The aim must be to respond effectively and to offer a programme of care that will help the misuser make positive changes in his or her life.*
- *People with serious and urgent alcohol and/or drug problems are likely to need a rapid response because of crisis and to capture fluctuating motivation. Serious deterioration, which may carry social, legal and care implications, may ensue if there is delay before assessment or if assessment procedures are prolonged.*

319. This section asks:

(i) What was the nature of the services available to meet the needs of an individual who has an enduring mental illness and substance abuse problems, and how were they organised and managed?
(ii) To what extent were the Drug and Alcohol Services responsive to WM's needs?
(iii) What changes have taken place since the homicide?
(iv) What improvements could the panel recommend?

Management and Organisation of the Drug and Alcohol Services

320. The Community Drug and Alcohol Service (originally known as Drug Concern), provided a service in 1994 jointly funded by the health and social services. The service was primarily for substance abusers who did not have a mental illness. It was originally part of the Mental Health Directorate of Harrow and Hillingdon Trust until April 1997 when it transferred into the West Harrow Locality Directorate for management purposes although serving the whole of Harrow. Inter-agency collaboration with statutory and voluntary sector providers was achieved by the Drug and Alcohol Service representation on the multi-agency Drug and Alcohol Strategy Development Group and the Harrow Drug Action Team. Features of the service included a clear policy on the voluntary nature of the service, which depended crucially on the motivation of clients. At the time of WM's appointments with the Drugs Service in 1994, it was the practice that if a client had failed to respond to two appointments, then the case was closed.

321. The service deals with about 800 clients who actively use the service in a year. About 500 assessments are carried out each year.

322. The Centre did not provide residential placements, but did have contacts with some rehabilitation units, which were prepared to take people with a dual

diagnosis. In 1993, financial responsibility for residential placements was bestowed on social services under community care arrangements. The panel was told that the rationale of residential rehabilitation units was that they have a policy of abstinence from all psychoactive drugs including prescribed medication. Any patient on long-term medication for mental illness was not therefore suitable for such rehabilitation. Dr. D explained to the panel that the philosophy behind the exclusion of those on psychiatric medication was that there was considerable cross-addiction between tranquillisers - a lot of people using stimulants or substances would then abuse prescribed medication. For that reason, a lot of residential units have strict criteria in relation to medication.

To what extent were the community Drug and Alcohol Services responsive to WM's needs?

First referral February 1994

323. The first referral was on 24 February 1994 from Northwick Park Hospital. An appointment was made for 3 March 1994, but WM failed to attend. Following that, a letter was sent from the community Drug and Alcohol Service office to the hospital suggesting that if they were in touch with him to "please encourage him/her to make contact with us for another appointment". A similar letter was sent to WM asking him to contact them.

324. From 31 March 1994 to 16 May 1994, WM was an in-patient in the Bentham Unit where the care treatment plan included concern with his drug misuse. There were many discussions with WM in which he declared his intention not to use drugs and to 'go straight'. For example, in February 1994, he said he was getting too old for drugs and burglary. He agreed that drugs had a bad effect on his mental health. On 10 May 1994, a drug screen was carried out but no abnormality was discovered. Several searches were also carried out.

Second referral May 1994

325. The second referral was made on 10 May 1994 by WM's probation officer. The supervision plan included an investigation of drug counselling options. However, attendance at the Drugs and Alcohol Service centre was not made a condition of the probation order - the probation officer's pre-sentence report to the magistrates did not include such a request. WM was sent an appointment for 18 May but he failed to attend. He did, however, attend a week later. The Drug and Alcohol Service records note that he had been remanded in prison on a charge of burglary, and that he had been using crack every night for six months at a cost of £20 per night. It was noted that when he smoked crack the voices would get worse. He told the drugs worker that he had been clean for nine weeks, and that he would like to abstain indefinitely. His word was accepted and it was not suggested that he should have a urine test.

326. Following this interview, the Drug and Alcohol Service staff held an allocation meeting where it was decided whether a service could be offered. The staff wrote to his probation officer on 31 May 94 as follows:

> "Unfortunately WM's history of psychotic mental illness and his need for long term medication would preclude him from virtually all rehabilitation centres. Any past history of violence would probably also preclude his acceptance at such a centre."

On the same day the Drug and Alcohol Service wrote to WM in the following words:

> "It seems. that drugs are not your main problem at the moment and so we do not feel that we have anything to offer you at this time. If you have any further queries, do not hesitate to contact us."

The service manager's explanation of this letter was that WM's main problem was viewed as his mental health difficulty.

327. The probation officer was not prepared to accept this answer and on 1 June 1994, the Drug and Alcohol Service record a telephone conversation with the probation officer, where the latter is seeking residential rehabilitation for WM. He was due back in court on 13 June and was likely to receive a custodial sentence. The response from the Drug and Alcohol Service was as follows:

> "I pointed out that WM would be extremely unlikely to be suitable for residential rehabilitation because of his history of psychiatric mental illness and the need for long term medication. Also it seems that he has some history of violence which would also preclude him from acceptance... Probation officer wanted a residential programme to be organised for court purposes and said that the court would be satisfied with no less."

328. Two days later, in a telephone call between the Drug and Alcohol Service and the MDO scheme co-ordinator, the latter stated that she felt that WM might benefit from some support from the service. The outcome was a further appointment being sent to WM for 15 June which he kept. The duty worker's record of the interview states:

> "WM had not used drugs for 3 months and he had no inclination to do so. He did not feel that he needed to attend here again. I felt this was reasonable and felt that there was very little we could offer him at this time... I phoned [the MDO scheme co-ordinator] and informed her of the above which she was quite happy about."

329. On 26 August the Drug and Alcohol Service closed the case at their review meeting.

330. At a probation interview on 4 July 1994, it had been noted that WM was determined to stay free of drugs. However, less than three weeks later, on 20 July 1994 WM's mother telephoned the probation officer to say that WM had started taking drugs again and she was extremely concerned. Nine days later, he was seen by his probation officer and admitted to using cannabis. On 24 August 1994, WM's mother informed Probation that WM was in hospital and it is recorded that WM appeared to have had a breakdown - he was hearing voices and his mother had observed what looked like drug smoking equipment in WM's flat - tins cans with holes in.

Third Referral September 1994

331. The clinical notes of WM's hospital admission in August 1994 record that he had been using "crack", cannabis, LSD and alcohol over the last two weeks. A urine drug screen was planned. The primary diagnosis was drug-induced psychosis. On 1 September 1994, there was a referral to the community Drug and Alcohol Service by a hospital doctor:

"Inpatient at NPH to be discharged in the next week. Discharged 5.9.94 Admitted psychotic episode which he puts down to crack/cannabis use. Said to Dr. B that he wanted help to remain abstinent. Asked for referral"

332. An appointment was sent for 8 September 1994 but WM failed to attend. Despite subsequent referrals to the Drug and Alcohol Service, he was not seen again by them. In an interview with Probation on 29 September 1994, it was noted that WM was reluctant to engage in discussion on drug issues. They discussed the relevance of referral to the service, but it appeared that WM had little motivation to tackle the drug issue.

The Quarterly probation report of June to September 1994 stated that:

"WM. admits to current use of crack cocaine. Drug Concern will again be approached with a view to working with WM to decide practical strategies to avoid drug use."

333. On 12 October 1994, the consultant psychiatrist, Dr. D, wrote to the GP following his review of WM at the outpatient clinic. It stated that:

"WM had been taking drugs. Failed to keep his appointment with Drug Counselling. Advised to make contact with drug service as clearly this is the root of a lot of his difficulties."

On 20 October 1994 WM attended for a probation interview and the records note that:

"[WM] denied using any other drug (i.e. other than medications) at present. Says hasn't used crack for two seeks, but admits that his use is a problem. Probation officer to speak to Drug Concern - possible re-referral. W agreed."

Fourth referral November 1994

334. The fourth referral to the community Drug and Alcohol Service was on 7 November 1994 from the probation officer. The service records note that WM was:

"Schizophrenic, occasional crack user. Discharged from Fernley ward NPH about 3 weeks ago, complaining of hearing voices. Has CPN based at Atkins House. Was seen a while ago by our service. Probation officer was told he was not suitable for our service. To discuss at allocation.
Action: probation satellite for assessment:"

The Drug and Alcohol Service records also note that the probation officer felt:

"unhappy with previous decision in June 94 that WM was unsuitable for our service."

It was therefore suggested that the community psychiatric nurse would be contacted about doing a joint assessment. The records note that:

"Team strongly feel that WM is not appropriate for counselling as he appeared very 'flat', also possible history of violence. Probation officer said she is not aware of this, ask her to double check. Team recommend: Joint sessions ..."

335. On 11 November 1994 the service records note:

> "a new CPN at Atkins House is involved called PN. I am to contact him. CM [probation officer] seemed surprised when I explained discussion at allocation meeting but did say that he was very doped up on psychiatric medicine and agree he is non-responsive. Explained I would see him on a joint session basis only.

336. The duty appointment was arranged for 14 November at the "probation satellite" - this refers to the attendance of the drugs advisory worker at the probation office. However, WM failed to attend. The Drug and Alcohol Service noted that the probation officer would get in touch with them once she had seen WM and, following contact with the community mental health team, the nurse was to follow him up on three missed depot injections. On this day (14th), WM was reviewed in outpatients clinic by his consultant psychiatrist. Dr. D noted that WM had missed recent depot injections, he was drinking very heavily and abusing drugs, and had failed to keep his appointment with the community Drug and Alcohol Service. Following his review, Dr. D wrote to the GP and stated that WM had once again agreed to start attending the drug clinic and to resume his previous medication.

337. On 17 November 1994, there had been no further contact with the community Drug and Alcohol Service and the case was closed. This was the agency's standard practice after two failures to attend.

338. The quarterly probation report (September 1994 to January 1995) noted the following:

> "WM now admits to using Crack although he attempts to minimise the exact usage. Work has sought to increase his awareness of the danger of taking illegal drugs while receiving psychiatric medication."

339. The probation officer attended the multi-disciplinary Section 117 meeting on 26 January 1995 to consider the future services to be provided for WM. No one was invited to attend from the community Drug and Alcohol Service. One of the outcomes from the meeting was that the probation officer was to re-refer WM to the Drug and Alcohol Service. When the probation officer saw WM on 2 February 1995, she noted that he was resistant to attending the Drug service at present.

340. On 6 March 1995 at a probation interview, WM stated that he had not used drugs since the end of January. The probation officer informed him that she was not convinced of the truth of this, but saw little benefit in referral to the Drug and Alcohol Service at that time. She agreed to review this at a later date and to address the drugs issue regularly. The quarterly probation report dated March 1995 notes:

> "Concern about WM's use of drugs has heightened this quarter as myself and mental health professionals believe he is using to a significant degree. He is unwilling at present to be completely honest about his usage, admitting it at one and then denying at a later stage. Such a stance means that according to Drug Concern's policy which requires a degree of motivation to stop using, he is unsuitable for treatment. It seems little can be done for him at present. Further at a meeting I attended with mental health professionals involved in this case, at the end of January, Dr. D psychiatrist expressed doubt about the schizophrenia

diagnosis. Dr. D's assessment is that WM's recent mental illness was drug induced."

341. At the probation interview on 1 June 1995, there was a discussion on drug use. WM claimed not to be currently using illicit drugs, and stated that the main deterrent was the physical sickness it caused him. The Probation Service's closing summary (14 June 1995) noted that:

> "He reports less use of crack cocaine. Given his poor use of the service in the past, I have not referred him to Drug Concern again. We have agreed that he will ring should he view his usage of drugs as increasing. My aim is to give the responsibility for accepting help back to WM. All else is stable at present. He continues to have daily contact with his mother whom I have both spoken to and seen on occasions.
> Work has sought throughout the order to tackle the main factor associated with WM's offending - his drug use. As long as he continues to use there is some risk of re-offending."

Fifth referral (self) October 1995

342. On 3 October 1995, WM telephoned the Drug and Alcohol Service requesting help with his alcohol problem. He was given an appointment for 19 October 1995 at 9.30am but he failed to attend. A new appointment was sent for 7 November 1995, but he failed to confirm that he would attend. A letter was sent to WM saying:

> "you did not confirm your appointment for 7.11.95, this appointment has now been cancelled. If you wish to be seen by our service in the future, please contact us for another appointment."

343. On 31 October 1995, Dr. D wrote to the community psychiatric nurse seeking a review and he also asked her to confirm whether WM was attending the drug clinic. The court report by Dr. D in February 1996 informed the court of drug and alcohol abuse, "though WM says not for the past four months".

344. On 8 February 1996, WM received a twelve-month Probation Order. The Probation six point plan included referral to the community Drug and Alcohol Service. WM told the probation officer on 15 February that he had not used drugs for some time. The Order was breached and later revoked.

345. When Dr. D interviewed WM on 11th June 1996 for a court report, WM stated he had been taking crack cocaine for four to eight weeks before the offence and was spending £200 per week on this habit. He had previously consumed ten to twelve units of alcohol three times a week. Dr. D saw WM on 14 October 1996 in the outpatients' clinic. WM denied drug misuse and only admitted to minimal alcohol use. Dr. D told us that whilst he had considered specialist rehabilitation for WM earlier, neither this, nor in-patient admission was considered in October 1996, because WM was attending at the outpatient clinic, he was denying substance misuse and he was taking his depot regularly.

> "I think that my alarm bells would have sparked if he had stopped taking his depot. We were not aware of all this criminal activity at that time."

346. According to the locum hospital doctor who interviewed WM on 26 February 1997, WM said that he had no taken drugs for weeks. However, family

members recognised signs of deterioration and recurrence of the pattern involving drug misuse.

347. Following the serious offence on 23 March 1997, WM told those interviewing him at this time that he could not recall any details of the assault. He said that he had consumed crack cocaine the previous day, but until then he had not had any crack or other drugs for four months. He had also been drinking and he admitted to drinking four cans of strong lager on a daily basis.

What changes have taken place since the homicide?

348. The panel visited the Drug and Alcohol Service premises and heard of recent improvements to the service which included:

(i) Improved collaboration with the community mental health team including three seconded social workers who are line-managed by the local authority manager of the West Team with day-to-day management by the manager of the Community Drug and Alcohol Service. Dr. D explained the new services as follows:

"there are now services such as the intensive community support team, which will actually deal with people who are difficult to engage in services, visit them at home, etc., and work with them in a more intensive way than perhaps is available within the generic services . That service is now available. If that had been available at the time, that may have been something that we would have made available. Again, I do not feel that it would have made a difference in the outcome."

(ii) An open, Drop-in clinic is held twice weekly so that if a client wants to access the service but is unable to attend organised set appointments, then he/she can attend the Drop-in clinic.

(iii) Greater attention was being paid to the needs of those with dual diagnosis including:

- the installation of a shared computer system between the Drug services and Northwick Park Hospital, which will enable clients to be checked. This would include being able to check on whether a patient is known to be violent.
- Even though the service does not case manage a patient on the CPA, with a primary mental health diagnosis, it will contribute as part of the patient's care team and attend CPA reviews. Patients with a dual diagnosis may be jointly managed or managed by the Drug and Alcohol Service depending upon the primary presenting problem of the patient.
- Failure to attend by a patient with known mental illness would now have resulted in contact not just with the referrer but also with the CPA manager. The policy of two failures to attend resulting in case closures is still in being, since the service is primarily voluntary.

(iv) The panel were told that more attention is given to adults with a dual diagnosis in that assessments for this group have improved, and the drugs service is more aware of the necessity to meet the needs of this group of patients.

Improved links between the drugs service and criminal justice

349. The panel was informed that collaboration with the criminal justice system has improved since 1994. There is now a criminal justice worker from the Drug and Alcohol Service who works with the mentally disordered offender, and provides sessional input at the local probation service. This worker also attends the case meetings of the mentally disordered offenders' team and the community mental health team case review meetings. Also,

(i) There is increasing use of conditions to attend drugs services as part of a probation order. This would have testing and treatment orders attached.
(ii) Plans were in progress for an arrest referral scheme in co-operation with and funded by the police aimed to assess people in the cells and divert them out of custody. This was to be established in September 1999.

Conclusions

350. From 1993, the records show clear concern by health, probation and his mother over WM's use of drugs and that fact that they exacerbated the symptoms of his mental illness. However, health or social services officers rarely saw him under the influence of drugs or alcohol.

351. Probation and the Community Drug & Alcohol Service records show the unsuitability of the latter service, as then constituted, to deal with patients with the complex needs of WM. Whilst they were prepared to accept referral for assessment purposes, they were unable to offer any significant assistance and made no recommendations to others involved in his care. The Community Drug & Alcohol Service records give the first suggestion of WM as a violent man and this influenced the way he was treated.

352. Residential rehabilitation services were seen as an option by WM's consultant,. The probation officer requested such services for WM but the drug service considered that he was not suitable for them.

353. The Drug & Alcohol Service relied heavily upon patients being far more organised than WM was, in terms of confirming appointments and attending at set times. It should also be noted that these appointments were sent to the flat which he had ceased to occupy soon after he moved there, preferring instead to stay at his mother's home. Therefore he may not have received some of the correspondence.

354. The numerous attempts of ward and probation to get help from the Drug & Alcohol Service proved unavailing. The efforts of the probation officer to obtain support for WM with his drug misuse, and her disagreement with the Drug & Alcohol Service's refusal to accept referral also proved to be futile.

355. There is no evidence that a representative of the drug service was invited to attend the s117 review meeting on 25 January 1995, even though drugs were known to be one of the major issues in WM's care.

356. Whilst WM frequently expressed hopes to nurses and doctors to stay off drugs, it was apparent he lacked the motivation or incentives to stick to any such plan. There is no example of his keeping any undertaking or promise. Had the open

clinic existed in 1994 and 1995, it is possible that WM would have been seen more frequently following referrals.

357. Decisions relating to future action were sometimes influenced by the fact that WM stated that he was no longer taking illicit drugs. Only in the probation records is there evidence that such statements were not believed. No drug screens were suggested for him by probation or the drugs services.

358. Given the increase in substance misuse in recent years, and findings from the National Inquiry into Suicide and Homicides (1999), we are disappointed that the National Standards Framework on Mental Health and the Modernised Care Programme Approach policy guidance issued in 1999 by the NHS Executive, pays limited attention to the role and contribution of community Drug and Alcohol Services.

We recommend that Harrow & Hillingdon Healthcare Trust and Harrow Social Services:

a. **ensure that Department of Health Circular LAC(93)2 and subsequent central guidance on drug and alcohol misuse issues relating to community care assessments and service provision are being fully implemented, and that past barriers to service provision identified in this Inquiry have been removed;**
b. **ensure that all staff working in specialist mental health services and community Drug and Alcohol Services have access to regular evidence-based training on substance misuse and risk assessment;**
c. **put in place monitoring of the use of the new powers to deal with drug offenders;**
d. **develop joint strategies in conjunction with primary care and voluntary agencies to overcome the cycle of short-term in-patient admissions followed by a return to Drug and/or alcohol misuse for certain individuals like WM**

We recommend that the Department of Health should consider the preparation of national guidance on the care of those mentally disordered offenders who abuse substances.

PROBATION SERVICE

359. In 1995, several central government circulars were issued relating to the interface between the criminal justice system and mental health services. 'National Standards for the Supervision of Offenders in the Community' was introduced for the Probation Services. Concurrent guidance was issued by the Department of Health to Social Services (LAC(95)29), drawing attention to community care issues and the need for collaboration with the Probation Services. The Home Office also published a guidance document in 1995 aimed at promoting effective working between Health and Probation Services.[1] A study, which was referred to at this time, had found that of the offending population in contact with the probation service, 46% had alcohol problems; 35% had drug problems; 14% had mental health problems and 25% had chronic housing problems[2]. WM had two spells of probation during the time span covered by this Inquiry. This section asks:

(i) How effective was probation in reducing his risk of reoffending, addressing his alcohol and Drug misuse and supporting his treatment for mental illness?
(ii) To what extent did mental health services work with probation officers?
(iii) What recommendations, if any, could be made for improvements in the service?

How effective was probation?

360. A psychiatric report was requested by the probation officer from a consultant psychiatrist at Northwick Park Hospital in July 1986. WM was initially reluctant to accept treatment, and the probation officer took the view that Social Services involvement was more appropriate than the Probation Service, given that compulsory powers under the Mental Health Act 1983 might be required. WM was subsequently given a two year conditional discharge by the court.

361. In October 1987, responsibility for WM was transferred from the Harrow probation officer to the probation officer in Kilburn, when WM changed address. He was further charged with possession of an offensive weapon and motoring offences, and he was in breach of his conditional discharge. The new probation officer produced a report for Harrow Magistrates' Court in October 1987, and recommended a further remand on bail for an up-to-date assessment of his mental condition. Contact with WM was subsequently lost. Criminal records show that WM was sentenced at Birmingham Crown Court to 18 months imprisonment. When he was released in May 1992, there was no statutory requirement for after-care by the Probation Service.

362. There is no evidence that he came before the probation services in London, apart from requests for reports, until he was placed under a probation order in June 1994 for one year. The Supervision plan was:

a. Weekly reporting;
b. Investigation of drug counselling options;

Reference

[1] *Probation and Health: A guidance document aimed at promoting effective working between Health and Probation Services, 1995, HMSO*

[2] *Pitchard C. and Cox M. (1993) People on Probation: Their Social circumstances and their Characteristics, as cited in Probation and Health above.*

c. Liaison with Mental Health Service and monitoring of depot injections
d. Consideration of strategies to avoid further offending using material from probation service guidance "Targets for Change".

363. He reported reasonably regularly initially. In an interview on 27 June 1994 he stated that he had attended the Drug and Alcohol Service but had been informed that no further appointments were to be offered as he was not using at that time. The probation officer was not prepared to accept this outcome and liased with the Drug and Alcohol Service. In interviews in July, WM stated his determination to stay free of drugs and the possibility of his getting involved in the community through voluntary work was discussed. On 20 July, WM's mother telephoned to say that he had started taking drugs again and she was extremely concerned. At a subsequent interview, WM admitted to using cannabis occasionally. The next week the probation officer made a home visit, where she met WM's mother whom she described as:

> "somewhat anxious, clearly under pressure in caring for brother - has mental illness history".

364. On 19 August 1994, WM failed to attend for his probation interview. A letter was sent to him and a telephone call made to his consultant psychiatrist whose secretary informed the probation officer that he had missed his last appointment. The probation officer then telephoned the community psychiatric nurse and learnt that WM was attending fortnightly for injections. On 24 August, WM's mother telephoned Probation to say that he had been admitted to hospital, hearing voices. The next day, Probation were notified of WM's hospital admission by the community nurse. WM's mother also telephoned the probation officer about an unpaid council tax bill of £350.

365. The probation office was notified on 5 September 1994 that WM had been discharged from hospital. WM was asked to come for an appointment on 22 September 1994. He failed to attend. The probation officer telephoned WM's mother who said that she saw WM daily and that he was coping at present. His mother was asked to remind him of his appointment and a letter was sent for 29 September 1994. Contact between the probation officer and the hospital revealed that WM was believed to be taking drugs again. At his appointment on 29 September, the probation officer noted that WM was reluctant to engage in discussion on drug use.

366. The quarterly probation report for June to September 1994 stated that:

> "Drug Concern *(i.e. the community Drug and Alcohol Service)* will again be approached with a view to working with W to decide practical strategies to avoid drug use. Liaison continues between myself and the Mental Health Services. ... WM was hospitalised for one week at end of September complaining of hearing voices. This breakdown was considered to have been drug induced.

367. He failed to attend the next appointment with Probation but turned up a few days before the newly notified date saying that he had got the dates mixed up. He had had his depot the week before. The records note that he:

> "Seemed dazed as usual but denied using any other drug at present. Says hasn't used crack for two seeks, but admits that his use is a problem."

WM agreed to the probation officer making another referral to the Drug & Alcohol Service.

368. He failed to attend the next appointment, which was followed up with a letter and fresh appointment. The probation officer telephoned the community psychiatric nurse and learned that WM had failed to attend for his last depot appointments. Following contact with the Drug & Alcohol Service, an appointment was made for probation and the drugs worker to interview WM on 14 November 1994, but he did not arrive. On 22 November 1994, WM came to the probation officer apologising for his failure to attend, but saying that he had been to Ireland to visit a sick relative. He was reprimanded and instructed to report to the Probation duty officer on 1 December. 1994.

369. On 1 December 1994, WM attended and stated that he had been offered housing transfer to Cricklewood. On 15 December 1994, the community nurse telephoned to confirm that WM had received his depot having failed three earlier appointments. They discussed the action that could be taken if WM failed to appear for appointments at the clinic, and the previous use of Section 48/49 of the Mental Health Act which he was no longer subject to. The probation officer agreed to encourage WM to attend. The same day WM failed to attend for his probation appointment. He was sent a letter and attended on 19 December 1994 when he was given his next four appointments and warned that if one was missed an order would automatically be returned to court. WM explained his absence at clinic appointments by saying that the injections hurt and he only attended hospital for injection when feeling unwell. The probation officer contacted the community nurse and was informed that she was discussing WM with the consultant psychiatrist the next day.

370. The quarterly probation report for September 1994 to January 1995 states:

> "WM's reporting has not been satisfactory this quarter and he has been warned of Breach action. FTRs [failures to report] it seems. were due to depression brought on by the death of an uncle. WM now admits to using Crack although he attempts to minimise the exact usage. Work has sought to increase his awareness of the danger of taking illegal drugs while receiving psychiatric medication. Liaison with community mental health team office reveals that WM is not attending properly for depot injections. 3 injections to date have been missed. Meeting to be held between health and probation at end of Jan."

371. WM attended on 3 January 1995, and they discussed the forthcoming after-care review meeting (s117) and purpose of it. At the multi-disciplinary meeting on 26 January 1995, the probation officer recorded that he was:

> "No longer receiving injections due to failure to attend clinic. Doctor's feeling is that W. perhaps invents symptoms. Feeling by all that family are efficient in manipulating benefit system. .... probation officer to re-refer to Drug Concern."

At the next meeting on 2 February 1995, the probation officer discussed the content of the meeting on 26 January 1995 at which WM had not been present. The records note that:

> "W resistant to attending Drug Concern at present... explained failed to attend hospital appt. as due to dislike of physical side effects of medication."

372. On 15 February 1995, probation records note that WM was due to appear at Harrow Magistrates Court on 1 March 1995 for motoring offences. He failed to attend on 2 March 1995 and a letter was sent. Four days later he reported and explained that he had not attended as he had gone to Scotland for a funeral. The records note:

> "says he has not used drugs since end Jan. Informed him that I am not convinced of the truth of this. Sees little benefit in referral to Drug Concern at present. Agreed to review at later date to address drugs issue regularly."

373. The court hearing was adjourned to 30 March 1995, but in the meantime on 16 March he appeared at Harrow Magistrates Court following overnight arrest. He was charged with burglary and remanded in prison. The quarterly probation report for March 1995 noted:

> "Concern about WM's use of drugs has heightened this quarter as myself and mental health professionals believe he is using to a significant degree. He is unwilling at present to be completely honest about his usage, admitting it at one point and then denying at a later stage. Such a stance means that according to Drug Concern's policy which requires a degree of motivation to stop using, he is unsuitable for treatment. It seems little can be done for him at present. Further at a meeting I attended with mental health professionals involved in this case, at the end of Jan. Dr. D, psychiatrist expressed doubt about the schizophrenia diagnosis. Dr. D's assessment is that WM's present mental illness was drug induced. I informed the psychiatrist that I believe WM is using his contact with mental health services to avoid the consequences of his offending. He ... is not receiving his depot injections regularly. At time of writing WM is in custody at Wormwood Scrubs awaiting sentence on an offence of residential burglary (elderly victim)."

374. On 20 April 1995, WM attended Harrow Magistrates' Court on two counts of burglary. The case was adjourned to 26 April for committal proceedings. On 18 May 1995, all charges against him were dropped, but proceedings against his brother were continued.

375. At the probation interview on 1 June 1995, WM's drug use was discussed but he claimed not to be currently using. They discussed his motivation to keep off drugs and the physical sickness caused. The probation officer reminded him of the services of the Drug and Alcohol Service, and gave him the telephone number to use when probation order was finished. His final probation interview was fixed for 13 June 1995. Predictably he failed to attend and probation closed the case on 14 June 1995.

376. The full closing summary is as follows:

> "Following committal to Harrow Crown Court the charge of residential burglary (co-def, brother) against WM was dropped. His brother was apparently the true culprit and charges against him continue. WM has reported satisfactorily since his release. He reports less use of crack cocaine. Given his poor use of the service in the past, I have not referred him to Drug Concern again. We have agreed that he will ring should he view his usage of drugs as increasing. My aim is to give the responsibility for accepting help back to WM. All else is stable at present. He continues to have daily contact with his mother whom I have both spoken to and seen on occasions. Work has sought throughout the order to tackle the main factor associated with WM's offending - his drug use. As long as

he continues to use there is some risk of re-offending. He continues to be under the care of the psychiatric services. WM at the close of this order indicates increased understanding and awareness of the trauma caused to the victim of his crime and similar crimes."

377. Probation was the most significant contact of the statutory services between June 1994 and July 1995. There was excellent communication between the probation officer and the health services. The probation officer checked with them when he failed to attend for probation appointments. There was also contact with WM's mother, who took advantage of the fact that WM was on probation to use the probation officer as a key worker for WM, phoning up when she was concerned about his drug taking, or his council debts. The probation officer made one of the very few home visits to WM and his mother (as required under National Standards).

378. The probation officer persisted in her attempts to engage the Drug and Alcohol Service in dealing with WM's drug problems, but such efforts were of no avail given the operational policies of that agency. In hindsight, it is unfortunate that attendance for drug counselling was not made a condition of the probation order, as when WM failed to attend for drug appointments, there was little action that the probation officer could take.

379. Despite the increasing failure of WM to attend for probation, he was not referred back to court for breach of the probation order in March 1995 when he turned up, having gone to Scotland for a funeral.

380. The probation officer took the role of a key worker during this year. She explained to WM the purpose of the s117 after-care review meeting and then briefed him on its content afterwards.

381. The format for records kept by the probation officer were structured and exemplary in their clarity, comprehensiveness, and analysis of the situation.

382. However, the Probation Service was singularly ineffective in meeting the plan set out in June 1994:

1. Weekly reporting was not kept towards the end of the probation order;
2. Investigation of drug counselling options: these were investigated but no constructive support was provided by the community Drug and Alcohol Service (Drug Concern) for a variety of reasons;
3. Liaison with Mental Health Service and monitoring of depot injections: monitoring took place, and the probation officer was assertive in liasing with Health to ascertain his attendance. It is possible that his attendance was marginally influenced by his contact with the probation officer, but only during the first months of probation - thereafter his attendance for depots deteriorated;
4. Consideration of strategies to avoid further offending using material from Targets for Change: these were not defined and there is no evidence of any other strategy adopted. At the end of the probation period, he was again being prosecuted for continuing offences.

Probation reports and supervision in 1996

383. Following a pre-sentence report on 10 January 1996 from the same probation officer, WM received a combined twelve-month Probation Order and 100 hours

Community Service Order at Harrow Magistrates' Court for various motoring offences.

The Probation plan was:

a. Weekly reporting
b. Monitor Community Service
c. Monitor payment of fines, (including backlog of approximately £280)
d. Offence focused work to challenge attitude to driving offence
e. Liase with Mental Health Services to co-ordinate treatment and care
f. Referral to Harrow Drug and Alcohol Concern

384. WM was himself surprised at the sentences since he expected to go to prison. At his probation interview on 15 February 1996, he said that he had not used drugs for some time. He was continuing to receive fortnightly depot injection and attended a local gym regularly. On 28 February 1996, he failed to attend Hendon Magistrates' Court and a warrant with bail was issued the following day. He failed to attend his probation appointment on 13 March 1996. His mother telephoned six days later to say he was in bed with 'flu. He was asked to report on 25 March 1996, but failed to do so.

385. On 3 April 1996, an application was made to Harrow Magistrates' Court for a summons for breach of the Combination Order. Community Service reported that he had completed only one hour of the order. WM had handed in a medical certificate for a six-month period with schizophrenia as the medical diagnosis.

386. On 16 April 1996, he failed to attend the probation interview and on 19 April 1996, he failed to attend Harrow Magistrates' Court for the breach hearing. A warrant without bail was issued. On 29 April 1996, he again failed to attend for probation. Psychiatric reports were requested for court hearings.

387. On 13 June 1996 at Brent Magistrates Court, he was sentenced to six months imprisonment for motoring offences. The court was unable to deal with breach of the Combination Order as Brent was not the supervising court. The probation officer pursued the breach of probation, and after contact with solicitors and the police, she was advised to apply direct to prison for a production order. WM was currently in custody on burglary charges awaiting committal. On 3 July 1996, a letter was sent to the prison Governor to deal with the outstanding warrant. On 10 July 1996, a hearing took place at Harrow Magistrates' Court for breach of the Combination Order. The order was revoked and he received two weeks' custody to run concurrently with his present sentence.

388. Probation records during 1996 show a relentless pursuit of the breach of probation order, illustrating the conscientiousness of the probation officer in bringing the seriousness of breach to the court's attention.

389. The probation order had little effect during this time because of WM's failure to attend and his on-going criminal activities.

390. In view of WM's enduring mental illness, it is surprising that he was given a Community Service Order of 100 hours - albeit for unpaid work - which ended after only one hour of service with the production of a sick note. There is no evidence of the assessment on which the probation officer based her opinion.

391. Very little of the 1996 probation plan was therefore implemented during the few months that it ran.

392. We regret the fact that the Inquiry Panel was unable to interview the probation officer involved, who was a key witness of fact. She was advised not to attend the Inquiry by her employer. Although the Probation Service did make available full records (with WM's consent) and a manager did come to see us, the quality of evidence to us was limited by the absence of direct knowledge.

We recommend that:

Middlesex Probation Service ensure that its staff only propose to Courts the making of a Community Service Order for a person suffering with a mental disorder after consultation with the appropriate specialist medical staff from the mental health services.

HOUSING SERVICE

393. For much of the time between 1986 and the homicide in 1997, WM experienced difficulties with accommodation. This section asks:

(i) What were the difficulties and how did the statutory and other agencies respond to them?
(ii) What improvements would the panel recommend?

Response to homelessness

394. In May 1992, WM was released from prison with no apparent arrangements for his after-care. At the end of August 1992, he took temporary refuge with his aunt who was living in Harrow. Records show WM's dependency on letters from health and social services to support his housing application as a homeless person. On 2 March 1993, it was reported that WM was moving into bed and breakfast accommodation.

395. It took from September 1992 to March 1993 to secure bed and breakfast accommodation for WM, even though it was clear that his mental condition was likely to be exacerbated by his lack of accommodation and dependence on his aunt and grandmother to provide him with temporary help. The overcrowding may also have had an effect on the mental health of WM's relatives.

396. Six months elapsed before he was able to obtain bed and breakfast accommodation. Harrow Housing Department records were not retained so the reasons for delay are unknown to us.

397. The allocation of an unfurnished flat was regarded as sufficient on its own to satisfy his accommodation need and desire to live independently from his family. There was no assessment of his housing support needs, despite a number of background factors from earlier records that indicated his vulnerability.

First tenancy - April 1993 to August 1993

398. Within less than a month of his moving into bed and breakfast accommodation, he secured a tenancy with Network Housing Association. Yet less then three weeks after he had moved in (13 April 1993), a petition against him was presented to Network Housing from other tenants. He was advised about the complaints of noise from his neighbours, and of his having four adults, two children and a baby residing at this flat. His neighbours were under the impression that the block of flats was for sole occupation by older (forty year old and over) tenants. WM reported that his sister and children stayed a few nights and other friends visited. It was pointed out to him in writing that this was a breach of the tenancy agreement. WM was asked to contact the housing officer to discuss a very serious matter. On the day that he received the letter, he telephoned the housing officer to apologise and explain, and promised that there would be no recurrence. However a few days later, the housing officer checked with a neighbour and it is recorded that there was no improvement in the situation. It was believed that he had sublet his accommodation. A man, woman and three children were reported as being still at the property.

399. Less than a month after his move, a Notice Seeking Possession was served on WM in person. He was advised that court proceedings would not begin before 17 May 1993. Evidence of further complaints from neighbours continued during April and May, with one neighbour keeping a diary of unacceptable activities by those occupying the property. A meeting with neighbours took place in late May 1993 following a burglary. Concerns were raised about security, WM's friends and the noise. In June, a neighbour telephoned the housing officer because WM had gone out leaving the gas cooker on. The housing officer arranged for their maintenance service to visit as the gaslight had gone out. On 22 June 1993, a visit was made and a further Notice Seeking Possession was served since the previous one was considered invalid.

400. By the end of June 1993, the housing officer was investigating the possibility of transferring WM to another property. Further complaints were received from neighbours including WM's brother kicking the door in; that WM was not living at the property and instead his brother was using the flat; noise caused by a friend of WM who was knocking on door to use phone early in morning; WM dumping a rug and resulting rat infestation. The diary of events recorded by a neighbour listed on-going complaints on a daily basis. WM denied any knowledge of men with keys to his flat. Meanwhile, he was offered a property elsewhere but his mother telephoned to say that WM could not accept it as it was too far from all support.

401. WM was admitted to hospital on 14 July 1993. Medical and nursing notes describe his self-reported experiences, personal difficulties with living independently and inappropriate housing allocation. They also show that on Friday 30 July 1993, the ward staff rang Network Housing saying that WM was due to be discharged on Monday 2 August 1993 and inquired whether he had been found accommodation? The ward staff was advised that Network Housing was almost ready to make him an offer of another flat. The housing record of the conversation states

> "I said that maybe he would have to go into Bed and Breakfast accommodation as neither his tenancy flat nor the flat under consideration of offer are habitable from the point of view that there is no bed or utensils, etc. for him to have basic comfort. We left it that I would speak to my colleagues on Monday and arrange for WM's mother to see the property. In the meantime I stressed the need for WM to have a social worker to possibly arrange B&B and grant or loan from the Social Fund."

On this Friday, the ward staff also contacted the community mental health team.

402. WM was discharged from hospital on the Monday to his mother's address - a few days later she contacted the community mental health team. Her anger that WM had been discharged from hospital, offered a new tenancy with no furniture, and given no social worker was recorded. The following day, the community mental health team's duty service contacted Network Housing who confirmed that they had offered WM a flat, and that he seemed to lack the basic furnishing to actually move in. However, it seems that WM told the community mental health team that things were in hand, and that he did not need their help. This understanding was confirmed in writing and they took no further action.

403. Although Government guidance had been issued (Housing and Community Care Circular 10/92), it is apparent that arrangements and protocols for joint assessment between housing, health and social services had not yet been developed in Harrow. The Housing Association records show that WM was nominated for housing because of his homelessness and medical circumstances, but they were provided with very little detail about his social and psychiatric history.

404. Commendably, a flat was obtained within a month of WM being in bed and breakfast accommodation. However, the tenancy was unfurnished and he was provided with no practical support.

405. He proved to be a difficult tenant, yet the nuisance he caused the neighbours appear not to be directly related to his mental illness or drug problems. This was his first experience of living on his own and having to take responsibility in an environment devoid of people of his own generation, cultural affinity and social support.

406. Network Housing records fill a significant gap in the records of the mental health services, showing a dimension which appears to be completely missing. The health and social services records provide details of his wishes to have a transfer and issues about the lack of furniture, but little about the enmity of neighbours, eviction notices, etc.

407. There was almost non-existent collaboration across the agencies. It is not surprising that WM soon started spending more and more time at his mother's flat for support and company.

408. A main finding of the Audit Commission report on Harrow & Hillingdon Healthcare Trust (September 1995) was that there were no formal relationships with Housing Services and it was recommended that such systems be developed.

Second tenancy from August 1993 to 1997

409. The last record of referral by WM or his mother for social work support over accommodation or financial issues, is in November 1993.

410. It appears that WM spent almost no time at his new flat. On 2 December 1993, WM made a housing transfer request because he wanted to be near his family. He was sent notification of a property defects inspection due later that month. In January 1994, WM applied for a Homeswap from his flat. A request in March 1994 by the bail information officer at Wormwood Scrubs Prison for confirmation of his permanent address for bail purposes led to confirmation that he had been a tenant since 9 August 1993. However, clinical records concerning his hospital admissions in 1994 suggest that he was living with his mother.

411. In August 1994, clinical records show that during his hospital admission it came to light that he had received a summons for non-payment of Council tax. It is probable that the Council tax related to his occupation of the Housing Association flat(s).

412. In February 1995, WM was sent a letter stating that he was in arrears with rent. In March, a neighbour telephoned the housing officer to report strangers in

WM's flat, and asked if he was subletting. A visit to the flat took place in July 1995, and damp was reported. A letter was sent to WM at his mother's address and stated:

> "As Brent Council are paying Housing Benefit to you to live at *(address of Housing Association flat)*, it is important that we get you moved back in as soon as possible..."

413. In August 1995, the GP wrote supporting WM's transfer request. The housing officer made an abortive visit to see WM and his mother on 11 September 1995 at his flat. The mother was advised by telephone that it was unlikely that WM would be offered accommodation any closer to her. His mother responded that she would contact her solicitor. On 20 September, WM completed a housing transfer request form in which he gave reasons for the transfer request:

> "because I cannot walk up the stairs of my flat without pain in my hip because of my injections in my hip, plus I want to get closer to my carer (mother) and flat has dampness".

414. On 31 January 1996, a letter from WM's solicitor set out the problems with the flat including a leak in the bathroom, furry mould, no fire escape and dampness. Network Housing were advised that if there was no reply to the issues listed within fourteen days, the matter would go to court. On 27 February 1996, the Network housing officer wrote to WM asking him to contact her about the transfer and the present housing circumstances. On 1st March 1996, a surveyor visited the flat. Network Housing's contact with the community nurse revealed that she did not have the flat as the address for WM, and the last time she had seen him was two months ago. The housing officer sent a letter to WM (at his mother's address) stating that it was urgent that he arranged access so that work on repairing an overflow at his flat could be carried out.

415. For much of 1996 WM was in prison, but there is no information as to who was living in the flat at that time.

416. In January 1997, WM's sister wrote a "To whom it may concern notice" stating that she was living in WM's flat "with her disabled brother as his carer." She stated that he only had a one bedroom flat, and wanted to have a larger place so she could take care of him. Correspondence between Network Housing and their solicitors in February show concern that WM's sister, and not WM was not living at the property. Legal advice on a Notice to Quit was provided to Network Housing. Letters from the Department of Social Security to WM's sister at the flat (in August and December 1996, and February 1997), suggest that she was the main occupant.

417. On 10 February 1997, a Notice of Seeking Possession was issued against WM because of his failure to use the flat as his principal residence and his sub-letting of it. He was required to leave by 17 March 1997. The next day, WM's mother rang on his behalf and made an appointment for him to be seen on 13 February 1997. His mother informed Network Housing that she had been in hospital for three weeks, and whilst there, WM stayed in her flat to be near the 'phone. The housing worker recorded that three male friends of WM had stayed in the flat. The worker did not inquire where WM's sister was residing. On 13 February 1997, a file note in the housing records note that WM stated that his flat had stairs which he could not walk up since his depot injections

made his hip sore. On 14 February 1997, Network Housing received legal advice recommending that a further Notice to be served.

418. On 18 February 1997, the housing officer telephoned DS, the community nurse who administered WM's depot injections. It is recorded that the community nurse told the housing officer that she could give her no information about the man, "because he never spoke of personal issues". She said he has a probation officer but didn't know his name or number."

419. On 12 March 1997, the housing officer telephoned the social security office to explain that WM's mother received the carer's allowance, and that WM's sister was not receiving this. The lettings section was told that WM was not going to be on the transfer list for a two bedroom flat. WM was informed in writing that he would remain on the transfer list on Band 6, that is, least priority, for a one bedroom flat in the Harrow area:

> "Miss ML [WM's sister] is not your main carer, your mother is claiming as your main carer. You have overcrowded the property yourself and must take responsibility for this."

420. It is our understanding that during this time, WM's mother was in and out of hospital and stayed with her other daughter. WM's sister assumed the role of caring, catering and cleaning for him in the flat. One of his brothers was also in occupation.

421. The allocation of a different flat was seen as the answer to the problems which had arisen from WM's first tenancy. There was pressure for hospital discharge at a time when the Housing Association advised that neither his tenancy flat, nor the flat under consideration of offer, were habitable since there was no bed, utensils or other items necessary for basic comfort. Again, little practical support with the move was given and there is very little contact across the agencies. WM was discharged from hospital to his mother who organised furnishings.

422. It appears that Network Housing were reluctant to see to the repairs in WM's flat until prompted by his solicitor's letter (31 January 1996), when a surveyor was sent round within a month. It also appears that the Housing Association was ignorant about WM's movements, including imprisonment. This undoubtedly affected written communications with him, and access to the flat.

423. The housing service did not consider meeting the needs of WM in the context of his family relationships. The possibility of his sharing larger accommodation with a family member was not explored at the time he requested to be transferred in late 1996, and Network Housing were adamant that he would only be transferred as a single tenant.

424. The response to WM's sister's request to be recognised by Network Housing as his main carer was determined on the basis of which family member received social security payments for this purpose. One of the reasons for seeking to terminate WM's tenancy was that it appeared that he had ceased to occupy his flat, and had sub-let to his sister. Whilst a housing service has reason to prevent unlawful occupation, it is questionable whether the approach was sufficiently flexible and sensitive to the change in family circumstances, and we would be concerned at the wider implications for informal care in the community.

425. One of the reasons WM gave for wishing to move to a ground floor flat was soreness to his hip following injections (20.9.95). A similar complaint about pain from injections was noted by an occupational therapist (10.9.93), and by his probation officer (19.12.94). These complaints appear never to have been followed up.

426. It is evident that in February 1997, near the time WM and his mother sought admission to hospital, he was under threat of eviction. A Notice to Quit had been issued on 10 February requiring him to leave on 17 March. It is evident also that his mother sought to explain the family circumstances. The response to an enquiry from Network Housing by the community nurse (18 February 1997) is indicative of the lack of any overview about WM's circumstances and social support network. The community nurse could have had access to all the information which Network Housing were requesting.

427. Although Network Housing were aware that WM had a mental disorder, (there is no evidence that they were aware of his drug misuse), and no attempt was made to discuss implications of their actions with the mental health services.

428. It is pertinent to this Inquiry to draw attention to findings from a study in relation to drug and alcohol users[1], which was published in 1994. The study examined the role of housing and community care, and was based on an inner London borough. Each of the following factors were raised by tenants as 'spoiling', or detracting from, the benefits of stable housing, and providing temptation or inducement either to relapse, or to continue or increase drug and alcohol use:-

- no experience of managing a tenancy: many clients from parental home/institutional/prison/squatting background
- lack of assistance with furnishing
- lack of information about available help, including Social Fund applications
- long periods without essentials, including bed, cooker, fridge and bedclothes
- lack of money and lack of employment prospects, leading to resumption of criminal activity
- too much time on hands
- boredom, and lack of stimulation
- social isolation (and craving for intimate relationships)
- inability to breakout of the society of other users, because of lack of alternative company

429. We formed the view that neither WM nor his family were clear about what services and standards they were entitled to expect. The Government Charter, "YOU and YOUR SERVICES - A Charter To Improve Services For People Needing Ongoing Support Or Care", issued in 1999, sets a national framework for local health, housing and social services to work together on behalf of users and their carers. Local and Health authorities are required to publish a joint local Charter making explicit their local standards. The process of consultation is intended to involve independent service providers including Social Landlords.

We recommend that:

Reference

[1] *Keys to change: a study of he role of local authority housing in the care and rehabilitation of Drug and alcohol users in the London Borough of Lambeth, Home Office - Drugs Prevention Unit paper, Dec.1994*

a. **Harrow Council ensure that its Housing Department and all local Social Landlords consult with the mental health services prior to issuing a Notice to Quit to a tenant who has complex needs;**
b. **Harrow Housing and Social Services, and Harrow & Hillingdon Healthcare NHS Trust take into account the findings of this Inquiry when producing a joint local Charter for people in need of on-going support and their carers;**
c. **Harrow Social Services and Harrow & Hillingdon Healthcare NHS Trust ensure that housing representation is considered by staff for care programme review meetings.**

INTER-AGENCY ISSUES

430. WM's health and social care needs were responded to through fragmented service delivery systems in the specialist services listed below:

- Hospital in-patient care and treatment
- Day Hospital activities and occupational therapy
- Out-patient department
- Local clinic for depot injections
- Community mental health team duty system
- Mentally disordered offenders scheme
- Forensic mental health services
- Community Drug and Alcohol Service

The Care Programme Approach, integrated with community care assessment and care management, was intended to overcome fragmentation. From 1992 onwards, there is no evidence that WM received a comprehensive assessment or programme of interventions tailored to his individual needs.

431. His accommodation need was regarded as a single issue. No assessment of his vulnerability and support needs was undertaken. He was nominated by local authority housing to a Social Landlord (Housing Association) with sparse information exchange. The allocation of his first tenancy was to an inappropriate environment and failed. His inability to manage alone led, for a significant time, to the under-occupation of his second tenancy (whilst he stayed with his mother), and latterly to overcrowding (when his sister and brother moved to live with him).

432. His financial need was referred to voluntary agencies providing welfare benefits advice. There is evidence of scepticism by mental health professionals, and his probation officer of the entitlements which he and his carer received. However, there was no assessment of his capabilities for training and employment as an alternative to this source of income. In contrast, there is evidence of concern that the cost of his illicit drug usage was being met from income from crime.

433. It is evident that WM lacked motivation to change his life-style because of his lack of purposeful daytime activity. However, apart from attendance at the day hospital for four months for a limited range of group activity, and a suggestion by his probation officer that he consider voluntary work, no other options were discussed with WM. A later recommendation to a court from his probation officer that he undertake a period of compulsory community service appears not to have been discussed with mental health professionals. WM was able to produce a sickness certificate to the Community Service manager that he was unfit for work on grounds of his mental illness.

434. WM is a member of an ethnic minority and affinity relationships were confined to his family members. No attempt was made by any professional to understand the strengths and coping strategies within his family or to engage in partnership with them over the care of WM. All agencies believed that WM should have assumed greater responsibility for himself but there was, perhaps, an underestimation of the degree of WM's alienation from the norm.

435. In outcome, each agency that became involved with WM failed to bring about significant change.

436. The Harrow Community Care Plan for 1999-2000 shows direction in service development which is relevant to someone with needs similar to WM:

- *Brent and Harrow Health Improvement Programme* – top two priorities:
  - Economic factors which cause poor health
  - Mental health
- *Social Services White Paper* – three key themes for Adult Services:
  - Helping people live independently
  - Creating fairer, more consistent services for all
  - Making sure services fit individual needs
- *Introduction of Government 'National Strategy for Carers* (Feb.1999):
  - Develop a strategy for carers and run an advocacy service for carers
- *Training on CPA:*
  - Programme to extend to a wider range of professionals
- *Plans for mental health services*:
  - Development of additional housing support
  - Develop community support and residential provision for mentally disordered offenders, and promote integrated multi-disciplinary service
  - 'Dual Diagnosis' – identify extent of dual diagnosis in collaboration with other professional teams. and ensure more concerted approach
  - Develop initiatives for further carer recognition and improved working relationships with professionals
- *Plans for Alcohol and Drug Services:*
  - Improve access to housing for drug/alcohol users
  - Improve capacity in local mental health services to respond to people who have mental health problems. and drug/alcohol problems
- *Housing Services* (Note: Harrow has the smallest proportion - around 10%) of Council and Housing Association dwellings of any London Borough):
  - Joint finance initiative for 'floating support scheme' to provide housing support worker, welfare advice and advocacy service for vulnerable tenants with mental health problems to enable them to retain and maintain their tenancies

437. The above list is indicative of shortfalls during the period of WM's care and treatment in Harrow that may have made a difference.

The role of the Voluntary Sector

438. WM's needs fell into many different categories covered by the voluntary sector. He suffered from mental disorder; misused alcohol and drugs; had a long history of criminal offending and imprisonment; was unemployed and came from a family of Irish travellers.

439. A perusal of the records relating to the care and treatment of WM shows that during the years under our investigation, he had very little contact with the voluntary sector. In a previous section we addressed the role of Network Housing Association, an independent service provider. The only other voluntary agency that appeared to have dealings with WM was the Citizen's Advice Bureau.

440. The panel wrote to local charities and other agencies in Harrow to ascertain information on the services provided for those suffering from mental illness and who abused drink or alcohol.

441. **WPF Counselling North West Middlesex** informed the panel that it had been working in that area for 30 years helping people with individual counselling for a very broad range of mental health and emotional difficulties. However it was not in a position to help those with addictions without the client first being 'clean' or 'dry' for at least six months prior to counselling. This rule obviously excluded WM.

442. **National Schizophrenia Fellowship (NSF)**
The Harrow Assessment Unit of the National Schizophrenia Fellowship (NSF) informed the panel that there were four services provided by the NSF in Harrow:

Members support: offers information, advice and support to members and on occasion to the general public;
Phoenix Employment Project supports people returning to employment;
Harrow Home Treatment offers information and advice; family support and some family intervention work to users, their families and other carers; and
Harrow Assessment Unit provides four assessment places and two places for crisis admissions (access at anytime, seven days a week).

443. Both the Harrow Home Treatment and Harrow Assessment Unit accept referrals from the community mental health teams and in addition, the Home Treatment service also takes referrals from primary care services. Neither accepts self-referral.

The NSF outlined the scope of these two services as follows:

> "A primary diagnosis of alcohol or substance misuse would exclude acceptance by both these services. A history of alcohol or substance misuse would not exclude acceptance by either service. A concurrent diagnosis of alcohol or substance misuse would not exclude acceptance but would have to be considered against such factors as the nature and extent of the problem; the willingness or ability of the person to manage it; the willingness of the person to make effective use of the service; the risk of harm to self or others; the ability of the service to manage the risk; and, where necessary, the viability of any joint treatment or risk management plan.
>
> Substance misuse is considered a significant risk factor in the Unit's referral process. Where there is a history then the nature of the problem is explored with the referrer and with the prospective resident - where invited to visit the Unit in advance of admission. The Unit plan of care will always involve close liaison with the Community Mental Health Team and also with the Community Drug and Alcohol Service where necessary. In some cases a contract which will include a clause on reviewing the placement in the event of problems may be drawn up between the resident, the Unit and the Care Manager. Substance misuse does complicate matters for everyone but in the absence of serious management problems for the service is most often viewed as another problem to work with."

444. **The Samaritans** also responded sending information about its 24-hour telephone answering service.

Voluntary services for Irish adult service users/clients.

445. A survey was carried out by BIAS - formerly known as Brent Irish Advisory Service - amongst voluntary organisations providing generic services to ascertain whether Irish people are using generic services/ sources for support. The findings, published in 1999, concluded that Irish users/clients are not generally monitored by voluntary agencies in Harrow. However, Harrow Association of Disabled People (HAD) monitoring showed Irish membership on a par with other ethnic minorities, and all voluntary organisations contacted said that they were aware of having Irish clients. The survey concluded that the full extent of need or unmet need among the Irish community in Harrow could only become apparent through provision of Irish-specific services. A borough-based Irish organisation to represent the interests and needs of the local Irish community, and which would act as a voice for vulnerable members of that community, was required if barriers to accessing services and consultation were to be addressed. It recommended that funding be provided for an Irish community group to work with all sections of the Irish community in the borough of Harrow.

Future services:

Addaction

446. A new service is being set up by Addaction, a national charity which assists individuals to manage and deal with the effects and consequences of drug use. It will be known as Addaction Brent. The main aim will be to provide a gateway service for all individuals wishing to gain information, advice and support in dealing with their drug use. They will be offering a street-based service, where individuals can access the service both by drop-in, and by appointment. The purpose will be to assess individuals, and assist them in accessing services that are appropriate to their needs, for example, referral to specialist drug/alcohol agencies and information on detoxification etc.

447. There were local voluntary services that were relevant to the needs of WM. We found no evidence that WM or his family were referred to them. The duty placed upon the health authority and social services authority under s117 of the Mental Health Act 1983 requires them to provide after-care services, in co-operation with relevant voluntary agencies. There is no evidence that the contribution of voluntary agencies was considered at the after-care review meeting on 25 January 1995.

We recommend that:

Brent & Harrow Health Authority and Harrow Social Services review operations to ensure that the co-operation of voluntary agencies with a contribution to make towards people with mental health needs who misuse drugs and alcohol is being sought pursuant to s117 of the Mental Health Act 1983.

ETHNICITY AND CULTURAL ISSUES

448. WM told us that although he was born in Birmingham. His mother and father are Irish so he regarded himself as Irish, "even though I am a British citizen." He is part of an extended Irish family. The family were former travellers, or as he and other family members describe themselves, "gypsies". They have lived in housing accommodation for some 30 - 35 years. This extended and close-knit family comprised two generations born in the Republic of Ireland, and two generations born in this country. WM's family network live in Northwest London.

449. In this section we ask:

a. Did clinical and community care assessments of WM, and intervention programmes, seek an understanding of cultural influences, and were these reflected in care and treatment programmes.
b. To what extent were services sensitive to transcultural issues and the experience of discrimination?

Personal records

450. The only references to WM's ethnic background and cultural identity that we found in clinical assessment records about him (from 1986 to 1997) were:

a. By his first Consultant Psychiatrist in psychiatric reports in 1986, who described him as:

> "...a reticent, unsophisticated lad of itinerant Irish background"

b. A nursing assessment report dated 14.7.93, which noted:

> "Mixes in the travelling community circle"

c. A day hospital assessment form (undated) following his hospital admission in 1993, which records WM's replies to set questions:

Family and contact:	"Mother and seven siblings – I see them regularly when I travel because they are Gypsies"
Do you have any friends?	"I do not have outside friends, my family are my friends"

451. Northwick Park Hospital admission forms that provide for ethnic classification appear in his file in 1994, and on both admissions (22.2.94 and 23.8.94) he is recorded as "White UK" and "England" respectively.

452. All reports completed by forensic psychiatrists from March 1994 and up to his conviction for homicide, refer to him as "Caucasian" - no mention is made of his Irish background.

453. An Approved Social Worker assessment report, dated 1.3.93, classified his ethnicity as "White, UK". Thereafter, Harrow Social Services referral forms (27.9.93, 24.3.94, 14.7.94 and in 1997) record his ethnicity as "UK Irish" or

"Irish". Otherwise, his ethnic origins and cultural identity are not discussed in any of the community mental health team records.

454. A Harrow Drug and Alcohol Service assessment document dated 25.5.94, recorded his ethnic group as "R/C" and his culture as "Irish".

455. A probation report in July 1986, under the heading Family Background recorded "he is a native of Birmingham" and "After leaving school he spent some time with relatives in...Eire". The pre-sentence report prepared by the probation officer who formerly supervised him (June 1994 to June 1995) for a court hearing on 11.1.96 stated:

> "From his account it would appear he had led an unsettled life. WM is the eldest of seven children from a travelling family."

457. The probation case notes show that during his period of compulsory supervision, some of his reasons for failure to report related to visits to Ireland to see relatives.

Discussion

458. Between 1992 and 1997, WM had extensive contact with the mental health service. The assessments and service response was not, in our view, commensurate with WM's personal history, family circumstances and complex needs. The response to the mental health crisis in February 1997, in particular, did not reflect revised operational policy at the time. We discussed these issues with RA, the former Social Services manager for the East community mental health team (September 1994 to August 1998). He accepted that there had been a number of shortfalls in service response from his own review of the records following the homicide. He commented that in February 1997, no one pulled the full history together for a multi-disciplinary assessment. RA was concerned that our particular findings in respect of WM's care and treatment should not be presumed to reflect the general standard. He stated that WM was the exception. He believed that the standards of performance and professional competencies in the service were good. He also believed that there had been a genuine misunderstanding about the role of the community nurse.

459. We formed the impression from our formal and informal interviews with the staff involved that there were experienced professionals, very committed and competent. So why was the approach to WM's needs and those of his informal carer exceptional?

460. It was apparent from all witnesses of fact to our Inquiry that they were aware that WM had an Irish background and most knew that his family were travellers. The scant references to his ethnicity and cultural heritage in written records suggests that little importance or value was attached to this dimension in analysis of his personal or social problems.

461. Over the period of our Inquiry, WM lived for the most part in Harrow. One of his maternal uncles is reported to have committed suicide, and another, who is reported to have suffered with chronic schizophrenia, was cared for by the family until his death some five years ago. WM's mother and aunt acted as informal carers, and both are reported to have had health-related problems of their own. They were known to have accommodation problems. WM's family

circumstances were known to Harrow mental health services and many of the staff had an Irish background.

462. In Appendix B, we provide an overview of studies that we looked at to increase our own knowledge and understanding of some of the difficulties experienced within the Irish community in this country. WM's family and social context mirror many of the factors found in relation to co-morbidity, poor housing conditions and low income. However, WM is a member of a minority community within a minority, that is, travellers, and about which there is limited research.

463. Many of the staff who were involved in the care and treatment of WM are of Irish parentage. Dr. D believed that he was sympathetic to the needs of the family. We discussed some aspects of minority experience with one of WM's family members. We do not presume that the particular individual's views and experiences are representative, but they provide some insights. The family member responded:

> *"You know that we are gypsies, don't you?*
>
> *We are travellers at the end of the day. A lot of people are racist against travellers...in the general community. If they know you are a traveller, they treat you like dirt.*
>
> *In Ireland they will tell you that there is more discrimination against travellers than black people or Indian people. That is what it is like – In pubs in Ireland you have "No dogs and no travellers." You have some over here, but every pub in Ireland is like that...not every Irish person, just a lot of Irish people do not like travellers.*
>
> *I must admit that there are a lot of dirty travellers...They leave rubbish every where. We put everything into black plastic bags. We have got big transit vans and dump it off in rubbish places. There are a lot of dirty travellers who give us a bad name. That is why we have got the name, but they class everyone the same."*

464. The panel asked how - given that there was a large Irish community where the family lived - people would know whom was a traveller?

> *"Just by the way I talk. They would know because we talk a different language. You would understand some words – but a lot of English people know it anyway – street-wise people."*

465. We asked how the family member had learnt to live with contemporary discrimination.

> *"I do not know. I do not mix or anything like that. I stay with my own. I am not allowed to mix with country people, as we call you. It is no offence or anything, but that is what we call you. It is not that I find anything wrong with you or anything, it is nothing like that. I do talk to people and I am polite to people who are polite to me."*

466. Contemporaneous records during the times of WM's early contact with the mental health services indicate that his social network was exclusively among the travelling community, and in particular his own family. The coping

strategies that individuals and families develop are influenced not only by cultural, social and economic factors, but experiences of general hostility or discrimination from belonging to a particular minority group. None of the professionals who became involved sought to explain WM's and his family's behaviour in these terms.

467. In contrast, there is evidence of a professional disposition that WM's and his mother's presentation of mental health problems were linked to anti-social behaviour and attempted manipulation. For example, medical responses to requests for hospital admissions in 1994, as shown in records, question family motives and suspect avoidance from police or court action. According to the probation officer's record of the s117 review meeting in 1995, there was a shared concern among the professionals present over the family's attempt to maximise welfare benefits. Yet, at no stage was an assessment undertaken of WM's capabilities, his occupational support needs or his employability in order to examine alternative means of income. It appears that professional attitude rather than proper assessment informed judgement.

468. In terms of direct knowledge of WM's living conditions and life style, the only visits to his home environment which were undertaken between 1986 to 1997, were:

- (according to his recollection) – visits by an Irish community psychiatric nurse to administer injections following his move to Brent in 1986,
- a visit by an approved social worker and psychiatrist to his aunt's home in 1992 when he returned to Harrow in response to a referral by the family,
- a visit by his probation officer to his mother's home to see both of them in June 1994 (National Standards for the Supervision of Offenders required at least one home visit),
- a visit by the community psychiatric nurse to his mother's house in December 1994 (as routine follow-up to missed appointments at the depot clinic) – the nurse was told by his mother that she had just missed him.

469. No professional visited WM at either of his Housing Association tenancies.

470. We found nothing in service responses that demonstrated sensitivity to transcultural issues, nor evidence of thinking that actively sought to develop a working partnership with the family over the management of WM's health and social care needs. The strength of relationships and the efforts made by family members to protect and sustain WM's health should have been evaluated. Very little was offered to WM by which he might achieve something or which fed-back any positive views about his and his family's worth. It appeared that so long as his mental illness was being managed, the rest was up to him.

471. We believe that WM's ethnic and cultural background played a significant role in the manner in which he and his mother presented their problems, and how his behaviour was perceived and responded to by professionals.

Institutional context

471. Service documents were given to our Inquiry, which provide an institutional context. A local audit of the Care Programme Approach on behalf of the statutory service providers in Harrow, undertaken in 1993, used the classification "Caucasian" and otherwise identified people from "ethnic minority groups" as "Asian" or "Afro-Caribbean". In 1995, the Audit Commission review

sought to assess the extent to which Harrow & Hillingdon Healthcare NHS Trust's strategy for mental health services was based on a "sound estimate of need" and "comprehensive range of services, in terms of client group, level of need and geographical location". The statutory authorities accepted the subsequent Report, yet in none of the 150 page Report's analysis, findings, recommendations and subsequent action plans, was mention made of racial and cultural diversity.

472. An Operational Policy on Services for Mentally Disordered Offenders, introduced in December 1995, stated that the 'needs-led' scheme "is committed to providing a high-quality service to all individuals **regardless** of their age, gender, ethnic origin, disability, sexual orientation, religious beliefs or cultural background." Although intended as an anti-discrimination statement, the term "regardless" is unfortunate as it can be construed as services being indifferent to, rather than sensitive to, diversity.

473. In 1996, a report was published by Brent Irish Advisory Service on the Irish experience of mental health services in the neighbouring borough of Brent. The Joint Consultative Committee for Harrow commissioned the same agency to research the community care needs of the Irish Community in Harrow. Both reports highlighted a general lack of awareness amongst the statutory services about Irish issues. The Harrow report concluded that resistance to acknowledgement of the Irish community as distinct from the host community, results in a tolerance of exclusion and inequity in service provision for Irish people.

We recommend that:

a. **Brent & Harrow Health Authority require forensic psychiatric service providers to use the same methods for denoting ethnicity as used by community mental health service providers;**
b. **Harrow Council, Brent & Harrow Health Authority and Harrow & Hillingdon Healthcare NHS Trust include evidence from Irish studies in staff training programmes;**
c. **Quality assurance monitoring reports include analysis of the number of Care Programmes by ethnic classification of service users.**

RECORDS AND RECORD KEEPING

474. This section looks at the systems of records and record keeping, the extent to which they were accessible, and the overall standards. The following issues will be considered:

- The types, location and access of different records relating to WM
- The standards of record keeping

The types, location and access of different records relating to WM

a) There were numerous different sets of records relating to WM. During our investigation of the circumstances, we had access to the following records:
   - Northwick Park Hospital file containing in-patient, day hospital, and outpatient notes
   - East Team Community Mental Health Team file containing fieldworker notes and entries from the Mentally Disordered Offenders (MDO) scheme co-ordinator
   - Harrow Social Services computerised (CARES) system
   - Depot clinic records
   - Bentham Unit file
   - Harrow Community Drug and Alcohol Service File
   - GP file
   - Probation Service file
   - Wormwood Scrubs Prison file
   - Network Housing Association file

475. Only the panel, with WM's consent, has had access to all of the above. Thus, as so often happens, it is only after an incident such as a homicide that all the relevant records on a patient are brought together to complete the picture. The need for a system to link together the various recording systems in hospital, clinic, community team and primary health care settings is obvious – new technology can bring enormous benefits. In the context of joint community care teams, Social Services and Health records are already integrated. Since Housing is an essential service provider in the context of community care, and Health, Housing and Social Services have common basic information requirements, then, with user consent, their records should also be integrated.

476. As it is, the convention of passing copies of reports or letters among professions is still the most wide spread method of information exchange between professionals involved in an individual's care. Our review of files shows that there is a strong culture of sending copies of letters and reports between agencies on a need to know basis. Thus for example, a report to the GP following an out-patient attendance or for a court, would often be copied to the community nurse, the social worker, the probation officer (if relevant) and the MDO Scheme co-ordinator. Even if the role of these professionals in receiving this information was not clarified, the information was at least passed on.

477. Although WM was someone whose whereabouts frequently changed, there was good liaison between the agencies except with Housing. Liaison between the criminal justice system and the mental health services was undoubtedly assisted by the functions of the MDO scheme co-ordinator. However, WM's change of circumstances were not recorded in any systematic way.

Standards of record keeping

478. It was apparent to the panel as we perused the Health and Social Services records that record keeping was not always to a good standard. Defects included errors in identifying the patient; confusing WM with other patients of similar name; mistakes over the month and year; failures to amend records to ensure the correct home address; wrong General Practice and mis-filed records.

479. Mental Health/Community Care screening proforma was not used in response to referrals about WM to facilitate on going needs assessment.

Patient identifier

480. One of the specific areas identified for further investigation by Harrow & Hillingdon Healthcare NHS Trust (4 July 1997) was the mis-filing of clinical notes, and the fact that many pieces of clinical information frequently do not contain the patient identifier or date of birth. The Trust Board was informed that a review of the use of the patient identifier and date of birth would be conducted immediately, the results published and the Management Team and Division of Psychiatry would agree a protocol for the use of patient identifier/date of birth by all members of staff writing in clinical notes.

481. The Director of Elderly Care and Mental Health Services (at the time of the incident) told the panel that following the review of the patient identifier, there was now in place the use of an adhesive patient information slip. The slip was attached to all patient records, as well as the new national health number. The matter was reported back through the Division of Psychiatry to ensure that all clinicians and their secretaries were aware of this process, so that when letters come in, they are given the correct identification. The Director informed the panel that the mental health audit review during the next twelve months would probably include an audit of record keeping.

Missing records

481. It was not until after the review commissioned by the Healthcare Trust had been completed (May 1997), that the notes of the s117 meeting held on 26 January 1995 about WM came to light. They had been mis-filed in the records of a patient with a similar name.

482. On 27 February 1997, the medical team meeting reviewed WM's visit to the hospital the day before. The clinical notes of Dr. D state:

> "to duty Dr. in NPH (?where are the notes)"

Whereabouts of a patient

483. The Community Mental Health Team file showed WM's flat as his home address, but he spent substantial periods of time with his mother - a fact known to his consultant psychiatrist. Accordingly, on 24 January 1996, Dr. D wrote to WM offering an appointment on 2 February for interview for a court report. The letter was sent to both WM's and his mother's addresses. In fact, Dr. D had been informed by the probation officer that WM had been remanded, but the communication did not make clear where WM had been remanded to. Dr. D

interviewed WM in Wormwood Scrubs Prison. Omissions of detail and dependence on local knowledge by individual practitioners may be a reflection of a pressured working environment.

Wrong GP

484. There are many examples of letters being sent to the WM's former GP long after he had moved and registered with another GP (17 November 1993). The change in GP was known to the community mental health team. On 8 June 1994, a letter was sent to Dr. R, GP, from Dr. D following an outpatient review of WM on 6 June 1994. This mistake was later noticed, and the same letter is sent to the correct GP, Dr. T, on 5 July 1994. However, a discharge summary prepared by a senior house officer under Dr. D (14 September 1994) was again sent to the former GP, Dr. R . The Practice records note in handwriting that WM was "not [on] our list". Dr. D reviewed WM in outpatients on 10 October 1994, and the subsequent letter was sent on 12 October 1994 to Dr. R, GP. The letter seen by the Panel contains a hand-written note "not our list" and the address was also changed in handwriting. Dr. D's letter following the outpatient review on 14 November 1994 was also sent to the wrong GP - a year after the GP had been changed.

485. Hospital and community staff working under considerable pressure need to be supported by reliable comprehensive record keeping systems. The task is made more difficult when the patient is part of a large family with similar names, and frequently changes address or moves in with relatives. The continuity of care, and awareness of issues arising with other agencies can be improved with better sharing and access to other record keeping systems, and good administrative support.

We recommend that:

a. **Harrow Council and Harrow & Brent Health Authority give priority to the development of an integrated record and information system across all mental health service sites**
b. **Harrow Council and Harrow & Hillingdon Healthcare Trust ensure that service user consent is encouraged for information sharing between the mental health services and housing services, particularly to facilitate notification of change of personal circumstances**
c. **Ensure that standards for record keeping are set and that management systems are in place for audit purposes, and**
d. **Ensure that a quality assurance system is in place for correspondence addresses, particularly appointment letters to service users and reports to GPs.**

PART THREE :CONCLUSIONS AND RECOMMENDATIONS

Conclusions

486. WM did not plead diminished responsibility at his trial, and all the psychiatrists who examined him after the offence have been in agreement that his mental illness was not a direct cause of the homicide. It is more likely that his substance abuse played a major part in his attack on the victim.

487. The appointment of this Independent Inquiry was in accordance with Health Department requirements under Circular HSG (94)27. We have concluded that there were failings in the provision of services to WM and his main carer - his mother - and that central and local guidance was not always followed in his care and treatment. Since WM's mental illness was not the cause of the homicidal behaviour, it cannot be said that had these weaknesses and failings in the statutory services not occurred, the homicide would have been prevented. However, in outcome, interventions by health and social services, and criminal justice agencies, were ineffective - a holistic and collectively strategic approach may have had greater impact. Our recommendations embody lessons from this Inquiry and their implementation should ensure a better quality of service delivery to people suffering from mental illness who misuse alcohol and/or drugs, and to their carers.

We recommend that:

1. **Whenever a medical member of a clinical team assesses a person at their, and their carer's urgent request for psychiatric hospital admission,**
   a. **A consultant psychiatrist (or deputy i.e. Senior Registrar) is consulted before a decision concerning admission is taken, and**
   b. **There is follow-up action to ensure that a community care assessment is undertaken by a Community Mental Health Team.**

2. **Harrow & Hillingdon Healthcare NHS Trust and Harrow Social Services should ensure that any history of alcohol and/or drug misuse is included in all risk assessment processes.**

3. **Peer review (i.e. request for review by another consultant) should be considered in cases of protracted unresponsive patients – particularly those (like WM) who have escalating levels of antisocial/disorganised behaviour in the community.**

4. **Individuals who have co-morbidity problems (that is, mental illness, substance misuse and criminal behaviour), should receive an enhanced care programme which is based on multi-disciplinary and multi-agency assessment; and care co-ordinators should ensure that joint reviews are undertaken, at least six monthly.**

5. **Harrow Council and Brent & Harrow Health Authority should review their joint guidance on the implementation of their duties under s117 of the Mental Health Act 1983,**
   and
6. **Ensure that adequate resources (staffing levels, training and information systems) are made available to support the Modernised**

Care Programme Approach national policy guidance. and significantly improve implementation performance compared to 1991.

7. Harrow & Hillingdon Healthcare NHS Trust and Harrow Social Services should ensure that quality assurance monitoring is in place and that the statutory provisions relating to the needs of carers, and standards set under the National Standards Framework for Mental Health, are properly implemented.

8. Harrow & Hillingdon Healthcare NHS Trust should review the provision of clinics for depot medication in the light of the findings from this Inquiry.

9. Members of Harrow & Hillingdon Healthcare NHS Trust and members of Harrow Social Services Committee should ensure that quality assurance monitoring is in place, and that the statutory provisions relating to the assessment of the needs of carers are implemented.

10. Harrow & Hillingdon Healthcare NHS Trust and Harrow Social Services should ensure that Department of Health Circular LAC(93)2 and subsequent central guidance on drug and alcohol misuse issues relating to community care assessments and service provision are being fully implemented, and that past barriers to service provision identified in this Inquiry have been removed;
And
11. Ensure that all staff working in specialist mental health services and community Drug and Alcohol Services have access to regular evidence-based training on substance misuse and risk assessment;
And
12. Put in place monitoring of the use of the new powers to deal with drug offenders;
And
13. Develop joint strategies in conjunction with primary care and voluntary agencies to overcome the cycle of short-term in-patient admissions followed by a return to drug and/or alcohol misuse for certain individuals like WM.

14. Middlesex Probation Service should ensure that its staff only propose to courts the making of a Community Service Order for a person suffering with a mental disorder, after consultation with the appropriate specialist medical staff from the mental health services.

15. Harrow Council should ensure that its Housing Department and all local Social Landlords consult with the mental health services prior to issuing a Notice to Quit to a tenant who has complex needs.

16. Harrow Housing and Social Services, and Harrow & Hillingdon Healthcare NHS Trust should take into account the findings of this Inquiry when producing a joint local Charter for people in need of on-going support and their carers.

17. Harrow Social Services and Harrow & Hillingdon Healthcare NHS Trust should ensure that housing representation is considered by staff for care programme review meetings.

18. Harrow Council and Harrow & Brent Health Authority should give priority to the development of an integrated record and information system across all mental health service sites.

19. Harrow Council and Harrow & Hillingdon Healthcare NHS Trust should ensure that service user consent is encouraged for information sharing between the mental health services and housing services, particularly to facilitate notification of change of personal circumstances;
And
20. Ensure that standards for record keeping are set, and that management systems are in place for audit purposes;
And
21. Ensure that a quality assurance system is in place for correspondence addresses, particularly appointment letters to service users and reports to GPs.

22. Brent & Harrow Health Authority and Harrow Social Services should review operations to ensure that the co-operation of voluntary agencies with a contribution to make towards people with mental health needs who misuse drugs and alcohol is being sought pursuant to s117 of the Mental Health Act 1983.

23. Brent & Harrow Health Authority should require forensic psychiatric service providers to use the same methods for denoting ethnicity as used by community mental health service providers;

24. Harrow Council, Brent & Harrow and Health Authority, and Harrow & Hillingdon Healthcare NHS Trust should include evidence from Irish studies in staff training programmes;
And
25. Quality assurance monitoring reports should include analysis of the number of Care Programmes by ethnic classification of service users.

26. We recommend that the Department of Health should consider the preparation of national guidance on the care of those mentally disordered offenders who abuse substances.