

**THE INDEPENDENT REVIEW INTO THE
CARE AND TREATMENT OF MR ANTHONY HARDY
SEPTEMBER 2005**

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Preface

The independent review of the care and treatment of Anthony Hardy was commissioned by North Central London Strategic Health Authority and the London Borough of Camden with the support and cooperation of the Metropolitan Police. It was commissioned in accordance with guidance published by the Department of Health in circular HSG(94)27, *The Discharge of Mentally Disordered People and their Continuing Care in the Community*.

The **Terms of Reference** are as follows:

Stage 1 - Fact Finding

- 1 to report on the treatment, care and housing services provided to Anthony Hardy by the NHS and Local Authority from 18 January 2002 (the time of the first murder) until his arrest on 2 January 2003, in the context of his previous history

Stage 2 - Evaluation

- 2 to assess the suitability and appropriateness of those services in view of the patient's assessed health, social care and housing needs and previous history
- 3 to review the extent to which those services, and the decisions of the mental health act managers, corresponded with statutory obligations, relevant national guidance and local operational policies and to identify any deficiencies
- 4 to examine the adequacy of inter-agency collaboration between the NHS, Local Authority and the police and the effectiveness of communications with/between all agencies who had contact with Anthony Hardy
- 5 to make recommendations to the responsible bodies so that, as far as possible in similar circumstances in the future, harm to patients, staff and the public is avoided

Approach

The panel will conduct its work in private and be expected to take as its starting point the internal management inquiries supplemented as necessary by access to source documents and interviews, as determined by the panel. The panel is

encouraged to seek to engage actively with relatives of the victims, as well as others (eg. staff), who are identified as key contributors to their work.

It will follow established good practice in the conduct of interviews, for example offering the opportunity for interviewees to be accompanied and given the opportunity to comment on the factual accuracy of notes.

Timetable

The precise timetable will depend on a number of factors, including the panel's own assessment of the need for information and the number of interviews necessary. The panel is asked to have completed the review, or a substantial part of it, within six months of starting work. Monthly reports on progress should be provided to the Strategic Health Authority and the London Borough of Camden.

Publication

The outcome of the review will be made public. The nature and form of publication will be determined by North Central London Strategic Health Authority and the London Borough of Camden. The decision on publication will be taken in consultation with the Metropolitan Police and will take into account the view of the chair of the review panel, relatives and other interested parties.

Panel Membership

The panel was chaired by Robert Robinson, a solicitor specialising in mental health law. He is also a legal member of the Mental Health Review Tribunal and a former Mental Health Act Commissioner. Mr Robert Robinson has chaired previous independent inquiries into the care and treatment of mental health service users following a homicide.

He was joined by Ken Coleman, a former assistant director of social services for the London Borough of Westminster who has held senior positions in North West Thames Regional Health Authority and Brent & Harrow Health Authority. He is a member of the Care Standards Tribunals and the Mental Health Review Tribunals and has sat on two formal inquiry panels.

Professor Tom Sensky, a Professor of Psychological Medicine and a consultant psychiatrist, was also a member of the panel. He chaired the Royal College of Psychiatrists' Special Working Party on Clinical Assessment and Management of Risk

and been a member of an independent homicide inquiry. He has a long standing interest in evidence-based practice and has run workshops and seminars on this both nationally and internationally.

Mary Walker was project manager for the review. She is an associate of Verita, a specialist consultancy service that helps public sector organisations in the management and conduct of inquiries, investigations and reviews. Ms Walker has held senior positions in social services and has worked for the Social Services Inspectorate. She has also acted as a panel member for other independent reviews.

Chapter 1 Introduction

1. Overview

1.1.1 This Inquiry was established in July 2004, because in 2002 Anthony Hardy killed three women in his flat in Camden. He killed Sally White, who was 38, on 19th or 20th January. He killed Elizabeth Valad, who was 29, on 19th or 20th December. He killed Bridgette Maclennan, who was 34, on 24th or 25th December.

1.1.2 On 25th November 2003 Mr Hardy, then 52, pleaded guilty to murdering the three women. He was sentenced to life imprisonment.

1.1.3 Sally White's body was found by the police in Mr Hardy's flat on 20th January 2002, when they came to arrest him for pouring acid from a discarded car battery into a neighbour's flat and painting grossly offensive graffiti on her front door. He was remanded in custody. A post-mortem examination showed that Sally White's death was due to cardiovascular disease. A Coroner's inquest subsequently concluded that she had died of natural causes. As a result, Mr Hardy was not prosecuted in connection with her death. He was eventually transferred from prison to a psychiatric unit and detained under section 37 of the Mental Health Act. He had a history of mental illness, and was well known to the clinical team who treated him.

1.1.4 Mr Hardy remained an in-patient for some months. During this time, the team caring for him continued to have concerns about his risk to others. Apart from a brief period in July 2002, he showed no signs of any mental state abnormalities. During the admission he sought help in overcoming his long-standing problems with alcohol, and was referred to specialist alcohol services, but he continued to drink alcohol. He was discharged from section 37 by the hospital managers in early November. He then returned home, initially on leave. Following a discharge planning meeting, which took place in mid-November, he left hospital.

1.1.5 Within six weeks of leaving hospital Mr Hardy killed Elizabeth Valad, and a week later he killed Bridgette Maclennan. After killing them he cut up their bodies for disposal. It was the discovery of body parts in a refuse bin on 30th December 2002 which led to his arrest.

1.1.6 We know that each of his three victims agreed to go with Mr Hardy to his flat and to have sex with him, but it is not known how he killed them. In so far as he has said anything at all about the murders, his account is impossible to believe and inconsistent with his guilty pleas. The explanation he gave to psychiatrists who assessed him while he was on remand in 2003 was that Elizabeth Valad and Bridgette Maclennan suffocated under the weight of his body after he fell asleep during bondage sex. He told the same psychiatrists that because he was so drunk at the time, he had not even known that Sally White was in his flat on 19th/20th January 2002 and he was therefore unable to say how she died.

1.1.7 In the context of this Inquiry into the care and treatment Mr Hardy received from Mental Health Services during 2002, it is clearly relevant to consider whether he was suffering from symptoms of mental illness when he committed the three murders. The conclusion we have reached, the evidence for which is to be found elsewhere in this report, is that Mr Hardy's diagnosed mental illness is of no relevance to the offences. This was also the view of Dr K, consultant forensic psychiatrist, who assessed him in 2003. In his report, which was written before the guilty pleas were entered, Dr K offered the following explanation:

"I believe the onset of diabetes with its subsequent sexual dysfunction was an enormous blow for the defendant to whom sexual activity has been so important throughout his adult life. His distress, anger and frustration at the diminution of his sexual prowess has been expressed in increasingly sadistic sexual activity, particularly when under the influence of alcohol. If the jury accept that the defendant did in fact intend to kill or seriously harm his three victims, then I believe the offending is linked to the defendant's sadistic personality, his intoxication with alcohol and his rage at his sexual dysfunction induced by diabetes."

While the fact that three women died in similar circumstances rules out any reasonable possibility that their deaths were accidental, Mr Hardy's guilty pleas amount to a conclusive admission that he acted intentionally and that he knew what he was doing. We agree with Dr K's analysis. Mr Hardy killed his victims

because he achieved a satisfaction in the actions which resulted in their deaths that he had not been capable of achieving through other sexual activity.

1.1.8 It is well recognised that when faced with tragic events, people try to make sense of them. Events like the three murders which led to this Inquiry demand explanations in order to restore confidence that day to day living is indeed safe. More particularly, there is a very strong urge to find someone to blame. If someone can be found blameworthy for not recognising what was going to happen, this could go some way to reassuring those most directly affected by the tragic deaths, as well as the general public, that something similar would never happen again.

1.1.9 When someone who murders has a history of mental illness, the media commonly attribute the former to the latter, even in the absence of any clear evidence. This problem is compounded by the well-meaning but potentially misguided efforts of pressure groups seeking to use such tragedies to argue the case for better care for the mentally ill. Both reporting in the media and the action of pressure groups just described serve to reinforce the view that mental illness was responsible for the murders, and that, were it not for inadequacies in the treatment the individual received, the tragic outcomes would have been averted. Clearly, each case must be considered separately, but overall it remains true that the most murders are committed by people who do not have mental illness, and those with mental illness are much more likely to be the victims of violence than its perpetrators.

1.1.10 Having investigated the circumstances of Mr Hardy's care in great detail, our conclusion, even with the benefit of hindsight, is that Mr Hardy alone was responsible for his actions. We acknowledge that this conclusion provides a very limited answer to the questions which are in people's minds.

1.1.11 It is clearly the responsibility of an inquiry such as this to scrutinise with the utmost care every aspect of the perpetrator's psychiatric history in the search for answers. Our experience has been that the evidence in this particular case calls into question widely shared assumptions about the capacity of mental health professionals to predict and manage aberrant behaviour. The three assumptions we have in mind are: first, that depravity is in itself a manifestation of mental disorder and therefore properly a matter for psychiatric intervention; second, that unlike other forms of violence, violence that occurs among people with mental disorder is

predictable by psychiatrists; and third that, if they are performing properly, psychiatrists, or more generally Mental Health Services, are able to prevent people who suffer from mental disorder committing acts of violence.

1.1.12 With regard to the first assumption, the sense in which it is true is that depraved behaviour is evidence of an aberrant personality, and psychiatry interests itself in disorders of personality. But psychiatrists define and limit, by the use of diagnostic criteria, what they regard as a personality disorder. In so far as psychiatry interests itself in abnormalities of personality it generally does so with a view to treatment. In Mr Hardy's case, as we discuss in the chapter of this report on personality disorder, those who assessed him found that he neither met the diagnostic criteria for antisocial or dissocial personality disorder, nor were his abnormalities of personality amenable to treatment. When looking at a single case where there has been a tragic outcome it is tempting, with hindsight, to infer that the abnormalities of personality, which were manifested in the perpetrator's actions - in Mr Hardy's case when he killed his three victims - were present at an earlier date. The logic of the argument is that had mental health professionals taken note of what should have been apparent to them, they could have intervened to prevent him acting as he did. This argument, if it is to have any force, depends on an unstated premise: that the features of his personality that were, or should have been, apparent before he committed the three murders, or at least before he committed the second and third murders, were predictive of homicide such that psychiatrists would have been justified in detaining him, possibly indefinitely, to prevent him from committing murder.

1.1.13 This takes us to the second and third assumptions.

1.1.14 If acts of violence, and specifically homicide, were predictable with a high degree of certainty, not only psychiatry but the whole criminal justice system would surely operate according to different principles. In looking retrospectively at a case from the vantage point of certainty about the outcome, there is a risk that one wrongly attributes a predictive quality to facts that were known before the tragic outcome. Specific features of mental disorder can under some circumstances increase the risk of violence to others. However, it does not follow that all, or even most, violence can be explained by mental state abnormalities attributable to mental disorder. Most murders are committed by people who have no mental illness. We have concluded that mental illness was not a contributory factor in

these three murders. Our view is that Mr Hardy's violence was no more predictable than is most other criminal violence, committed by people who have no psychiatric history.

1.1.15 The third assumption draws not so much on the notion of the predictability of violence but on the fact that society invests psychiatrists, and Mental Health Services generally, with legal powers and resources which enable them to detain and treat those who are mentally disordered and potentially violent. The assumption is that treatment properly administered will reduce the risk of violence and that until the risk is sufficiently reduced the necessary legal powers of detention are available and should be used. This has a particular resonance in Mr Hardy's case, given how soon after he was discharged from detention under the Mental Health Act he killed his second and third victims. Mr Hardy was detained because he was assessed as being mentally ill and in need of treatment for mental illness. It is not the proper role of Mental Health Services to contain people who may be violent but whose violence is not connected to the mental illness for which they are being treated. If society wishes to detain people who are thought to be potentially violent, or otherwise to manage them so as to reduce the risk that they will behave violently, this is distinct from psychiatric treatment.

1.1.16 In scrutinising an individual case in great detail, it is almost inevitable that shortcomings in the patient's care and treatment will be identified. When any failings in care are discovered, there is a temptation to attribute the tragic outcome to these. This assumes that with perfect care by the clinical team, and infinite resources at their disposal, the homicides would have been prevented.

1.1.17 We have criticisms of Mr Hardy's care and management. We have examined particularly carefully the possibility that the aspects of his care we criticise could have contributed to increasing the likelihood that he would commit homicide. However, we can find no justification for making a causal link between any of the shortcomings we have identified and the outcome. Furthermore, with the benefit of hindsight, we cannot identify any interventions consistent with good clinical practice that were likely to have altered the outcome. In referring to the outcome for this purpose, we are not thinking specifically of the three victims and the precise circumstances in which they died, but of Mr Hardy's motivation to kill and the opportunity for him to do so.

1.1.18 The comparison we would make is with a case where someone's dangerousness is linked to a disturbed mental state in the context of a treatable mental illness. In such a case there may be a causal relationship between a failure to treat the illness and the patient's actions, such that had the illness been treated the patient would not have acted dangerously. This is not such a case. We consider that the only way to have prevented Mr Hardy from offending would have been to detain him where he would not have had access to potential victims. That is an easy proposition to formulate but it would not have been possible to justify such an approach on the basis of what was known at the time.

2. Inquiry Process

1.2.1 This Inquiry was established in July 2004. The panel interviewed Mr Hardy in prison in July 2004. Thereafter evidence was taken from 31 witnesses during the period from July 2004 to February 2005. The witnesses included a woman who had been assaulted by Mr Hardy and Elizabeth Valad's mother. We are grateful to all those who gave evidence, for some of whom it was a difficult experience to recall the dreadful events which are briefly described above. The Inquiry was also assisted by expert evidence from Professor Anthony Maden, Professor of Forensic Psychiatry at Imperial College and an Honorary Consultant at the West London Mental Health NHS Trust, where he is the Clinical Director and Consultant in the Dangerous and Severe Personality Disorder Service. In addition to oral evidence, the Inquiry received documents from a number of sources including:

- Camden and Islington Mental Health and Social Care Trust
- London Borough of Camden
- Metropolitan Police
- Crown Prosecution Service

This report was drafted between January and July 2005.

3. Structure of the Report

1.3.1 We took the decision not to identify any of those referred to in this report, with the exception of Mr Hardy himself, Sally White, Elizabeth Valad, Bridgitte Maclennan and Professor Maden. This is because of the publicity this case has attracted and our wish to ensure that individuals are not singled out for personal criticism which could be stressful for them and potentially unfair. If it is suggested

that there is a public interest in naming any of the people referred to in this report, this is a matter which in our view should be decided by those who commissioned the Inquiry.

1.3.2 The report begins with a narrative chapter, covering the period 20th January to 30th December 2002. This is based largely on medical notes and other contemporaneous records, including police statements, supplemented by the written and oral evidence to this Inquiry.

1.3.3 The ten chapters which follow (chapters 3 - 12) are thematic. In each we take a separate aspect of the case, discuss the issues raised and draw conclusions. We have placed the thematic chapters in alphabetical order, but they can be read in any order. We have tried to help the reader by including cross-references between thematic chapters and back to the narrative chapter.

1.3.4 Our recommendations, which follow from the discussion and analysis in the thematic chapters, are in chapter 13. There is then, in chapter 14, a summary of the report. It may assist readers to start with the summary, which provides a comprehensive overview, before reading the individual thematic chapters. The summary is followed by a number of appendices, including a key to the people referred to by initials in the body of the report and a glossary.

Chapter 2 Narrative

20th January 2002 - 30th December 2002

1. Introduction

2.1.1 In this part of the report we recount the significant events and developments during the period from Mr Hardy's arrest on 20th January 2002, for criminal damage and the suspected murder of Sally White, until 30th December 2002, when police found the dismembered bodies of Elizabeth Valad and Bridgitte Maclennan.

2.1.2 Information about Mr Hardy's psychiatric history can be found in Chapter 8 Mental Illness. His history of violence and of criminal offending is summarised in Appendix 3 Forensic History. His engagement with community mental health services in the period preceding these events is covered in Chapter 4 Community Mental Health Services.

2. Arrest and Remand in Custody

2.2.1 At 06.40am on 20th January 2002 the police were called to a flat in Royal College Street London NW1. On the front door in large black letters was written "Fuck you, slut you're a cunt". The lower part of the door from the letter box down was wet with a clear liquid and at the foot of the door was a large pool of liquid which was bubbling. There was also liquid inside the door which had been poured through the letter box. A trail of drips and footprints led to the flat below, 4 Hartland. The police knocked on the door but there was no reply. They returned soon afterwards with other officers. The door was answered by the tenant, Mr Hardy.

2.2.2 Mr Hardy was questioned about the graffiti and the criminal damage to the flat above. He admitted that he had poured car battery acid through the letter box, using a plastic bottle which he had adapted to act as a funnel. He also showed police officers a can of black paint which he had used to write on the door.

2.2.3 While police were in the flat they asked him to let them into the bedroom, the door to which was locked. Mr Hardy told them it was his lodger's room to which he did not have a key.

2.2.4 He was arrested for criminal damage and handcuffed. A police officer handed him his jacket, which had been hanging on the back of the front door, and noticed something in the lining. It was a key. The officer tried it in the lock of the bedroom door, which it opened. Inside the bedroom the officers found the dead body of Sally White lying on the bed. She was naked. Her face was covered with a towel.

2.2.5 At this point Mr Hardy is described by the officers as going bright red and dripping with sweat. He was arrested on suspicion of murder.

2.2.6 Investigation of the bedroom found smudges of blood on one of the walls next to the bed. There was also blood on the pillows. Next to the bed there was a bucket containing warm soapy water and a sponge. The temperature of the water was 25 degrees Celsius compared with the ambient air temperature of 17 degrees Celsius. There were also clothes belonging to Sally White, including a hooded sweatshirt with a blood stain in the hood which corresponded to a small wound on her head. Some other clothing, including her tights and bra, had been cut into pieces, having apparently been removed from her body after she died.

2.2.7 The police were quickly able to establish Sally White's identity. At the time of her death she was 38 years old. She had last been seen alive the previous day, 19th January 2002, when she had attended the Manna Society in London SE1, a homelessness charity. She had been homeless for a number of years. It was known to the police that she had worked as a prostitute. The police believed that this was how she had met Mr Hardy.

2.2.8 Mr Hardy was taken to Kentish Town police station where he was questioned. He responded to all questions about Sally White with the words "No Comment".

2.2.9 On 22nd January Mr Hardy appeared at Highbury Corner Magistrates' Court, charged with criminal damage. He was seen at court by two psychiatrists and a social worker attached to the Psychiatric Diversion Team. He gave them the following account of events of 19th / 20th January:

"On the Saturday [19th January], he had drunk until he could drink no more, taking wine and beer as well as cider. He had previously filled the fridge with alcohol to make sure of his supply, and is not sure how much he had drunk. He states that he "blacked out" (as he had on

occasions in the past), but remembers pouring acid through the neighbour's door and daubing a slogan. He denies any memory of the woman in his flat. His account of his reasoning for the incident with the neighbour is that, when disinhibited through drink or manic, he becomes angry about an incident concerning water dripping through his ceiling from his neighbour's flat. He stated that he had been too depressed to approach her and had let the water drip until the council offices opened, the council had told him to write to her, and he had put a letter through her door she had done nothing, and then sent away a council plumber, stating that her flat was not a council flat. She had eventually been instructed by the housing manager to have the matter sorted out. Mr Hardy knew nothing of an earlier incident of a corrosive substance being poured through the neighbour's door last November, nor of various incidents with her car, but conceded he might have been responsible."

2.2.10 On mental state examination, he was found to be *"downcast and depressed, and at times he seemed on the verge of tears"*. The recommendation of the Psychiatric Diversion Team was that he was fit to be remanded in custody but that:

"Mr Hardy currently presents in a fragile state, still suffering from recent alcohol withdrawal, with depressive thoughts and ruminations consequent upon the situation in which he finds himself. He has active suicidal ideation and has been considering ways in which he might kill himself. Presuming that he will be remanded in custody today, he will need to be placed on constant watch ..."

He was taken from the court to Pentonville Prison, where he remained until his transfer to psychiatric hospital on 8th April 2002.

2.2.11 A post-mortem examination was carried out on Sally White by Dr Y, a consultant forensic pathologist. In his report, dated 31st January 2002, he concluded that her death was “consistent with natural causes”, and “was a result of coronary artery disease, which is the preponderant evidence”. The wound to the head was “consistent with a single blunt impact upon a stumble or collapse, and contact with the back of the head with a broad hard surface or the floor”. The wound had not caused her death. No other significant injuries were found. Examination of the cardiovascular system showed “severe coronary atheroma with 40-60% occlusion in proximal anterior branch”.

2.2.12 Following receipt of the post-mortem examination report, the Crown Prosecution Service decided in February that there was insufficient evidence to prosecute Mr Hardy for killing Sally White. This meant that the only charge was in respect of the criminal damage to the upstairs neighbour’s flat. He was willing to plead guilty to that matter.

2.2.13 While on remand Mr Hardy was seen on a number of occasions by forensic psychiatrists from the North London Forensic Service who provided a psychiatric in-reach service to the prison. On mental state examination, he was found to be depressed and suicidal. The forensic psychiatrists communicated with Dr E, who was Mr Hardy’s general adult psychiatrist in Camden. The decision was made in February to recommend to the court that he should be made subject to a hospital order, under section 37 of the Mental Health Act. Dr E’s preference was that he should initially be admitted to the Mornington Unit adult intensive care ward, rather than to Cardigan ward, which is an adult acute ward. This was agreed with Dr D, the Mornington Unit consultant psychiatrist. A nurse from the Mornington Unit assessed Mr Hardy in prison but while on remand he was not seen by a doctor from either the Mornington Unit or Cardigan ward.

2.2.14 On 12th March Mr Hardy attended Highbury Corner Magistrates’ Court where he was assessed by two psychiatrists from the Psychiatric Diversion Team. They signed medical recommendations for an order under section 37. The first recommendation described him as suffering from depression “with intrusive thoughts of self-harm”. Admission and treatment in hospital were said to be necessary “in the interests of his mental health and his safety”. The second recommendation referred to “prominent suicidal ideation” and recommended admission as a means of reducing the risk of suicide. Mr Hardy duly pleaded guilty

to the offence of criminal damage and a hospital order was made, directing that he be admitted to the Mornington Unit within 28 days.

3. Mornington Unit

2.3.1 On 8th April 2002 Mr Hardy was admitted to the Mornington Unit at St Pancras Hospital under section 37 of the Mental Health Act. The Mornington Unit is a psychiatric intensive care unit. The purpose of the admission was said to be for an assessment of his mental health and for risk formulation with forensic psychiatric input. When assessed by a psychiatrist on 8th April Mr Hardy said that he was feeling fine and that he had no thoughts of self-harm or suicide or of harm to others. He was seen on 9th April by Dr D, consultant psychiatrist, who found no symptoms of mental illness.

2.3.2 On 10th April he was described as subdued and slightly depressed. He said that he wanted to return to his flat. He agreed to a referral being made to the Alcohol Advisory Service and this was done on 18th April.

2.3.3 While Mr Hardy was a patient on the Mornington Unit, Dr D obtained from a service manager within the Trust, who had been involved at an earlier stage, some details of what the police had found on 20th January. The entry Dr D made in the medical notes on 25th April includes the following points: that Sally White's naked body had been found in a locked room; that Mr Hardy denied having keys to the room but they were found in his pocket; that a bucket and sponge were found; and that it was possible he had been trying to clean the body. Dr D was also told that there were marks on Sally White's body but that the post-mortem examination had concluded that she had died of natural causes.

2.3.4 On 29th April Mr Hardy was transferred from the Mornington Unit to Cardigan ward at St Luke's Hospital. The Mornington Unit discharge summary, prepared by Dr D, concluded that: "*Mr Hardy remained stable throughout his admission with no evidence of mental illness. He was granted increasing escorted leave. He spent a lot of time in bed and watching television.*" In relation to the suicidal thoughts that he had experienced while on remand, the discharge summary records that according to Mr Hardy these had stopped when he knew he was moving to hospital.

2.3.5 The discharge summary also contains Mr Hardy's account of the events of 19th/20th January. In relation to the criminal damage to the neighbour's flat, he is reported as having said that he had only a *"limited memory of the events due to alcoholic blackouts"*. He said that *"on the day of the incident he had drunk 6 litres of 7.5% cider which was his usual alcohol intake at the time. He had also drunk an additional bottle of wine"*. He said that he had found the car battery some days previously and poured its contents into a plastic bowl. He had described how he had cut the bottom off a plastic cider bottle and used it as a funnel to pour the battery acid through the letter box of the flat. He had also said that he had painted the graffiti on the door. However, as regards Sally White's body, he continued to claim that *"he had no knowledge of the woman or how she came to be in his flat"*. His account was not accepted by Dr D, who considered that his claim that he had suffered an alcoholic blackout was unconvincing and that his supposed loss of memory was inconsistent with the planning and execution involved in the criminal damage matter.

4. Cardigan Ward

2.4.1 On 30th April, the day after his transfer to Cardigan ward, Mr Hardy appealed to the hospital managers for discharge from section 37.

2.4.2 On 2nd May he was reviewed by the Cardigan ward consultant psychiatrist Dr E. He described himself as feeling well. When asked to explain the events leading up to his arrest on 20th January, he said that he had been drinking excessively after Christmas because he was feeling low. He then felt himself to be getting high in mood. He explained his actions towards the upstairs neighbour as resulting from anger towards her because of past problems with water leaking into his flat, but he said that it was because he had become manic in January that he behaved as he did. He told Dr E that he no longer felt any antipathy towards the neighbour. He offered no explanation for the presence of Sally White in his flat. Dr E's assessment of mental state was that Mr Hardy was euthymic, meaning that his mood was neither depressed nor elevated, and that he was not psychotic. Dr E granted him one hour's unescorted leave a day and, at Mr Hardy's request, he reduced the dose of antipsychotic medication (chlorpromazine), which was prescribed in addition to lithium. Dr E's impression, as recorded in the notes, was that:

“Mr Hardy appears euthymic. He described some manic symptoms and alcohol dependence at the time of the index offence; however, I note that psychiatric examination after the event did not reveal significant manic symptoms. His remorse for the events seemed superficial. There was harassment of his neighbour in the absence of significant mood abnormalities.”

Dr E’s plan was to keep him in hospital and to continue to assess him. He also decided to complete a full risk assessment and this was done that day.

2.4.3 The weekly summary dated 5th May reported that his mental state had been very stable with no evidence of mania or delusional thinking, and that on interview he was lucid and pleasant. It was said that he was quite quiet on the ward and isolated himself in his room, although he also attended some groups and was interested in occupational therapy. It was reported that he was using his leave as stipulated.

2.4.4 On 8th May he was granted eight hours unescorted leave from the hospital for the purpose of collecting the keys to his flat, which had been retained by the police, and for an appointment at the Alcohol Advisory Service. When he returned to the ward at 6pm he smelt of alcohol. He was unsteady on his feet and fell over, hitting his head. He was examined by a junior doctor and admitted drinking six pints of strong cider. Later he admitted that he had gone straight from the hospital to a pub and had missed his appointment at the Alcohol Advisory Service.

2.4.5 The following day all his leave was stopped. When he was reviewed by Dr E, he admitted drinking four litres of cider and said he had no recollection of coming back to the hospital.

2.4.6 The weekly summary for 11th May reported that he had remained stable in mental state with no evidence of mania, depression or delusions but that he was isolative. When he was reviewed a week after the drinking incident he accepted that he had a problem with alcohol, which he described as a psychological compulsion rather than a physical addiction. On mental state examination he was found to be neither manic nor depressed. His unescorted leave was reinstated.

2.4.7 Another appointment was made for him to attend the Alcohol Advisory Service, with a nurse escort, on 23rd May. He was also referred to a dual diagnosis group facilitated by Camden Mind.

2.4.8 On 23rd May he went out on leave escorted by a nurse. They briefly visited his flat where he collected some clothes and papers. He then attended the appointment with Mr V at the Alcohol Advisory Service, for an initial assessment.

2.4.9 On 28th May Mr Hardy returned from one hour's unescorted leave smelling of alcohol. On questioning he said that he had drunk one pint of beer. He was reviewed on a ward round by Dr E on 30th May. He confirmed his willingness to undertake further work with the Alcohol Advisory Service. He said that he felt that he was in limbo and did not know what to do to help himself. His unescorted leave was increased from one to two hours a day. Two days later, on 30th May, it appeared to a nurse that he had again been drinking alcohol while on unescorted leave as there was a smell of alcohol on his breath when he returned to the ward.

2.4.10 The weekly summary dated 3rd June recorded that his mental state appeared stable with no evidence of delusions or mania but that he was possibly slightly low in mood. It also reported that, following a discussion, he had told his primary nurse that he wanted to stop drinking altogether. He admitted that he had recently gone to a pub once or twice but said that he had not got drunk. It was recorded that although he was more communicative, he was still tending to isolate himself in his room with little interaction with other patients or staff.

2.4.11 He was granted additional unescorted leave to go back to his flat in order to be there, on 10th June, when the police returned property that had been removed as part of their investigation in January. He returned from six hours' unescorted leave without evidence of alcohol consumption.

2.4.12 He was next reviewed by Dr E at a ward round on 13th June. He said that he felt well. He was due to see Mr V at the Alcohol Advisory Service that afternoon. He said that his aim was to be able to drink small amounts of alcohol rather than complete abstinence. He requested periods of extended leave to enable him to visit his flat. Dr E increased his daily unescorted leave to six hours.

2.4.13 He attended the Alcohol Advisory Service on 13th June and on that same day an appointment was made for him to go the following week to be assessed for the

Camden Mind dual diagnosis group. The weekly summary dated 16th June recorded that he had remained stable in mental state, that he was spending most of his time in his room but was using his leave as agreed. On 19th June he attended the Camden Mind dual diagnosis group for the assessment.

2.4.14 On 20th June there was a Managers' Hearing of his application to be discharged from section 37. He was unsuccessful. The managers' reasons for refusing discharge were:

“We are satisfied that Mr Hardy is still suffering from a mental disorder the nature of which makes continued treatment in hospital appropriate. Community services to help him with his severe alcohol problem are not yet fully in place. The risk of relapse, leading to failure to take medication for his mental illness, is too great both in terms of risk to self and to others, given his history”.

Following the hearing he told nurses that he understood that before he could be discharged a structured programme would have to be set up in the community.

2.4.15 On the night of 22nd June, nurses believed that he had been drinking alcohol. He was unsteady on his feet and his speech was slurred. He initially denied it, but when challenged he admitted that he had been drinking. On 23rd June, in response to this incident, his leave was stopped. When he was seen by a doctor he admitted to drinking six litres of strong cider. He told the doctor that being drunk made him feel *“slightly manic, gregarious, generous”*. He complained that he was bored on the ward. No abnormalities were noted on mental state examination. He was further reviewed at a ward round on 24th June. His ground leave was restored and leave was also granted for him to attend the dual diagnosis group and the Alcohol Recovery Project. He attended the Alcohol Recovery Project for the first time on the 25th June. He was reviewed again on 27th June. He said that he found the Alcohol Recovery Project very helpful. Leave was granted for him to attend the Project's daily programme.

2.4.16 On 27th June Dr E wrote to Dr C, a consultant forensic psychiatrist at the North London Forensic Service, to request a forensic opinion on Mr Hardy. The letter asked for:

“Any advice you would like to offer about planning Mr Hardy’s discharge from hospital, particularly with regard to the risk he may pose towards his neighbour.”

In the letter, Dr E outlined his treatment plan as follows:

“My current plan is to maintain him on lithium. He has been engaged with an alcohol day programme in the community and he has been allowed increasing periods of leave during the day in the community. He has spent some periods of unescorted leave at his flat, with no problems reported. He expresses remorse about his behaviour towards his neighbour and has expressed no animosity towards her since being in hospital.”

Dr E also commented that:

“He seems well motivated to continue treatment with lithium and he has a good understanding of the symptoms of bipolar affective disorder.”

2.4.17 On 3rd July, when Mr Hardy returned from leave, it appeared to nurses that he was under the influence of alcohol. They noticed that he smelt of alcohol and was unsteady on his feet. He denied that he had been drinking. His room was searched and an empty cider bottle was found. He was breathalysed and tested positive. His leave was stopped.

2.4.18 He was reviewed by Dr E at a ward round on 4th July. On interview, there was no evidence of any manic or depressive symptoms. He explained his drinking the previous day by saying that he needed to get up the courage to speak to a woman with whom he wished to start a relationship. He said that he had drunk less than on previous occasions and that the alcohol had given him less pleasure than

normal. He felt that he did not have the coping mechanisms to deal with his drinking problem at that time. He also said that he was able to go for long periods without drinking and would then binge in response to stress. He described it as being like a camel crossing the desert. However, he was positive about attending the Alcohol Recovery Project and the dual diagnosis group. His leave was stopped for one week.

2.4.19 At that same ward round he was told that the team had been informed that the Housing Department wished to evict him from his flat. He understood this was because of his neighbour's concerns. He told Dr E that he had no hostile feelings towards her. It is recorded that he was shocked by this news because he had understood that he would be offered a transfer to a new flat.

2.4.20 Dr E completed a new Full Risk Assessment form on 5th July. On that same day the ward was informed that Mr Hardy had been accepted for the Mind dual diagnosis group.

2.4.21 Mr Hardy was next reviewed at a ward round on 8th July. He was given one hour's unescorted leave each day and also leave to attend the Alcohol Recovery Project and the Mind dual diagnosis group.

2.4.22 On 12th July he attended the creative workshop in the occupational therapy department and decorated a glass bottle with the words "Sally Rose White R.I.P.". The weekly summary dated 14th July reported that there had been an incident on 2nd July when he had been abusive to another patient but that overall he was pleasant, settled, communicative and compliant with treatment. He was reviewed at a ward round on 15th July. He reported that he had received a Notice of Seeking Possession from the Housing Department telling him that possession would be taken of his flat on 12th August.

2.4.23 On 18th July he went out on leave to attend the Alcohol Advisory Service. He did not return on time and when nursing staff contacted the Alcohol Advisory Service they were told that he had not attended that day. When he did return to the ward, 45 minutes late, he said that he had not been aware of the appointment at the Alcohol Advisory Service and had instead attended the Alcohol Recovery Project. This explanation was accepted. Later that evening it was noted that his breath smelt of alcohol. When he was questioned about this he admitted that he

had been drinking alcohol in his room. His leave was stopped. A telephone call to the Alcohol Recovery Project confirmed that he had indeed attended there.

2.4.24 On 19th July he talked to his primary nurse about alcohol:

“admitted openly that can stop drinking. Likes the effect of alcohol. Makes him feel good and sociable. Apparently had been drinking yesterday since morning. Wants help to stop drinking.”

2.4.25 On 22nd July he was reviewed at a ward round which was also a Care Programme Approach (CPA) meeting. It was attended by Mr V from the Alcohol Advisory Service and also by Mr R, his care co-ordinator, as well as by clinical staff from the ward. The meeting reviewed his involvement with alcohol services. It was reported that he was aiming for controlled drinking. His request to be prescribed Antabuse was considered but it was decided that it should not be prescribed. His housing situation was also reviewed. The notes of the CPA meeting record that he was being formally evicted by Camden Council and that he had sought legal advice to challenge this.

2.4.26 It was noted on this occasion that his mood appeared hypomanic. He was prescribed sodium valproate, as an additional mood stabiliser, and he consented to this. Because of concerns about his mental state, the decision was made not to reinstate his community leave but to restrict him to the hospital grounds for the next week.

2.4.27 On 23rd July he was seen by Dr B, Specialist Registrar to Dr C, from the North London Forensic Service. It is recorded in the medical notes by Dr B that *“a report i.e. risk assessment will be sent to Dr E in the next one to two weeks”*. After the interview with Dr B, Mr Hardy approached nursing staff to request access to his medical and nursing notes. He told them that he *“wants to have some facts changed”*. He was advised to speak to Dr E about access to his medical and nursing notes.

2.4.28 He was next reviewed at a ward round on 25th July. He asked why he had been started on sodium valproate. It was explained to him that:

“we did not think that Tony was in a manic episode, however it was difficult to know exactly when there were slight symptoms of mania. It was explained that valproate / valproic acid in combination with lithium was effective in mood stabilisation.”

He also wanted to know why a forensic assessment had been sought and it was explained to him that this was normal where someone had been convicted of an offence. He repeated his request for access to his notes and was told that Dr E would have to review them first but then he would be permitted to read them on the ward. He was told that if he wanted access to the North London Forensic Service’s notes he would have to apply direct to them.

2.4.29 The weekly summary dated 26th July reported that he remained settled in mood with no behaviour to suggest any perceptual delusional disturbances and that his behaviour had been appropriate. He was next reviewed at a ward round on 29th July. His leave to visit the Alcohol Recovery Project on Tuesdays, Wednesdays and Thursdays was reinstated. It was noted that on Mondays and Fridays he was occupied in the hospital with ward activities and occupational therapies. On mental state examination, he was noted to be calmer and less irritable than the previous week.

2.4.30 On 30th July he spoke to a nurse about his relationship with a twenty-five year old married woman whose husband was in jail. He complained about sexual dysfunction, specifically impotence problems which he attributed to diabetes. He also complained that he had experienced a loss of libido since starting on sodium valproate.

2.4.31 On the night of 1st August, nurses smelt alcohol on his breath and he was noted to be unsteady on his feet. He was advised to go to bed. He did so and slept. In response to this incident the junior doctor on the ward made an entry in the notes the following day:

“If there are any suspicions that Tony has been drinking alcohol then he should be breathalysed. If results positive then leave should be stopped.”

That same evening it was noted by his primary nurse that his speech was a bit slurred but Mr Hardy denied that he had drunk any alcohol. He was not breathalysed on that occasion.

2.4.32 The weekly summary dated 2nd August reported that he was stable in mood and that there was no behaviour to suggest any abnormality in mood, although staff suspected that he was continuing to drink alcohol. At the ward round on 5th August Dr E considered the nursing reports that Mr Hardy had been drinking alcohol. The decision was made to institute random breathalysing. On 6th August when he returned from leave to the Alcohol Recovery Project he was breathalysed and the result was negative. He was breathalysed again on returning from leave on 8th August. Again the result was negative. The weekly summary dated 12th August reported that he had remained settled in mood and mental state. At the ward round on 12th August his leave was increased to include six hours' unescorted leave on either Saturday or Sunday, but not both, and four hours' unescorted leave on Friday.

2.4.33 On 19th August the Senior House Officer on Cardigan ward referred Mr Hardy to a consultant in connection with erectile impotence.

2.4.34 The weekly summary dated 26th August recorded that his mental state remained stable and that no manic symptoms had been observed since he was started on sodium valproate. There was also no evidence of low mood or of recent alcohol use. It was reported that he was attending alcohol services and the Mind dual diagnosis group as well as his weekly timetable of activities on the ward and occupational therapy.

2.4.35 On 28th August he was seen by Dr C, consultant forensic psychiatrist, in connection with the forensic assessment. Immediately after meeting Dr C he sought reassurance from his primary nurse. He was concerned that Dr C had asked him about Sally White. He commented that it was a painful subject, “like waking up into a nightmare”, and he repeated what he had said previously that if he had believed he was responsible for Sally White’s death he would have wanted to kill himself.

2.4.36 On 30th August it was noted by nursing staff that his breath smelt of alcohol. This was not followed up. The following day he returned from leave smelling strongly of peppermints. He appeared unsteady on his feet but there was no smell of alcohol. No action was taken.

2.4.37 He was interviewed by Dr E on 2nd September. He said that he had no current symptoms of mood disorder. He told Dr E that he felt that he was in control of his feelings about alcohol. No changes were made to the care plan. When he returned from leave at 5.30pm on 5th September no evidence of alcohol was detected. However, at 10pm nurses smelt alcohol on his breath and he appeared disoriented. The following morning when asked about this he denied he had been drinking. The weekly summary dated 8th September recorded that he had remained stable in mental state but that he had used alcohol recently on two occasions.

2.4.38 On 10th September he failed to return from his leave. He was treated as absent without leave and his details were passed to the police. This was in accordance with Trust policy. Enquiries were made of the Alcohol Recovery Project where he had been due to go that day. They said he had not attended. At 10am on 12th September he returned to the ward. He told nursing staff that he had wanted to take a holiday and had spent the night with a female friend. His leave was suspended until the next ward round. He was next reviewed at the ward round on 16th September. It was reported that he had been stable and settled on the ward. He was allowed daily unescorted ground leave of one hour.

2.4.39 On 20th September he was notified of the renewal of his detention under section 37 for a further six months, commencing on 12th September.

2.4.40 On 20th September he attended the creative workshop where he painted glass. It is reported that at one stage the female co-facilitator of the group touched a glass jar he had completed, leaving fingerprints. She apologised and he replied that:

“[it] was OK and when he was in his bath and looked at the jar it would remind him of [her].”

He was not challenged about this.

2.4.41 The weekly summary dated 22nd September said that he had remained mentally stable with no mania or alcohol use observed. He was described as quite isolative, spending most of his time in his room reading or watching television. He had discussed with his primary nurse increasing his occupational therapy attendance. He had also told his primary nurse that he was finding the groups at the Alcohol Recovery Project repetitive. He was reviewed at a ward round by Dr E on 23rd September. His request for leave to go to the Alcohol Recovery Project for four days a week was granted. His one hour's unescorted ground leave was continued. It was noted that a CPA review had been arranged for 3rd October, which was to be attended by Mr R and Mr V, and that a representative from the dual diagnosis group was also to be invited.

2.4.42 The weekly summary dated 29th September reported that he had remained mentally stable with no change in mood or behaviour, that he was isolative on the ward but compliant with his leave. It reported that there had been no evidence of alcohol use. On 3rd October he was told that the CPA meeting had been cancelled and he expressed disappointment. He requested leave to attend computer courses at Mind in Camden on the days that he attended the Alcohol Recovery Project. This was granted. The weekly summary dated 6th October recorded that his leave had been increased since the previous week and that he had started a computer course at Mind. On 7th October it was noted that he was regularly visiting a female patient, Ms Q, on another ward at the hospital. On 8th October when he returned from leave in the evening his breath smelt of alcohol. He denied drinking. He repeated this denial when he saw his primary nurse the following day. On that occasion he told his primary nurse that he was engaged to Ms Q.

2.4.43 He was reviewed at a ward round on 14th October when his leave was increased to include five hours' unescorted leave on Saturdays and Sundays. No problems were noted. When he returned from leave on 18th October nursing staff smelt alcohol on his breath. He denied drinking alcohol. He was breathalysed and the reading was between 0.01 and 0.03 units of alcohol. His behaviour was reported to be appropriate and there was no evidence of inebriation. His unescorted leave was cancelled.

2.4.44 He was reviewed at a ward round on 21st October. His engagement to Ms Q and the recent incident when he had returned to the ward smelling of alcohol were discussed. It was also noted that he was shortly due to have a Managers' Hearing. He denied alcohol use and questioned the breathalyser reading. The decision was to stop his unescorted leave for one week.

2.4.45 On 21st October nurses received a report from nursing staff on Ms Q's ward that the previous evening she and Mr Hardy had been found together, not fully clothed, in a room on the ward. As a consequence he had been banned from visiting her on the ward. He had previously been visiting her every day.

2.4.46 On 22nd October he made an application to the Mental Health Review Tribunal.

2.4.47 On 23rd October nursing staff received a report from an occupational therapist that he had tried to steal a CD from the music appreciation group:

"He left the group 15 minutes before the end to go to the bathroom and at this point I followed Tony out of the room and asked him to return a CD I'd seen him put behind his back and tuck in his trousers earlier."

He returned it immediately without comment and left the occupational therapy department without going back to the group.

2.4.48 On 30th October he attended Tottenham Mews Resource Centre. It was the first time he had been there since his arrest in January 2002. He stayed for only five minutes.

5. Discharge from Detention

2.5.1 On 4th November the Managers' Hearing took place at which he was discharged from section 37. The managers' written reasons for their decision were:

“Tony Hardy’s accommodation situation causes concern; under the Mental Health Act we concede there is a mental illness - but there is nothing at present to convince us that detention in Hospital continues to be necessary. He has a Natural Human Right to be treated in surroundings which will encourage and support his own efforts.”

They also made the following recommendation:

“The managers are extremely anxious about the delay in resolution of the housing for Tony: the social work representative has been urged to investigate and consolidate the accommodation for him as soon as possible”.

The decision form also summarises Mr Hardy's reason for seeking discharge:

“Accepts his mental illness but regards himself able (sic.) to live at home”.

2.5.2 Immediately after the Managers' Hearing he told nursing staff that he was willing to remain as an informal patient until the CPA meeting which had been postponed from 3rd October and was now due to take place on 14th November. He also requested that they refer him to an art, photography and IT programme which was being run locally by a voluntary sector organisation, called the Milton Skills Centre. Nursing staff requested a referral form which was faxed to the ward.

2.5.3 He was reviewed by Dr E on 7th November. He was noted to be well. Dr E told him that as an informal patient he was free to go on leave as he wished. It was agreed that he could go on leave for the weekend, from Friday 8th November until Sunday 10th November.

2.5.4 On 7th November it was noted by a junior doctor that he had been prescribed Apomorphine for resumption of sexual function. Mr Hardy had complained that it was not working. He was advised not to increase the dose until his next outpatients appointment with the doctor who had prescribed it.

2.5.5 On 7th November, in the absence of his care co-ordinator, Mr R, on extended sick leave, it was agreed that Mr S would temporarily take over as care co-ordinator.

2.5.6 Mr Hardy went home on leave at 9.30pm on Friday 8th November. He returned at 10pm on Saturday 9th November to collect possessions from his room and left the ward at 10.20pm. He returned the following morning, when he was seen by his primary nurse. He then went out on leave again and finally returned at 10pm on Sunday 10th November. The following morning he requested further leave. It was agreed that he could go on leave, to return on Thursday 14th November for the CPA meeting. He left the ward at 10pm on 11th November. He returned the following morning at 10.30am for medication, and again at 7pm. On the following day, 13th November, he came to the ward at 11.15pm to collect possessions. The weekly summary dated 10th November reported that he had remained stable in mood and mental state.

2.5.7 At some point between the Managers' Hearing and the CPA meeting, Dr E received and read the forensic report prepared by Dr B and jointly signed by Dr B and Dr C, his supervisor. The report is erroneously dated 12th September. It was sent to Dr E on 29th October. Its key findings and recommendations for future management of risk were: he continued to pose a risk of violent behaviour *“even when his mental illness is well controlled and when not intoxicated with alcohol”*; his mood disorder needed to be adequately controlled with mood stabilising medication; his alcohol use needed to be addressed; he would benefit from a psychological assessment of his personality, *“particularly an assessment of the degree of dissocial personality traits”*; he should not return to his previous accommodation because of the risk of further harassing his neighbour; he should be housed in some form of supported accommodation, where assessment of his mood and alcohol misuse could take place on a regular basis; and

“owing to the extremely suspicious circumstances surrounding his arrest, and his past violent offending ...it

would be wise for his consultant to make a limited disclosure to the Camden Multi-agency public protection panel informing them of his final placement ... [as] there is strong evidence to believe that he is at risk of re-offending and is likely to cause others serious physical or psychological harm”.

6. Discharge from Hospital

2.6.1 On 14th November the postponed CPA meeting took place. It was attended by Dr E and the junior ward doctor, the ward manager, the temporary care co-ordinator (Mr S), Mr V from the Alcohol Advisory Service and three people from the Housing Department. Mr Hardy attended with a representative from the firm of solicitors which had represented him at the Managers’ Hearing.

2.6.2 Confirmation had been received that there was no legal impediment to prevent him returning to his flat. He had been staying there while on leave from hospital. According to the notes of the CPA meeting, Dr E said that Mr Hardy was mentally stable and able to function independently. But, based on the past history, he had concerns about the risk to others. He referred to previous threats to neighbours. The Housing Department representatives said that the possession proceedings would continue. Medical information was shared with the housing team, concerning diagnosis and issues of risk. It is recorded that at the meeting Mr Hardy accepted that there would be an injunction, ordering him not to harass his neighbours in future, or that he would give an undertaking to that effect. He said he would have no objection to supported housing if a possession order was made. He also told the meeting that he felt dramatically better than before. He confirmed that he would continue to attend the Alcohol Recovery Project and the Mind dual diagnosis group. He said that he was happy with his medication and that he was able to deal with stressful situations. He gave assurances that he would continue with his medication. It was further recorded that a community care needs assessment was required.

2.6.3 Following the 14th November CPA meeting, a CPA form was completed. It contained the following actions and interventions:

“(i) Referral for supported accommodation; (ii) To see his care co-ordinator weekly; (iii) To return to the ward weekly for medication and physical observations; (iv) To have his meals on the ward until his social security benefits had been reinstated; and (v) To continue to attend the Alcohol Advisory Service and the Alcohol Recovery Project.”

2.6.4 On 14th November the care co-ordinator contacted a hostel to request that they send an application form.

2.6.5 On 15th November Dr E wrote to Dr B, following receipt of his report:

“Thank you very much for your helpful report. You may be interested to know that Mr Hardy was recently discharged from detention by our hospital managers and remains as an informal patient, spending some time on leave back at his flat.¹ However, he has also agreed to a placement in supportive accommodation.

He has recently started a relationship with a vulnerable female patient from another ward. Do you think that a Tarasoff warning is appropriate if he isn't willing to discuss his history with her?

Which particular psychological assessment instrument would you recommend for assessing his personality? We could easily do a SCID-II interview and questionnaire, but I suspect there might be some false negatives.”

2.6.6 On 15th November Mr Hardy packed the last of his belongings and said he would collect them the following day. In fact he did not return to the ward again until 19th November when he was noted to be mentally stable.

¹ This more accurately describes the position *before* the 14th November CPA meeting because on that date it was agreed that Mr Hardy would leave hospital

2.6.7 On 15th November he attended the Tottenham Mews Resource Centre for two hours. The following record was made: *“Socialising well with peers whom he knows. Talking freely about time on ward but not reasons for attending”*. No concerns were expressed. On 18th November he again attended Tottenham Mews, and sought advice on behalf of his partner, Ms Q.

2.6.8 On 19th November a request was made by a social worker from Camden Children and Family Services who was concerned about the possible risk posed by Mr Hardy to Ms Q’s children. It was agreed that a meeting would take place at which information about Mr Hardy would be shared with Camden Children and Family Services. On 21st November the care co-ordinator, Mr S, met Mr Hardy. He denied that he had been drinking and said that he had been taking his prescribed medication. He appeared settled in mood and said that he had no problems to report.

2.6.9 He next returned to the ward on 22nd November when he was seen by his primary nurse. He showed his primary nurse a letter from the solicitors who were acting for him in the housing possession action. It said that the council would not be getting a possession order at the hearing on 12th December. On the same day a copy of the latest Full Assessment Risk form, dated 5th July 2002, was faxed to Tottenham Mews at their request.

2.6.10 His next contact with the ward was a telephone call he made to his primary nurse on 26th November. He said that he was well and that he was not drinking. He described having Ms Q and another friend round for dinner. His only concern was that he was experiencing some difficulty in sorting out his social security benefits. On 26th November he attended Tottenham Mews. The record simply says: *“Spent time chatting with others”*. There were no concerns. On 28th November he stayed at Tottenham Mews for most of the day and was described as *“pleasant in mood”*. There were no concerns about him. The care co-ordinator, Mr S, met him on 29th November. He denied any mental health difficulties and said that he had not been drinking alcohol.

2.6.11 On 2nd December, at the request of Camden Children and Family Services, a meeting took place between Dr E and the consultant psychiatrist in charge of Ms Q’s treatment. The meeting was also attended by both Mr Hardy and Ms Q. The purpose was to disclose information to Ms Q about Mr Hardy’s history, specifically

in relation to the possible risk to Ms Q's children. Mr Hardy disclosed the attempted murder of his former wife and the discovery of Sally White's body in his flat.² Dr E recorded that on that date Mr Hardy was mentally stable and showed good insight into his previous symptoms. He remained compliant with treatment and said that he was abstaining from alcohol.

2.6.12 On 6th December he came to the ward and was seen by nursing staff. He attended occupational therapy in the morning and then saw the ward senior house officer. The occupational therapist reported that she suspected that he had been drinking because he spent 20-25 minutes in the toilet and came out smelling of alcohol. It is recorded that he appeared "red-faced and shaky". When the occupational therapist asked how he was feeling he said that he had flu and was feeling unwell. When asked by the ward doctor he denied that he had been drinking. The doctor was unable to smell alcohol on his breath. The impression of the two nurses and the doctor who saw him on 6th December was that he was stable in mood on that date.

2.6.13 On 12th December he attended Tottenham Mews for a short time. The next contact was on 13th December when he came to the ward to collect medication. He stayed on the ward for only a few minutes. He said that he was well. He appeared settled. He had heard from his solicitors that the housing possession action had been adjourned until the New Year. On 15th December he attended Tottenham Mews for the whole day and was described as socialising well. There was no evidence of symptoms of mental illness.

2.6.14 On 17th December Mr Hardy failed to attend an appointment with Mr R, his care co-ordinator who was now back from sick leave. Mr Hardy sent a postcard on 17th December explaining that he was not able to attend the appointment because he had to go to the Benefits Office. Mr R informed the ward and made a new appointment for 23rd December.

² For further details of Mr Hardy's history of violence see Appendix 3.

2.6.15 On 18th December a typed management plan recording what had been agreed at the 14th November CPA was prepared by the CMHT manager, Ms T. It contained the following:

“(1) Tony to attend Cardigan ward weekly on Fridays to collect TTA’s and to go to O.T. (2) Tony to see [Mr R] regularly at [the CMHT office]. (3) Tony will attend [Tottenham Mews] walk-in. (4) Supported accommodation being considered. Funding agreed for St Martins [hostel] but Tony not keen to go there, and is looking at alternative hostels. (5) If there are indications he is relapsing i.e. using alcohol or not keeping in contact with services, the situation should be reviewed urgently i.e. discussed with Dr E, Cardigan [ward] and [Mr R] and decision about what action needs to be taken.”

2.6.16 On 18th December Mr Hardy did not attend his appointment with Mr V at the Alcohol Advisory Service. He sent him a Christmas card which said “I decided I don’t need AAS any more thanks for all your help”. Mr V telephoned Dr E to inform him of this. On the following day he completed a discharge form, which recorded that Mr Hardy no longer wished to attend, and he sent a copy to Dr E.

2.6.17 On 19th December Mr Hardy was discussed at the Community Mental Health Team(CMHT) meeting where it was reported by Mr R that he had missed the previous day’s appointment. It was noted by Dr E that missing appointments was a risk indicator. The possibility was mentioned that he might have been using cannabis. It was noted that he should have been returning to the ward each Friday to collect medication, as he had done the previous Friday, 13th December. It was recorded in the notes by Dr E that if there was any evidence of mania when he returned to the ward on Friday 20th December the nurses should detain him using section 5 of the Mental Health Act, if he was not willing to remain informally. It was noted that he had an appointment to see Mr R on 23rd December. It was agreed that if he failed to attend the ward Mr R should be notified.

2.6.18 On 19th December he spent the whole day at Tottenham Mews. Staff thought that they smelt alcohol on his breath but did not confront him. He asked for help with a Disability Living Allowance application and this was dealt with.

2.6.19 On Friday 20th December he came to the ward at 11am to collect his medication. He told nursing staff that he had written to Mr R to inform him that he would not be able to attend the missed appointment on 17th December. He was reminded of the rearranged appointment with Mr R, which was due to take place on 23rd December. His primary nurse made an entry in the in-patient notes recording that he had come to the ward and that he had appeared stable in mental state.

2.6.20 On 21st December it is recorded that he visited the ward where Ms Q was a patient. This information was passed by the nursing staff on that ward to nurses on Cardigan ward.

2.6.21 On 23rd December he failed to attend his appointment with Mr R. He sent Mr R a letter stating that he was going to the British Library. Mr R sent him a new appointment for 2nd January 2003. Mr R drew up an action plan, which he recorded in the CMHT notes:

“ACTION PLAN - To be Typed and Faxed

- *Tony to attend appointments with Keyworker [Mr R] on a weekly basis; if he fails to attend, attempt to contact @ home, inform Cardigan ward and offer new appointment.*
- *Tony to attend Cardigan ward weekly to collect medication and attend O.T.*
- *If staff suspect Tony may have been drinking, care co-ordinator to be informed on [telephone number] and Cardigan ward on [telephone number].*
- *Liaise with [Ms Q's ward] and [Ms Q's care co-ordinator]*
- *If deemed necessary when Tony on Cardigan ward he can be placed on sec 5(2).”*

2.6.22 On 23rd December Mr R spoke to the co-ordinator at Tottenham Mews. She told him that Mr Hardy had said that he did not wish to go to the supported housing which had been suggested to him:

“Stated that he does not like the sound of St Martin of Tours as it is too strict and he is looking for somewhere that is more liberal in its regime.”

Mr R told the Tottenham Mews co-ordinator that Mr Hardy had missed his appointment and that he had rearranged it for 2nd January.

2.6.23 On Friday 27th December Mr Hardy went to Cardigan ward at 8.45pm to collect a week's supply of medication. He stayed for 10 minutes. He appeared mentally stable. On 30th December he attended Tottenham Mews for about three hours during which time he made a number of telephone calls. He informed staff that he had received notification from Mr R of the 2nd January appointment.

2.6.24 On 30th December the ward received a telephone call from the Serious Incident squad at Hendon Police Station asking for information about his whereabouts following the discovery of the dismembered bodies of Elizabeth Valad and Bridgitte Maclennan.

2.6.25 There was no further contact with Mr Hardy until he was arrested on 3rd January 2003.

Chapter 3 Alcohol

1. Introduction

3.1.1 Mr Hardy had long-standing problems with alcohol. This is evidenced by Dr F's report of 29th November 1995 where he recorded:

“Mr Hardy admitted that in recent years he had been prone to binges of heavy drinking, cider or vodka, though he denied symptoms of physical addiction”.

3.1.2 Mental Health Services recognised that alcohol was a risk factor, as recorded in the full risk assessment of 7th August 2001: *“increase in alcohol intake when unwell”*. Heavy drinking, and particularly binge drinking, was also identified as a precipitant of risk-taking behaviour. Since October 2000, there had been in place a written agreement between Mr Hardy and his care co-ordinator, which was renewed when the person in that role changed, the purpose of which was to identify early warning signs of a manic relapse. One of the indicators was *“increased use of alcohol or illicit drugs”*. The agreement also recorded that:

“Tony uses alcohol when feeling depressed also and sometimes to cope with life stresses. It does not always indicate early signs of a manic episode but [he] agreed that [the care co-ordinator] should check this out.”

3.1.3 In late December 2001 Mr Hardy contacted Mr R and said he wanted to see him urgently because he had been drinking very heavily over the Christmas period *“due to feeling physically unwell”*. In early January 2002, at his own request, Mr Hardy was referred by his general practitioner to Rugby House for detoxification. He went there on 7th January 2002. Mr Hardy told us that he continued to drink alcohol while he was there. He discharged himself after six days.

3.1.4 When he was arrested on 20th January 2002, following the criminal damage to the neighbour's flat and the discovery of Sally White's body, Mr Hardy said that he had been drinking heavily the night before and had no recollection of events. When seen by the Psychiatric Diversion Team at Highbury Corner Magistrates' Court on 22nd January 2002, he gave an account of his drinking on 19th January. Their report records that he told them that:

“He had drunk until he could drink no more, taking wine and

beer as well as cider. He had previously filled the fridge with alcohol to make sure of his supply, and is not sure how much he had drunk. He states that he ‘blacked out’ (as he had on occasions in the past), but remembers pouring acid through the neighbour’s door and daubing a slogan.”

3.1.5 A number of the witnesses we interviewed were sceptical about Mr Hardy’s claim that he had blacked out on the night of 19th/20th January 2002. Dr D put it in the following way in the discharge summary he prepared when Mr Hardy was transferred to Cardigan ward:

“This enterprise [pouring battery acid through the neighbour’s letter-box] therefore required some degree of planning and his memory for those events makes his amnesia for the other relevant events of that night all the more strange.”

When we asked Mr R about this, he commented:

“When I think of it, every time he had done something he seemed to have an alcoholic blackout and he could never remember doing anything.”

3.1.6 Against this background it can readily be appreciated why the in-patient care plan in 2002 included interventions to monitor and modify Mr Hardy’s use of alcohol. We now consider these. We go on to look at how the risks associated with alcohol were taken into account in planning and managing his discharge from hospital.

2. Interventions while Mr Hardy was an in-patient in 2002

3.2.1 From the outset, it was made clear to Mr Hardy that there were concerns about his use of alcohol. These arose from the interaction between alcohol use and his diagnosed mental disorder, and from the disinhibiting effect of alcohol as evidenced most recently, on Mr Hardy’s own account, by the events of 19th/20th January. Mr Hardy was told that he was not to drink alcohol either on the ward or when out on leave. Steps were taken to monitor his compliance and sanctions were imposed when he did drink.

3.2.2 He was also referred to specialist agencies for help with what he himself acknowledged was a problem. The Alcohol Advisory Service (AAS) is part of the

Trust. Mr Hardy was seen for an initial assessment on 23rd May 2002 by an alcohol worker, Mr V, who is also a qualified social worker. The outcome of the assessment was communicated to Dr E in a letter dated 6th June 2002. Mr V summarised the assessment in his evidence to us:

“Mr Hardy told me he had a 10-year history of dependent drinking. When I assessed him on 23 May he said he had been abstinent since he was remanded in custody in January of that year. However, he said he had had a lapse by drinking about five litres of cider while he was on Section 17 leave about two weeks prior to my assessment on 23 May. He stated that he drank in order to relieve feelings of depression. He said, “The world seems a better place, people feel friendlier, it makes it worthwhile to be alive.” He was clear that alcohol improved his mood but it also fuelled manic episodes. He felt the mood symptoms of depression or mania would come first and therefore he would drink both in order to relieve depressive symptoms but also to “get higher from being in a good place”, so it would also fuel manic episodes. His own assessment was an accurate one, which I would agree with, of why and how he used alcohol.”

Mr V questioned whether Mr Hardy in attending the service was genuinely motivated to overcome his problems with alcohol:

“I had the impression that Mr Hardy would tell me what he thought I wanted to hear, that he would give me the information about his drinking that would improve his chances of being released from his section. On assessment he told me, “If I don’t do something about my drinking I won’t be allowed out of hospital.” In his mind he was clear that he was keen to attend alcohol services so that would improve his chances of being discharged. On assessment his goal was to control his drinking to about two pints of alcohol two or three times a week, but in the next appointment, after having the opportunity to talk to me and for me to go over some information about alcohol with him, he said he decided to aim for abstinence, at least while he was an inpatient on the ward. As I said in my letter to Dr E dated 30 October [2002], my opinion was that a true picture of his motivation to engage in treatment and for him to work on his alcohol problem could only emerge when he was discharged and back home. Only then would he no longer feel coerced to say the right things in order to persuade us of his fitness to be discharged. That’s what I wrote to his consultant.”

3.2.3 Mr Hardy saw Mr V on five occasions in 2002: 23rd May, 13th and 20th June, 4th September and 16th October. Mr V also attended the discharge planning meeting on 14th November 2002. In summary, Mr V told us that although Mr Hardy was able to identify some of the adverse effects of alcohol, to both his physical and mental health, these were outweighed by his enjoyment of alcohol and what he saw as the benefits, in relieving his depressive symptoms and fuelling his manic episodes: *“there were more reasons for him to carry on drinking than not”*.

3.2.4 Mr V communicated his views to Dr E. The crucial point was that Mr Hardy’s stated commitment to moderate his alcohol consumption, or to become abstinent, would be tested only when he was free to make his own choices, following discharge from hospital.

3.2.5 During his in-patient stay Mr Hardy regularly attended a dual-diagnosis group run by Mind, which helped people think about their alcohol use in the context of their mental illness. He also attended, sometimes daily, the Alcohol Recovery Project, a voluntary sector service: *“available to anybody who has an alcohol or substance misuse problem, and who wishes to address the problem via group work”*. We are not aware of any feedback from these services to the mental health team, but Mr Hardy himself gave a positive account of the groups. He valued the opportunity to attend and generally enjoyed participating in groups.³

3.2.6 There were a number of occasions during his in-patient stay in 2002 when Mr Hardy returned to the ward from leave having consumed alcohol or was found to have consumed alcohol in his room. There were other occasions when nurses suspected he had been drinking alcohol but the evidence was inconclusive.

- On 8th May he returned from leave and was seen to be unsteady on his feet. When examined by a doctor he admitted that he had drunk six pints of strong cider while on leave and that he had gone to the pub instead of attending his appointment at AAS. His leave was stopped.
- On 28th May when he returned to the ward his breath smelt of alcohol. He said he had drunk one pint of beer. No action was taken.
- On 30th May it appeared to a nurse that he had been drinking but this was not confirmed.

³ Mr Hardy reported to his primary nurse on 3rd July that the convener of the one of the groups had told him he was *“God’s gift”* to the group.

- On 22nd June when he returned from leave it appeared that he had been drinking. He initially denied this but later admitted that he had drunk six litres of strong cider. His leave was stopped.
- On 3rd July he was unsteady on his feet and his breath smelt of alcohol. He initially denied drinking but an empty bottle of strong cider was found in his room.
- On 18th July he admitted drinking alcohol in his room.
- On 1st August he was unsteady on his feet and his breath smelt of alcohol. No action was taken.
- On 2nd August his speech was slurred but he denied that he had drunk alcohol.
- On 30th August his breath smelt of alcohol. No action was taken.
- On 5th September nurses smelt alcohol on his breath and he appeared disorientated. The following morning when asked about this he denied he had been drinking.
- On 8th October his breath smelled of alcohol. He denied that he had drunk alcohol. No action was taken.
- On 18th October his breath smelt of alcohol. He denied that he had drunk alcohol. He was breathalysed and tested positive. He continued to deny that he had been drinking and queried the accuracy of the test.

3.2.7 The response to Mr Hardy's alcohol consumption was somewhat inconsistent. There were occasions when his leave was suspended but others where it was not. Sometimes he was breathalysed, including a short period of random testing, and on other occasions his room was searched. When he returned to the ward from leave, nurses regularly recorded their observations of his mental state and whether or not he appeared to have been drinking. The great majority of observations were that there was no sign of alcohol. His bag was regularly searched when he returned from leave to make sure that he was not bringing alcohol onto the ward.

3.2.8 We also note that consideration was given to prescribing Antabuse, a drug which works by blocking the oxidation of alcohol,⁴ which Mr Hardy said he was willing to take. This was not done, correctly in our view, because of contra-indications and because Mr Hardy was saying that he was not aiming for complete

⁴ If alcohol is consumed this causes unpleasant flushing of the face, headache, choking sensations, rapid pulse, and feelings of anxiety.

abstinence.

3.2.9 In commenting on these interventions, the most important point is that appropriate and timely referrals were made to the specialist alcohol services and that the in-patient care plan included interventions designed to monitor Mr Hardy's alcohol use and to support him in his avowed intention of moderating his drinking. We consider that any failings in the enforcement regime while Mr Hardy was an in-patient are of secondary importance. The aim of modifying his pattern of alcohol use when he left hospital was not, in our view, going to be achieved by more efficient policing of his alcohol use as an in-patient.

3. Discharge from Hospital

3.3.1 One of the factors which weighed with the hospital managers when they decided to discharge Mr Hardy from detention under the Mental Health Act was that they believed he was dealing with his alcohol problem.⁵ We think the view they took was reasonable. He had conscientiously attended and participated in groups and had said on a number of occasions to nurses that he wished to moderate his drinking. We consider that further prolonging his in-patient stay would not have increased the likelihood that this long-standing problem would have been resolved.

3.3.2 The position had been correctly stated by Mr V, as quoted in paragraph 3.2.2 above: the test would be when Mr Hardy was free to make his own choices. What happened was that, following discharge, he missed an appointment with Mr V on 18th December 2002 and sent him a Christmas card in which he wrote "I decided I don't need AAS any more thanks for all your help". On 19th December Mr V completed a discharge form, which recorded the missed appointment and the message in the Christmas card, and advised that Mr Hardy could be referred again by services or could refer himself. A copy of the discharge form was sent to Dr E, who had also been informed by telephone of the missed appointment on 18th December.

3.3.3 As appears from the Narrative, observations made by mental health

⁵ See Chapter 7 Mental Health Act paragraph 7.5.6 where the managers are quoted as saying: *"At the time he was attending his alcohol counselling and the fact [was] that there had not recently been any abuse of alcohol, we felt that that particular issue was being addressed and he was addressing himself to it ...at least he gave us the impression he was aware of the effect alcohol was having on him, and he was doing something about it. The staff within the hospital were encouraging him to continue to attend alcohol counselling."*

professionals in December suggested that Mr Hardy had started drinking again, but they were inconclusive. Subsequently, when he was assessed by Dr I in 2003, he said that he was drinking four litres of strong cider a day during this period. But his account should be treated with some scepticism as he was then seeking to persuade Dr I that he was manic at the time he murdered Elizabeth Valad and Bridgitte Maclennan.

3.3.4 The agreed discharge plan included the following statement:

“If there are indications he is relapsing i.e. using alcohol or not keeping in contact with services, the situation should be reviewed urgently”.

The observations that he had been drinking alcohol were passed to Mr Hardy’s care co-ordinator and to nursing staff on Cardigan ward. However, no abnormalities of mental state, indicative of relapse, were noted during November and December 2002. In these circumstances, we consider there would have been no justification for re-admitting Mr Hardy to hospital under the Mental Health Act. The most that could have been done was to counsel him about his alcohol use, to encourage him to attend support services and to continue to monitor his mental state. Indeed, this was done when, for example, Mr Hardy was seen by a doctor on 6th December in response to the concerns expressed by the occupational therapist that he had been drinking.

4. Conclusion

3.4.1 We consider that Mental Health Services, in conjunction with the Trust’s alcohol services, did all that could reasonably have been expected of them in 2002 to manage Mr Hardy’s problems with alcohol. With hindsight it can be seen that the interventions made little, if any, difference.

Chapter 4 Community Mental Health Services

1 Introduction

4.1.1 During 2001/2002, when he was not in hospital, Mr Hardy was a client of the Kentish Town Community Mental Health Team (CMHT). They managed his care within the framework of the Care Programme Approach (CPA). He also made use of resources in the community which were not managed by the CMHT. The purpose of this chapter is to consider, in the context of the overall management plan, some specific issues raised in the course of this Inquiry:

- Were services justified in managing Mr Hardy in the community, rather than as a long-term hospital patient?
- Why was he not visited at home as part of the care plan?
- Why did the regular meetings with his care co-ordinator take place in a café?
- Was there adequate communication between the CMHT and other community services?
- Was the functioning of the CMHT satisfactory?

4.1.2 Before answering these questions we describe in some detail Mr Hardy's engagement with community mental health services during his time in Camden. We start by reviewing how he became a user of community mental health services in 1995 and how his care was managed thereafter. We then look separately at the situation in 2001/2002, before the events of January 2002.

2 Community Mental Health Services in Camden 1995 - 2001

4.2.1 Mr Hardy was formally referred to mental health services in Camden in May 1995. The referral was made to the Focus Homeless Outreach Team (Focus) by his key nurse at the Huntley Centre where he had been admitted three days previously. The referral form, dated 2nd May, described the circumstances of the admission:

“30.4.95 Informal admission. Anthony looked out of Ferndale Hotel window - saw Police van, jumped in. They decided to take him to A&E as he was ranting and raving and clearly psychotic. Not sure whether drug-induced, presenting as well now”

The form stated that he had “no community supports” and that he required advice on housing options and needed to be registered with a GP. He was discharged on 5th May when he returned to the Ferndale Hotel in King’s Cross where he had been living for the past five months.

4.2.2 Focus appear not to have assessed him in response to the initial referral but by August 1995 they had become actively involved. This followed his eviction from the Ferndale Hotel on 24th August. At that time he was found bed and breakfast accommodation in Wembley. A member of the Focus team was assigned to be his key-worker and made contact with one of the Trust’s community resources, called the Columbus project, a walk-in service which Mr Hardy had first attended in July 1995, having been referred by his GP. In their initial assessment, staff at Columbus concluded that the Jules Thorne day hospital was more suitable for him. One of the concerns Columbus staff expressed to the key-worker was a

“strong suspicion that Tony may be molesting the vulnerable people that he meets on his self-styled outreach session.”

We have no further information about this. He continued to attend Columbus fairly regularly until November 1995. Columbus later changed its name to Tottenham Mews Resource Centre, to which we refer elsewhere.

4.2.3 On 30th August 1995 there was a further admission to hospital, to the Accident and Emergency ward for one night after he took an overdose. He then returned to the accommodation in Wembley until he was evicted on 11th September because of his behaviour. He was reportedly described by the proprietor as being like a “wild animal”. He then found himself temporary accommodation where he remained until being readmitted to the Huntley Centre on 3rd October. Later that month, while still an in-patient, he was detained under section 3 of the Mental Health Act. He was eventually discharged on 2nd January 1996 to Argyle Walk

Registered Care Hostel in Camden.

4.2.4 In November 1995 a comprehensive needs assessment was carried out by his Focus key-worker prior to his discharge from hospital. This records that he had been homeless since his marriage broke down in 1986 and that he

“has resided in a combination of hostels, hotels, squats and occasionally on the streets.”

According to the assessment document:

“Tony has a history of eviction from properties following verbal/physical aggression, forgery and consuming drugs/alcohol on the premises.”

It records his own view of his situation as follows:

“Tony feels that he has wasted the past 5 years and feels that this time could have valuably been spent in employment training or at college. Instead Tony has tended to spend his time ‘drinking tea at day centres’ or ‘drinking alcohol on the streets’. Tony feels that he has tried very hard to link himself into psychiatric services and believes that much of the past year has been spent trying to get the help that he needs e.g. counselling, group work and help with his alcohol problem. Tony feels that not having had a fixed address has made it impossible for him to sustain college courses and that the expense involved has also acted as a deterrent.”

The assessed needs were: medium-term staffed accommodation to provide a greater degree of structure in his life; access to psychiatric services, such as the Jules Thorne day hospital; and help with planning his eventual resettlement. He was also assessed as needing a key-worker, who was a member of the Focus team. The assessment document records that Mr Hardy commented that it was

“the first time that anybody had asked him about his needs and listened to him for several years.”

4.2.5 He remained at Argyle Walk until May 1997 when he moved to a flat provided by the King's Terrace project, which offered some support but greater independence than the hostel. While he was living at Argyle Walk services were provided within the framework of CPA. CPA review meetings took place on 28th December 1995, 4th June 1996 and 23rd January 1997. The CPA care plans included regular contact with the Focus key-worker, support from hostel staff and "*ongoing medical responsibility and monitoring of mental state*" by the consultant psychiatrist who led the Focus team. He continued during most of this period to attend the Jules Thorne day hospital. In early 1997 his hostel key-worker prepared a summary of his time at Argyle Walk which included the following: there had been no episodes of psychosis and no hospital admissions; his mood had remained fairly constant, if somewhat subdued; he was doing his own shopping and preparing his own food; he was reliable in keeping appointments with professionals; and he had never been aggressive to staff or residents. The document concluded with the comment:

"that Mr Hardy's stability at Argyle Walk cannot be overstated" and that *"his only concern is in continuing his rehabilitation and becoming more independent."*

His Focus key-worker concurred and observed that:

"Tony is very motivated towards maintaining his mental health and is very responsive to any support offered."

4.2.6 The next CPA review, the first after he moved to King's Terrace, was on 31st July 1997. He was meeting weekly with his King's Terrace key-worker and every three weeks with the Focus key-worker. His medication was being monitored by his GP and he was being seen every three months by the Focus team consultant psychiatrist. His main daytime activity was visiting the Highgate day centre. His assessed needs included "*occasional encouragement to minimise isolation*". The next significant events occurred on 24th April 1998 when he was arrested for being drunk and disorderly at King's Cross station, and later that same day he was arrested for rape. The charge was subsequently reduced to indecent assault. His account of the alleged sexual assault was that the victim was a "sex worker in King's Cross" and that she had consented to the sexual activity that took place. He was bailed and returned to King's Terrace. His behaviour there immediately caused

concern because he assaulted another resident. He was clearly becoming manic with elevated mood, disinhibition and overfamiliarity, increased alcohol consumption, reduced sleep, financial profligacy and a heightened interest in religion. On 10th May he was detained under section 3 of the Mental Health Act and admitted to a secure intensive care unit. He was transferred after ten days to St Luke's hospital. He remained there until, following his discharge from section 3 by the hospital managers on 6th August, he returned to King's Terrace on 13th August after a CPA meeting. The understanding of risk at this time was that his behaviour prior to admission was associated with a deterioration in his mental state and that in future admission should be arranged in the early stages of any observed deterioration. The discharge plan was for him to be referred back to the day hospital, to see his Focus key-worker once a week and for the Focus consultant psychiatrist regularly to review his lithium levels. Support from the King's Terrace key-worker was to continue as before. The following hand-written note was made on the date of the CPA meeting:

"CPN [key-worker] does not see Mr Hardy alone. Mr Hardy to be on Supervision Register. He has no insight whatsoever. No regrets. Charges on sexual assault not going to proceed. All involved keen that admission should happen more swiftly next time. Mr Hardy tends to mask his symptoms."

The inference we draw from this is that his denial of the indecent assault allegation was not accepted by those involved in his care and management. We note that his key-worker at the time was a woman. On 26th August he entered into an agreement with her for recognising and responding to early warning signs of a manic episode.⁶ This agreement remained in place through successive changes of key-worker until 2001/2002.

4.2.7 The next CPA review was on 11th November 1998. The agreed plan included attendance at the day hospital. The frequency of contact with the Focus key-worker was reduced from weekly to monthly meetings. There was a further CPA meeting on 18th February 1999 which agreed that key-worker meetings would take place fortnightly, that Mr Hardy would attend *"course/study/day centre and*

⁶ Reference is made to the agreement in Chapter 3 Alcohol, paragraph 3.1.2

structured day activities”, and that efforts would be made to encourage him to attend social activities at King’s Terrace. At the next CPA meeting on 3rd June 1999 the only recorded change in the care plan was that he was awaiting a housing offer from Camden Council. It is noteworthy that at this time his meetings with the Focus key-worker generally took place in a café, while at an earlier date they were meeting in the Focus team office or at his accommodation. This change appears to have been by mutual agreement. Typically, the key-worker would call at King’s Terrace and they would go out together to a café.

4.2.8 There were no significant incidents or concerns during 1999. The next CPA meeting was on 20th January 2000, by which time Mr Hardy had moved to his flat in Camden. The care plan included three-weekly meetings with the Focus key-worker and a referral to the Kentish Town Community Mental Health Team (CMHT) to take over his management as he was now in permanent accommodation. On 20th July there was a further CPA meeting. The care plan included fortnightly meetings with his key-worker. He was not motivated to attend the Highgate day centre. Other possibilities were to be explored.

4.2.9 In summary, the period of two years following his discharge from hospital in August 1998 was unremarkable. The community care plan remained substantially the same throughout. The only significant change was the move from supported accommodation to his own flat. That went well, apart from the threats he received soon after moving to the flat.⁷ In general, Mr Hardy co-operated fully with the care plans. He was reliable in keeping appointments and he regularly attended community resources. There were occasions when his mental state was noted to be either somewhat higher or lower than normal, and there were also some concerns about his consumption of alcohol and his use of drugs, but the Focus team managed his care very effectively.

4.2.10 He remained with the Focus team until September 2000 when his care was transferred to the CMHT. This was formalised at a CPA meeting on 19th October 2000 where Mr Hardy expressed his gratitude to the Focus team “for all the help and good work you’ve done for me over the years”. The CMHT took over the Focus care plan and continued with it until the next CPA review on 19th January 2001. The new key-worker initially met with Mr Hardy at the CMHT office but thereafter

⁷ See Chapter 6 Housing paragraph 6.2.2

their meetings were always at a local café. As had been the case with previous key-workers, Mr Hardy was invariably asked to report on his mood and to talk about how he was spending his time. The meetings also provided an opportunity to discuss practical matters, such as the state of his flat. The first CMHT key-worker was a community psychiatric nurse and was thus able to discuss with Mr Hardy the concerns he then had about his medication. The CPA plan agreed at the 19th January meeting was the same as that which the CMHT had taken over from Focus. The most important element was to continue to meet every fortnight with the key-worker. The care plan recorded that these meetings would take place in a local café. There was a continuing concern about lack of daytime activity. At this meeting Mr Hardy expressed an interest in going to the Studio Upstairs at Diorama, a voluntary sector arts organisation. He wanted to join an art class. When he was first invited to attend, however, he was unable to do so because of his lack of confidence in new social situations, but by the end of 2001 he was going there fairly regularly.

4.2.11 The next CPA review took place on 4th July 2001. The agreed care plan was essentially unchanged and he continued to attend appointments with his key-worker.

4.2.12 The first year following the transfer of his care to the CMHT in September 2000 went well. His mental state remained stable. His behaviour gave no cause for concern. He appeared not to be drinking excessively, for example reporting to his key-worker in September 2001 that he had cut down and was then only drinking two pints a day. The general picture was reassuring, and contrasted markedly with the situation in 1995. There had been considerable progress. He was being effectively managed in the community.

3. Community Services in 2001/2002

4.3.1 In Chapter 11 we describe the operation of CPA and the main elements of Mr Hardy's care plan during this period.⁸ Care planning took place in accordance with the Trust's CPA policy: there were six-monthly CPA reviews; care planning was multi-disciplinary; Mr Hardy attended CPA meetings and participated in care planning; at all times he had a care co-ordinator with whom he met regularly;⁹ and proper records were kept of these meetings. By January 2002 the position was that

⁸ See Chapter 11 Risk Assessment and Risk Management, paragraphs 11.4.3 - 11.4.15

⁹ Following changes to CPA policy in 1999 the terminology changed from key-worker to care co-ordinator.

there were fortnightly meetings with his care co-ordinator, occasional attendance at the Trust's Tottenham Mews Resource Centre walk-in service,¹⁰ and fairly regular attendance at Diorama. His medical treatment was provided by his general practitioner but with access to the CMHT consultant psychiatrist if required. There was less structure in 2001/2002 than previously, but this was consistent with his stability since being discharged from hospital in August 1998.

4.3.2 From our review of the CMHT records and our interviews with members of the team we are satisfied that services were provided in accordance with CPA care plans. We have been generally impressed by the quality of the notes made by successive care co-ordinators. Among those we interviewed, both the CMHT manager and the two people who acted as care co-ordinator during 2002 - one for only a few weeks in the absence of the other - impressed us as conscientious and thoughtful. One aspect worth particular mention is that at the regular meetings with Mr Hardy an assessment of mental state was invariably made and recorded by the care co-ordinator. A typical example of an entry by the care co-ordinator in the CMHT notes is the following record of his meeting with Mr Hardy on 7th December 2001:

“Met with Tony in the [café] yesterday at 3.30pm. Tony states he feels very well; on his scale 0-20 he says he is about a 12 but is sleeping 8-9 hours a night and does not feel manic. Rate, tone and content of speech “normal”. Tony requested that I check his lithium levels which are within normal limits. Relayed information back to Tony this morning.”

4. Discussion and Conclusions

4.4.1 We now turn to the specific questions.

Were services justified in managing Mr Hardy in the community, rather than as a long-term hospital patient?

4.4.2 We consider that the history from 1995 to 2001 shows that Mr Hardy was being effectively managed in the community. The early period, until April 1998, was one of greater stability than he had enjoyed prior to the involvement of

¹⁰ This was formerly the Columbus project. He attended once in August 2001 and once in December 2001.

community mental health services. The events of April 1998 were consistent with a relapse in his mental illness. There is, however, no evidence that abnormality of mental state played any part in the alleged indecent assault.¹¹ His mental state was stabilised during the three-and-a-half month admission in 1998. Thereafter, he remained mentally stable in the community and, as far as is known, did not harm other people.

4.4.3 We consider elsewhere in this report the implications, for Mr Hardy's management by Mental Health Services, of the discovery of Sally White's body in his flat in January 2002.¹² It is our view that, from what was known at the time, the events of January 2002 did not provide a basis for changing fundamentally the way that Mr Hardy was managed. We consider that the plan, following his arrest and subsequent detention under the Mental Health Act, that Mr Hardy would be discharged back into the community was reasonable. As had occurred in 1998, there was a need for services to learn from what had happened and to consider whether adjustments needed to be made to the management plan.

Why was he not visited at home as part of the care plan?

4.4.4 Two reasons have been put forward for this. The first is that home visits were considered too risky. The risk assessment of 7th August 2001 included a section on staff safety and provided that this was to be safeguarded by "*joint home visits with at least one male member of staff*".¹³ We have seen, at paragraph 4.2.6 above, that this is in effect what had been agreed at the CPA meeting on 13th August 1998. However, we also note from the records that in late 1998 the female key-worker did on a number of occasions see him alone at his flat at King's Terrace. The second reason is that it was Mr Hardy's preference to be seen outside the home. We heard from Mr R, who took over as care co-ordinator in October 2001, that he did not have concerns for his safety when visiting Mr Hardy at home, as he did on one occasion on 23rd November 2001. His understanding was that it was Mr Hardy's choice not to be seen at home, rather than concerns about staff safety, that explained why home visits were not part of the care plan. Indeed, it appears from the records that the practice of meeting in a café developed because it was preferable, for Mr Hardy and possibly also for the key-worker to meet in a

¹¹ The victim told the police that "*during the assault he appeared in very sound mind and fully aware of what he was doing*".

¹² See Chapter 12

¹³ See Chapter 11 Risk Assessment and Risk Management, paragraph 11.4.13

café rather than at his flat in King's Terrace. The arrangement of meeting in a café was then continued when he moved to independent accommodation in Camden.

4.4.5 We accept that it is not unusual for people to choose not to be visited at home and that this is a choice which would normally be respected unless there were particular circumstances which indicated a need for the care co-ordinator to visit the home. Such circumstances could include concerns about the state of the home or the person's ability to cope independently. No such circumstances were identified in Mr Hardy's case, as he was seen as someone who could maintain his home and manage domestically. This was confirmed by Mr R's visit of November 2001 when he found the flat to be in reasonably good order.

4.4.6 Nonetheless, we consider it a weakness in the CPA planning process, over several years, that the question of visiting at home was not regularly reviewed. In particular we consider that fresh consideration should have been given to this at the six-monthly CPA reviews, whenever there was a change of key-worker/care co-ordinator, and when he was discharged from hospital in 2002.

4.4.7 While we consider that the threshold for excluding home visits from a care plan should be high, we do not criticise the view taken by the team to respect Mr Hardy's preference not to be visited at home. The arrangements had worked well and there was no reason to believe that home visits would provide significant additional information about his functioning or mental state. We therefore think it unlikely had this part of the care plan been reviewed, that there would have been any change unless Mr Hardy himself had asked to be visited at home.

4.4.8 We have considered whether, following discharge in November 2002, home visits would have provided the mental health team with information which would have enhanced their ability to manage the risk of violence. Our conclusion is that they probably would not have done so. Home visits would have been by prior appointment and, as was the case on 23rd November 2001, there is no reason to believe that Mr Hardy's domestic circumstances would have given rise to particular concern. We accept that a home visit in late December 2002, after Mr Hardy had murdered one or both of the women he killed at that time, would have been a very different matter. But he would surely have cancelled any such visit. In the absence of information that he was relapsing or behaving in ways that gave cause for concern, such a cancellation would not of itself warranted an unscheduled visit,

particularly if Mr Hardy indicated a willingness to meet on another date.

Why did the regular meetings with his care co-ordinator take place in a café?

4.4.9 We also concur with the decision to respect Mr Hardy's preference to be seen in a café rather than in the CMHT office. We have seen that this arrangement predated Mr Hardy's move to his flat in Camden. It worked well in that he had met regularly with successive care co-ordinators. In our view, the desirability of engaging Mr Hardy, through securing his regular attendance at a place where he chose to meet his care co-ordinator, outweighed any disadvantages of meeting in the informal setting of a local café. We have already commented above on the conscientious approach of successive care co-ordinators. We consider that the effectiveness of the meetings was not impaired by the informality of the setting.

Was there adequate communication between the CMHT and other community services?

4.4.10 We have reviewed the records kept by staff at Tottenham Mews Resource Centre during 2001/2002 and heard from the manager of the walk-in service which Mr Hardy used. Tottenham Mews Resource Centre is part of the Trust. We note that entries were made in the Tottenham Mews notes on every occasion when Mr Hardy attended. Copies of CPA plans and risk assessments were sent by the CMHT to Tottenham Mews. These were read by staff and kept with Mr Hardy's records. We also note that there was communication between staff at Tottenham Mews and Mr Hardy's care co-ordinator. For example, in December 2002 the manager relayed to the care co-ordinator the contents of a conversation between Mr Hardy and a member of the Tottenham Mews staff about his housing situation.¹⁴ We consider that the communication between staff at Tottenham Mews and the CMHT was satisfactory.

4.4.11 Mr Hardy was also attending Diorama in 2001. Diorama is a voluntary sector resource. As far as we are aware there was no agreement between the CMHT and Diorama for the exchange of information about individual mental health service users. The only communication of which we have been told was on 18th January 2002 when a member of staff at Diorama telephoned the CMHT manager and reported that Mr Hardy had spoken at Diorama about cannibalism. We have not found any record of this conversation but the CMHT team manager has confirmed

¹⁴ See Chapter 2 Narrative paragraph 2.6.22

that it took place. We have been told by staff at Diorama that Mr Hardy's remarks were made in the course of a general discussion about the fictional character, Hannibal Lecter. The next occasion when Mr Hardy was psychiatrically assessed was following his arrest on 20th January, when he did not appear to be manic or psychotic. It is difficult to know what weight to give to the reported remarks of 18th January.

4.4.12 We are concerned that there appear to be no written procedures for the exchange of information between the Trust and voluntary sector resources which are attended by mental health service users. While it remains important for all concerned that voluntary sector resources are independent of the statutory services, we consider that all CMHT's should meet with their local voluntary sector resources to develop protocols for regularly recording and sharing information about individuals in contact with them, particularly information relevant to risks to the patient or others. This is especially relevant when Mental Health Services refer patients to voluntary sector resources as part of their care plan, and/or fund such placements.

Was the functioning of the CMHT satisfactory?

4.4.13 From our meetings with the people directly involved in Mr Hardy's management during 2001/2002, and from reading the contemporaneous notes, we are satisfied that staff were conscientious in implementing the care plan and in recording relevant information. Although we heard from several people about the considerable pressures on CMHT staff during this time,¹⁵ we have seen no evidence that Mr Hardy's management in the community was compromised either by pressure of work or by other problems within the team. We consider that the way the team functioned in this case was satisfactory.

¹⁵ See chapter 5 Forensic and General Psychiatry paragraph 5.2.2

Chapter 5 Forensic and General Psychiatry

1 Introduction

5.1.1 Mr Hardy was assessed on a number of occasions by forensic psychiatrists. But no proposal was made to transfer his care to forensic psychiatric services. It is clear from the evidence we have heard that once the decision had been made not to prosecute Mr Hardy for any offence in connection with Sally White's death, there was no possibility of his care being transferred to forensic services. This meant that by default his care and management remained the responsibility of general adult psychiatric services. The question arises whether the better course, following his arrest in January 2002 and the decision to recommend detention under section 37 of the Mental Health Act, would have been for forensic psychiatric services to have taken over his care.

5.1.2 Although this question undoubtedly has more resonance with the benefit of hindsight, it was thought at the time by some of those directly involved in Mr Hardy's in-patient care during 2002 that he was not appropriately placed on a general adult acute mental illness ward. This was partly because he was not acutely ill during any part of his admission, but more because of their concerns about the risk he presented.

5.1.3 We have considered the following questions:

- Were there features of Mr Hardy's case as it was understood in 2002 that warranted a transfer of his care to forensic psychiatric services?
- Were there features of Mr Hardy's case as it was understood in 2002 that suggested he could not be adequately managed by general adult services?
- If he was not suitable for forensic services and yet could not be adequately managed by general services, what should have happened?

5.1.4 Before we answer these questions we describe the respective roles of forensic and general psychiatry and how they operated in this case.

2 General and Forensic Psychiatry

5.2.1 We have heard from a number of professionals about the pressures under which they work. This applies equally to general and forensic psychiatry. But there is a marked contrast between the way the two types of service operate. Typically, in general adult psychiatry, hospital admissions are short and there is a constant pressure to discharge patients when they are no longer acutely ill.¹⁶ Ms N, Senior Nursing Manager, told us about the pressures on nursing staff:

“[the ward manager] is an excellent practitioner but a lot of her time is taken up fire-fighting and trying to contain the ward and cover a shift ... We are trying to increase the nursing establishments on the wards but, like every other mental health trust in London and large parts of the country, we have a massive deficit and we are not getting any more money from anywhere else.”

5.2.2 In general psychiatry there are close links between in-patient and community mental health services. In the community, staff carry large caseloads. For example, Mr R told us that when he was working only two-and-a-half days a week he had a caseload of 25. The pressures on the Kentish Town CMHT were particularly severe in 2002, as we heard from the team manager, Ms T:

“The context is important: Mr Hardy was one client of about 150. There were five or six other clients who were extremely disturbing and disturbed and there had been a number of very serious incidents. One client had been shot dead by the police ... There had been two assaults on staff members and another client was extremely abusive and threatening to kill various members of staff, including Mr R.”

5.2.3 The resources within general adult services for psychological therapies are typically quite sparse, and nothing of this kind was provided to Mr Hardy. Essentially, he was treated as a person with a mental illness, bipolar affective disorder, who presented particular risks. That he had a history of violence did not make him an unusual patient in this context. It is estimated that 40-60% of admissions to psychiatric intensive care services have an offending history and that 30-50% of patients currently on the caseloads of London CMHT's have an offending

¹⁶ Mr Hardy's admission was exceptional in this respect.

history.¹⁷ But we are in no doubt that he was regarded as unusual by some of those who were directly involved in his care. This was confirmed in our interview with the Cardigan ward manager, Ms M, who told us:

“He was always considered to be a very serious risk history, but we had to work to some extent with what the courts and the Coroner had found”.

Mr S, who was Mr Hardy’s first associate nurse on Cardigan ward, spoke of the anxiety of nursing staff:

“There was always that anxiety for me and other colleagues. Whether it was things he was not telling us I don’t know. I think the anxiety was around his persona, his history. That was the main anxiety.”

We also heard from an occupational therapist, Ms W, that:

“The consensus was this man poses a threat ... There were lots of fears surrounding his placement on the ward.”

5.2.4 Forensic psychiatry is a tertiary service within the NHS. As was emphasised by the forensic psychiatrists who gave evidence to this Inquiry, their patients are predominantly people who have committed serious offences of violence, including sexual offences. Forensic in-patient services are provided in dedicated forensic units, which are more secure than general psychiatric wards. The following is a description their role:

“Forensic services provide specialist interventions in a secure setting with high levels of experienced and expert staff. These services provide care for approximately 1-2% of the total local service user population with severe mental health problems and because of these factors they are often referred to as high cost and low volume services.”¹⁸

Forensic psychiatrists, together with their nursing and social work colleagues in

¹⁷ North West London Strategic Health Authority, Forensic Mental Health in London - A Strategy for Action (August 2004) p.17.

¹⁸ North West London Strategic Health Authority, Forensic Mental Health in London - A Strategy for Action (August 2004) p.36.

specialist forensic teams, also manage patients in the community. In London approximately 9% of the expenditure of mental health trusts is spent on their forensic services. This figure excludes expenditure on high secure care and expenditure by primary care trusts on forensic placements in other NHS and private sector services.

5.2.5 Like any other specialist medical resource, it is obviously right that forensic psychiatric care is targeted at those whose need is greatest. A person's need for secure care is a function both of the severity of the mental disorder and the risks, particularly of harm to others, associated with it. But risk to others is a problematic notion if it is based on something other than a history of serious offending. The following is taken from the evidence of Dr A, consultant forensic psychiatrist:

“It is certainly the case that in the North London Forensic Service patients admitted to medium secure beds would generally be at the very serious end of offending or, very occasionally, I would imagine once or twice a year, people would be referred from the local services because of a physical inability to contain them despite having had a process of treatment ... Generally it tends to be grievous bodily harm and above in terms of violent offences, arsons and some sexual offences, again in the context of mental illness ...”

5.2.6 Forensic and general psychiatry operate in parallel. For a patient to be transferred from general to forensic services there would normally have to be a relevant intervening event such as a conviction for a serious offence of violence. A person who has been admitted to forensic services will almost invariably continue to be managed by those services throughout periods of in-patient treatment and for a considerable time following discharge into the community.

5.2.7 The main difference between how forensic and general psychiatric services operate concerns gate-keeping. While forensic services are able to exercise tight control over which patients come under their care, general psychiatrists are expected to manage whoever is referred to them by one of a number of routes, including self-referral and referral from primary care, social services and the police.

3 The involvement of forensic psychiatry in Mr Hardy's case

5.3.1 Although Mr Hardy was never a patient of forensic services, he was seen by a number of forensic psychiatrists. He had been assessed by Dr G in 1989, and in 1995 by Dr F. In the two-month period following his arrest in January 2002, he was seen by six forensic psychiatrists from the North London Forensic Service, two of whom provided the medical recommendations for his detention under section 37 of the Mental Health Act. After admission, he was assessed by Dr B and Dr C of the North London Forensic Service at the request of Dr E.

5.3.2 In 2002, prior to the making of the hospital order, the forensic psychiatrists performed two distinct roles. The first was through the Psychiatric Diversion Team at Highbury Corner Magistrates' Court, which provides assessments and reports for the court. The second was through the In-reach Mental Health Team at Pentonville prison. Dr A described the latter role:

“As the assessing doctor doing clinics, one's role was not to be a forensic psychiatrist as such, in terms of the detailed assessments one does, it was more a triaging process.”

5.3.3 We accept that in neither of these roles could they have been expected to carry out a detailed forensic psychiatric assessment of the kind later undertaken by Dr B. We also understand that once it was decided that Mr Hardy was not going to be prosecuted for any offence in connection with Sally White's death, forensic services were entitled to refer him back to general psychiatric services. This follows from the fact that Mr Hardy did not meet the forensic services' serious offence criterion.¹⁹

¹⁹ The North London Forensic Service has issued guidance to people referring patients to the service, which includes admission criteria. Of greatest relevance to the present discussion is: *“Those suitable for transfer from prisons will generally be charged with, or have been*

5.3.4 The next involvement was Dr B’s forensic assessment, which was done at Dr E’s request. We have commented elsewhere on the length of time taken to prepare the forensic assessment report, in the context of the discussion of Mr Hardy’s application to the hospital managers for discharge from detention.²⁰ The chronology was as follows:

27.06.02	Dr E wrote to Dr C, consultant forensic psychiatrist, requesting a forensic assessment.
23.07.02	Dr B, Dr C’s Specialist Registrar, examined Mr Hardy on Cardigan ward. His entry in the notes said that a report would be sent to Dr E within one to two weeks.
28.08.02	Dr C examined Mr Hardy on Cardigan ward.
29.10.02	Report completed and sent to Dr E.

5.3.5 Four months is a long time to prepare a report. We asked both Dr B and Dr C about this. One cause of the delay was that Dr B thought it necessary to ask Dr C to assess Mr Hardy. He explained his reasons to us:

“First was the issue of diagnostic uncertainty. Mr Hardy had been seen by numerous general adult and forensic consultants over a period of many years and there always seemed to be some uncertainty around whether his presentation and behaviour was related solely to personality, which I think was the impression of Dr G. There was a query of a clear diagnosis of bipolar disorder in Australia and Dr F was of the opinion that he had bipolar disorder and - paying some attention to Dr G’s opinion - with possibly some antisocial personality traits²¹. I felt a second opinion on the issue of his diagnosis would be helpful.

The second reason I felt it would benefit from Dr C seeing him was because of the circumstances surrounding his arrest. It was a very unusual and bizarre presentation and I felt having an extra opinion on this case would be helpful in coming to a clear conclusion because it was extremely difficult to decide what was the appropriate action to take.”

convicted of, a ‘grave’ offence in terms of Home Office classification. Broadly speaking, ‘grave’ offences are those which can carry a maximum sentence of life imprisonment.”

²⁰ See Chapter 7 Mental Health Act paragraphs 7.5.20 - 7.5.26

²¹ The diagnostic history is described in Chapter 8 Mental Illness, paragraph 8.2.1 - 8.2.6

This was a complicated and difficult case. Dr C told us that he and Dr B discussed it over a number of weeks:

*“I can’t remember precisely what was discussed on which particular Wednesday but I certainly recall that we gathered information over a period of time and the discussion about the case was heard on a number of Wednesdays as more information came in.”*²²

5.3.6 What was unsatisfactory, in our view, was that Dr E was not told why the report was delayed or given a date by which he could expect to receive it. The North London Forensic Service’s procedures for handling requests for assessments have been reviewed by Barnet, Enfield and Haringey Mental Health NHS Trust as part of a Serious Untoward Incident investigation arising from the Service’s involvement in Mr Hardy’s case. That investigation made a number of recommendations, of which two are relevant to this particular issue:

- *A referral protocol should be developed by the North London Forensic Service, which should include details of information required, including purpose of referral, degree of urgency, and imminent events that might affect this.*
- *The North London Forensic Service should strengthen the arrangements for referrals’ management and develop indicative timescales for completion of reports following referrals.*

We endorse these recommendations.

4 Questions and Discussion

5.4.1 We now turn to our questions.

Were there features of Mr Hardy’s case as it was understood in 2002 that warranted a transfer of his care to forensic psychiatric services?

5.4.2 Mr Hardy had no convictions for serious offences of violence or sexual offences. There was therefore no basis, applying the criteria for admission to forensic services, for his psychiatric care and management to be transferred to the North London Forensic Service. This is the answer we received not only from the

²² Dr C explained that the case was discussed both at his supervision sessions with Dr B and also within the team: *“I would also present [cases] to the team for discussion and adjust my recommendations in the light of that discussion.”*

Service's forensic psychiatrists but also from Professor Maden, who told us:

"It [would not have been] a sensible use of resources. There may be a case for an admission for assessment for a very specific purpose but to take on an open-ended commitment would be definitely contra-indicated."

5.4.3 What emerges clearly from the evidence of the forensic psychiatrists that they are in a position to decide which patients to treat. In addition to the serious offending history criterion, there is a criterion of treatability which excludes many people with personality disorders - this was probably what Professor Maden was referring to.²³ The criteria are applied in the context of unmet demand for forensic psychiatric beds, not least from acutely mentally ill prisoners who require treatment.²⁴

5.4.4 In questioning Dr A, consultant forensic psychiatrist, we asked whether it would be better if the criteria for admission to forensic services were based on an assessment of risk to others rather than, as is now the case, on the seriousness of the offending history. In making this suggestion we had in mind Dr B's statement in his October 2002 report on Mr Hardy:

"there is strong evidence to believe that he is at risk of re-offending and is likely to cause others serious physical or psychological harm."

Dr A's response, which also reflects the views of his forensic psychiatric colleagues, was:

"One has only to do some relatively simple calculations about the unmet need within the criminal justice system to see there is a huge unmet need and one would probably have to double the medium secure beds in order to be able to provide a service for that kind of approach. Personally - and I think this is a view shared by several colleagues - I also have a great deal of reservation about the idea of risk prediction and risk assessment as a tool for risk prediction ... It would be fair to say that risk prediction, no matter what resources you have, is an extraordinarily problematic notion. I remain of the view that the tools available

²³ The North London Forensic Service's criteria explicitly exclude people "classified as personality-disordered in the absence of mental illness".

²⁴ The North London Forensic Service's criteria state: "Priority is given to those currently in prison and in need of urgent transfer to hospital for treatment".

to us are of a very limited utility. They are helpful in providing an approach, for example, to structure professional judgement but to predict risk in any way that is clinically meaningful is very difficult.”

Were there features of Mr Hardy’s case as it was understood in 2002 that suggested he could not be adequately managed by general adult services?

5.4.5 We are left in no doubt by the evidence we have heard that many of those involved directly in Mr Hardy’s care in 2002 had serious concerns arising from their belief that he was dangerous. This caused them considerable unease. We are satisfied that what we have heard reflects what people were thinking and saying about him at the time. Their unease arose both from their knowledge that Sally White had died in unexplained circumstances in his flat and their perception of him as untrustworthy, manipulative and emotionally detached. This unease was heightened by Dr B’s assessment, both because of the conclusion about the likelihood that he would cause serious harm to others and because of Dr B’s detailed descriptions of the circumstances in which Sally White’s body was found and of Mr Hardy’s past violence towards his former wife.²⁵

5.4.6 If one goes back to the process by which Mr Hardy was admitted to the Mornington Unit and thereafter detained at St Luke’s under section 37 of the Mental Health Act, it appears to us that the actions of local services can best be understood as a response to the assessed risk to others. This is captured by the quotations in paragraph 5.2.3 above.

5.4.7 Admission under section 37 meant that Mr Hardy was contained and could be closely monitored. It also allowed time to obtain a forensic assessment. As the only alternative to admission to general adult services in early 2002 would have been release from prison direct into the community, the decision to admit was sensible.

5.4.8 Thereafter, the interventions available to the team were effective in treating Mr Hardy’s mental illness but had little impact on his use of alcohol and did not touch those features of his personality which were associated with an increased risk of violence. It is clear from the reaction to the managers’ decision to discharge him from section 37 that most, if not all, members of the multidisciplinary team believed that the risk to others was as high after seven months in hospital as it had

²⁵ See Appendix 3 Forensic History

been at the beginning of the admission. There was nothing in Dr B's assessment which contradicted this view. On the contrary, it confirmed and articulated people's concerns about risk. The situation which arose in November 2002, when Mr Hardy went home in circumstances which caused considerable anxiety to members of the team, was perhaps the inevitable consequence of the initial decision to admit.²⁶

5.4.9 The criteria for admission to forensic services, which excluded Mr Hardy, did not take account of his suitability for general adult services. Our concern is that general psychiatric services, who in terms of physical and human resources are less well endowed than forensic services, are not in a position to exclude someone like Mr Hardy. He came to them by default and they had to do their best. It is not simply that people were anxious. In our view, there were features of the case which made it unusually complex and difficult for general adult services to manage. These included, but were not confined to, the problems of assessing risk because of the combination of the serious history of violence against his former wife and the unanswered questions surrounding the discovery of Sally White's body. Our view is that it was these features, although they were not fully articulated at the time, that caused such unease. With the benefit of hindsight, we can say that this unease was well-founded. It does not follow that forensic services would have been better able to manage the risks, but it is worth asking whether they would have been able to add anything to what general services were able to provide.

If he was not suitable for forensic services and yet could not be adequately managed by general services, what should have happened?

5.4.10 We have thought about specific interventions which might have been part of Mr Hardy's management if he had been a forensic patient. As discussed elsewhere, we think it possible that more would have been done to assess his personality and to incorporate the findings into the care plan and the risk assessment.²⁷ We also think it possible, as is apparent from Dr B's assessment of risk, that forensic services would have made a stronger case for his continued detention under the

²⁶ The anxieties of members of the team are set out extensively in Chapter 12 Sally White's death paragraphs 12.5.4 - 12.5.7

²⁷ See Chapter 10 Personality Disorder, paragraphs 10.5.2 - 10.5.8

Mental Health Act if they had had responsibility for his management.²⁸

5.4.11 To put it no higher, our view is that this was a case in which general psychiatric services would have been assisted by receiving more input from forensic services. This is both because of the features of the case that made it unusually complex and difficult, and because of Dr B's assessment of the risk to others as a likelihood of "serious psychological or physical harm".²⁹ It is our understanding of the present arrangements in Camden, which are fairly typical of what exists elsewhere, that it was not open to the team in general services to ask forensic services for more than an assessment of the kind Dr E requested and received. We consider that in a case such as this there should be the possibility of joint multi-disciplinary working between general and forensic psychiatry. For example, members of the forensic service's multi-disciplinary team could have been asked to attend a case conference where one of the questions would have been what could forensic services have offered to the management of the case over and above what was being provided by general psychiatric services.

5.4.12 In suggesting that more input from forensic services could have been helpful, we are not saying that this would have necessitated transfer to a forensic bed. Our view is that the expertise and resources of forensic services could have been of assistance to those with responsibility for managing Mr Hardy. We consider there would be considerable benefit in a more collaborative approach to the management of patients who are assessed as presenting serious risks to others.

²⁸ See Chapter 7 Mental Health Act, paragraphs 7.5.12 - 7.5.19

²⁹ We were struck by the similarity between the words used by Dr B and the grounds for making a restricted hospital order under section 41 of the Mental Health Act: "*the risk of his committing further offences if set at large, [and] that it is necessary for the protection of the public from serious harm*". Similar words are also used in section 25A of the Act (After-care under supervision), "*a substantial risk of serious harm to ... the safety of other persons*", which reminds us that forensic psychiatry does not have a monopoly on patients who are assessed as representing a serious risk to others.

5.4.13 While we think it possible that greater forensic involvement in Mr Hardy's management could have delayed his discharge from detention, we do not conclude that it would have prevented him from committing murder when he was eventually discharged. This follows from our understanding of the three murders and our view that psychiatric interventions were not capable of changing whatever motivated him to kill.³⁰

³⁰ See Chapter 1 Introduction, paragraph 1.1.7

Chapter 6 Housing

1 Introduction

6.1.1 In this section of the report we consider how Camden Council's Housing Department and Mental Health Services dealt with the issues which arose in relation to Mr Hardy's housing after the discovery of Sally White's body in his flat in January 2002. We discuss the housing issues under the following headings:

- Mr Hardy's housing situation in January 2002
- The Housing Department's response to the events of January 2002 and subsequent developments
- Mental Health Services' activity in connection with Mr Hardy's housing situation
- Communication between Housing and Mental Health Services
- Discussion
- Conclusions

2 Mr Hardy's housing situation in January 2002

6.2.1 In January 2002 Mr Hardy was the tenant of 4 Hartland, a one-bedroom Council flat in Camden. He had lived there since January 2000. He had previously been living, since 1997, in temporary accommodation provided by a specialist housing project for people with mental health problems at 34 Kings Terrace, London NW1. The offer of permanent accommodation was based on a medical assessment and was supported by the Focus team within Camden which provides mental health services for homeless people.

6.2.2 Prior to the events of January 2002, there had been some difficulties with his accommodation. In May 2000 he moved out of the flat because he was frightened of being assaulted: the male friend of a young woman whom he knew had stolen from him and threatened to kill him. He was provided with temporary accommodation by Camden Council and he applied for a housing transfer. However, he returned to the flat in August 2000 and the transfer application did not proceed further. In 2001 he complained to the Housing Department of water coming into his bathroom when the bath in the flat above was drained. There was also another plumbing problem, described by his solicitors in correspondence with the Council as occurring because "the waste from the sink in the flat above him does not discharge properly and flows back up into his sink causing a nauseous smell". Both these problems were remedied in 2001.

6.2.3 The opinion of members of the CMHT, who took over Mr Hardy's care from the Focus team in September 2000, was that the flat was suitable accommodation for him. When Mr R, Mr Hardy's care co-ordinator, visited the flat on 23rd November 2001 he found it to be well furnished. The only problem was that Mr Hardy did not have a functioning cooker, but he had bought himself a gas hob and was waiting for it to be installed. He was capable of living independently and appeared to be managing well. There was no suggestion that he needed supported accommodation.

6.2.4 The Mental Health Services' care plan did not include home visits by members of the CMHT. Mr R's visit of November 2001 is the only one of which we are aware prior to January 2002. This was because Mr Hardy's preference was to see his care co-ordinator outside the home.³¹ The home visit took place because Mr Hardy was feeling physically unwell that day and preferred not to go out. Mr R told us that he did not have any concerns for his own safety when visiting Mr Hardy at home.

6.2.5 The situation prior to the two incidents of January 2002 was that Mr Hardy was settled in his flat. This was an important part of the overall picture of stability in his mental health and social circumstances. The first of those incidents occurred on 8th January 2002. The female resident of the **next door flat** found Mr Hardy rummaging through a bag of rubbish which she had left out on the communal balcony. When she challenged him he was threatening towards her and the following day he posted a highly offensive letter through her letter box. This caused her considerable distress and left her fearful for her safety. This was followed by the incident on 20th January which is described in Chapter 2.³² The victim was the occupier of **the flat above** Mr Hardy. She had previously complained of other acts of harassment, such as damage to her car. It is not known whether Mr Hardy was responsible for these, but it seems likely that he was.

³¹ This is discussed in Chapter 4 on Community Mental Health Services at paragraphs 4.4.4 - 4.4.8

³² See paragraph 2.2.1

3 The Housing Department's response to the events of January 2002 and subsequent developments.

6.3.1 The 8th January incident was reported immediately and was investigated by the Housing Department, initially by interviewing the victim on 15th January and taking a copy of the offensive letter. This was followed up on 22nd February by a letter to Mr Hardy, written by the newly appointed Estate Officer, inviting him to attend the District Housing Office to discuss complaints about his behaviour. It was only after that letter was sent that the Estate Officer learned, from the victim of the 8th January incident, that Mr Hardy was on remand. The incident of 20th January was not reported to the Housing Department by the victim. It is not clear from the records we have seen when they first became aware of it.³³ However, they were informed that day by the on-site supervisor that Sally White's body had been found in Mr Hardy's flat.

6.3.2 In the ensuing weeks there was some contact between the Estate Officer and Mr R, Mr Hardy's care co-ordinator, which we describe below. But no further action was taken by the Housing Department in relation to the January incidents until the summer. The victim of the 8th January incident had seen Mr Hardy when he returned to his flat on leave from the hospital. She was frightened of him and informed a local councillor and the Housing Department.

6.3.3 This spurred the Housing Department into action. On 1st July the decision was made by officers in the Housing Department to take possession proceedings, relying on the two January incidents. On that date the Area Manager spoke to Dr E. He recorded in a note of their conversation that Dr E considered the victim of the 8th January incident would be at risk if Mr Hardy were to return to live in his flat. This was subsequently confirmed in an exchange of correspondence which we set out in paragraph 6.5.2 below. The Area Manager also spoke to the Complementary Housing Management Service (CHMS) Co-ordinator who, according to the same note, said he would arrange for the case to be screened by the Council's Vulnerability Panel, which considers all cases where legal action is taken against vulnerable tenants. It is of interest to note that at the start of the legal process, it was in the mind of the responsible Area Manager that the outcome of the

³³ Indeed, the Housing file shows a persistent confusion between the two incidents: in a case history prepared in July 2002 both incidents were said to have been directed at the same victim and the 20th January incident was said to have taken place in February.

proceedings might be an injunction ordering Mr Hardy not to return to his flat. His view was communicated in an email sent by the Estate Officer to the Council's Legal Department on 3rd July:

“he would like to try and obtain an injunction ASAP to stop Mr Hardy returning to the property, and also serve a Notice Of Seeking Possession and take legal action to get the flat back. Dr E said that Mr Hardy may be released at any time”.

A statement was taken from one of the police officers who witnessed the criminal damage on 20th January, and the victim of the 8th January incident provided her own handwritten statement. The Housing file was sent to the Legal Department in early July. On 8th July initial legal advice was given by the Legal Department to the effect that the prospects of getting an outright possession order were not good because there was insufficient evidence of harassment and because Mr Hardy was in hospital receiving treatment for mental illness. On 11th July, after receipt of Dr E's letter of 2nd July,³⁴ a Notice of Seeking Possession was served on Mr Hardy. It referred to both January incidents.

6.3.4 Further emails were sent to the Legal Department by the Estate Officer on 5th and 26th July with additional information about the two January incidents. The 5th July email said that the victim of the 8th January incident *“was terrified of what Mr Hardy may do if he returns”*. It also mentioned that, together with another resident, she was *“getting a petition together demanding that [Mr Hardy] shouldn't be allowed to return to the property”*. On 15th July in the course of a meeting with the Area Manager, the victim of the 8th January incident said she was no longer willing to attend court to give evidence against Mr Hardy. Advice was sought from the Legal Department and given in a memorandum which said that:

“in order to succeed in obtaining an injunction against Mr Hardy we require a witness statement from the main complainant ... Hearsay evidence will not be accepted by the court.”

³⁴ See paragraph 6.5.2 below

The Estate Officer's email of 26th July for the first time provided contact details for the victim of the 20th January incident:

"She is willing to do witness statement and to attend court - although is worried about facing Mr Hardy. Could you please contact her and get a witness statement off her to help with the injunction application?"

6.3.5 Another email was sent by the Estate Officer on 21st August asking the Legal Department if they required any further information from Housing and advising them that, in response to the Notice of Seeking Possession, Mr Hardy had instructed solicitors. The email also said that Mr Hardy's detention was to be reviewed on 11th September and that *"his CPN thinks he may be held for another six months"*.³⁵ There followed an exchange of emails in September between the Estate Officer and the Legal Department which was about the availability of witnesses. The victim of the 8th January incident was still saying she was not willing to attend court to give evidence. The emails show that the person dealing with the case in the Legal Department had confused the two January incidents. There is no indication in the email correspondence, or on the Housing file, that the victim of the 20th January incident had been contacted by the Legal Department in response to the request made on 26th July.

6.3.6 On 10th October a formal request was made to the Council's Legal Department to issue possession proceedings.³⁶ It is not clear why this was not done sooner. The request prompted a reply, dated 15th October, from the Legal Department to the Estate Officer's email of 21st August:

"[AH's solicitor] informed me today that the above client (sic.) is due to return home soon and that he will explain to him that he has to abide by his tenancy conditions. We therefore need to wait and see what nuisance he will cause and then try to evict him. Hopefully, by then the neighbours will be willing to give evidence."

³⁵ This refers to the formal review of Mr Hardy's detention six months after the hospital order was made. By virtue of section 20 of the Mental Health Act, renewal is for a further six month period but the patient can be discharged at any time during that period under section 23 of the Act.

³⁶ This was made on a form headed *"London Borough of Camden, Application for Court Proceedings for Nuisance and Rent Arrears"* which was completed by the Estate Officer.

This last sentence is somewhat disingenuous because the victim of the 20th January incident had indicated in July her willingness to make a statement and to attend court but this offer had not, as far as we are aware, been taken up by the Legal Department. The email is significant because it makes clear that the lawyer who was handling the case in the Council's Legal Department considered that it was not going to be possible through legal proceedings to prevent Mr Hardy returning to occupy his flat. We can only assume that this advice was unwelcome, as staff in the Housing Department were attempting to achieve that which the Legal Department were saying was not possible.

6.3.7 The proceedings were finally issued in November. The exchange of emails which followed, between the Housing Department and the Legal Department, referred to an injunction, but it is clear that what the Legal Department had in mind was not an order preventing Mr Hardy from returning to his flat, but rather one requiring him to behave properly towards his neighbours if and when he did return.

6.3.8 As already noted, Mr Hardy had instructed solicitors to defend the possession proceedings. He had also applied for a housing transfer. This application was processed according to the normal procedures within the Council and was handled separately from the possession proceedings. A letter from the Rehousing Team dated 5th November, addressed to Mr Hardy's care co-ordinator, stated that the transfer application was active and that Mr Hardy had 133 points. The care co-ordinator's note of a telephone conversation that same day with the Rehousing Manager records "*has 133 points which is not much*". On 10th November Mr Hardy made a second housing transfer application, for a bigger flat, which he intended to share with Ms Q, the female patient he had met at St Luke's hospital. That application was received and processed in the normal way but had not been determined at the time of Mr Hardy's arrest in January 2003.

6.3.9 At the Managers' Hearing on 4th November, and again at the discharge planning meeting on 14th November, Mr Hardy stated his wish to return to his flat. However, it is also recorded, in a note made by one of those who attended from the Housing Department on 14th November, that Mr Hardy had said "*he was interested in supported housing as he had previous experience of it*". According to that note, he had also agreed to give an undertaking in the legal proceedings not to cause any further nuisance, harassment or criminal damage. The Housing

Department's understanding of what had been agreed was recorded in the form of a draft consent order, drawn up by the Legal Department, whereby Mr Hardy was to accept a suspended order for possession on terms that he would not be evicted until the Housing Department and Mental Health Services had "*investigate[d] the possibility of supported housing suitable to [Mr Hardy's] needs*". Our understanding of the draft order is that Mr Hardy would have been required to give up his tenancy only if he chose to accept an offer of supported accommodation.

6.3.10 The return date for the possession proceedings was 12th December. In the course of preparing for the hearing, the Legal Department requested that the Housing Department obtain a further psychiatric report from Dr E. In an email dated 20th November, the lawyer dealing with the case said:

"if we do not receive a report from the psychiatrist which confirms that he presents a danger, then we can only go by undertakings and when he does breach those undertakings then we can seek possession, as the last incident was 9 months ago".

As we describe below, the Area Manager made a further request by letter to Dr E on 22nd November.

6.3.11 If the agreement reached on 14th November was accurately recorded in the draft consent order, Mr Hardy soon repudiated it. His solicitors wrote to the Council's Legal Department on 11th December, which was the day before the first court hearing, stating that he would not consent to a possession order. They referred in their letter to the fact that by then he had been back in his flat since 14th November without incident. On Mr Hardy's application, the court hearing on 12th December was adjourned to allow time for a defence to be filed. The advice of the Council's Legal Department following that hearing was conveyed in an email to the Area Manager:

"we cannot pursue this case as [AH's] solicitors are citing the Human Rights Act as the incidents complained about is (sic) 10 months old. Solicitors also state he is living in his property and has been there for over a month and there has (sic) been no incidents. [The lawyer who

attended court on 12th December] advises that we cannot even hope to get a suspended possession order. I am therefore minded to adjourn the matter with liberty to restore in 12 months time. Therefore if there are any incidents we can bring it back to court straight away.”

This is essentially what had been predicted by the Legal Department before the proceedings were issued, as communicated in the email of 15th October. That is how matters stood at the time of Mr Hardy’s arrest in January 2003.

6.3.12 It is worth noting that within the Housing Department consideration was given to the possibility that, to enable the Council to obtain possession of his flat, Mr Hardy could be offered alternative accommodation. This was rejected on the grounds that it would have been wrong in principle simply to transfer him if, wherever he lived, he was likely to behave in an antisocial fashion and to present a risk to neighbours. This position was stated in a letter written by the Area Manager to the local councillor on 31st October:

“The Council will not transfer Mr Hardy to another property, as this would simply be moving the problem elsewhere and against our policy on addressing anti-social behaviour.”

6.3.13 The final point to note is that once it had been decided to take possession proceedings, the housing office notified the CHMS co-ordinator. That officer, with other representatives of Camden Council, attended the discharge planning meeting on 14th November. He also communicated with Mental Health Services, as recorded at paragraph 6.5.3 below. However, as far as we can tell he had no influence on the decisions made within the Housing Department in this case.

4 Mental Health Services' activity in connection with Mr Hardy's housing situation

6.4.1 It is not entirely clear how, following his admission to hospital in April 2002, Mental Health Services viewed the prospect of Mr Hardy returning to his flat. When the need for a section 37 hospital order was being discussed in February and March 2002, the consensus was that an immediate return home would have been undesirable because of the potential risk to neighbours. It would appear, however, that once he was admitted to hospital there was less concern than previously about this, but it was still referred to in risk assessments. The following record of a ward round on 23rd April gives an indication of how people were thinking at that time:

“Discussed Tony’s housing. Tony is willing to go back to his flat if Council permit it.”³⁷

The significance of this statement is that the mental health team appeared to accept that Mr Hardy would be returning to the flat on discharge from hospital unless prevented from doing so by the Council in its capacity as his landlord. While it may have been seen as undesirable for Mr Hardy to return to his flat, it was not part of any formal discharge plan that alternative accommodation should be sought.

6.4.2 It appears that, following contact with the Housing Department in July 2002 and subsequently, concern about the risk to neighbours was reawakened and communicated to the Housing Department, albeit that Mr Hardy had not during the admission expressed any hostility towards his neighbours.

6.4.3 The preferred position of Mental Health Services throughout most of the 2002 admission appears to have been that Mr Hardy should have been offered alternative accommodation by the Housing Department, but not specifically supported accommodation. The thinking behind this was that it would have removed him from the neighbours he had previously harassed and to that extent reduced the risk of further incidents. However, prior to the Housing Department initiating legal proceedings, Mental Health Services did not take any action to bring about their desired outcome.

³⁷ This discussion took place on the same day as a telephone conversation between Mr R and the Estate Officer. Mr R's record of the conversation states: *“Tony can return to his flat after discharge from hospital as there have been no complaints about the criminal damage caused to his [upstairs] neighbour.”*

6.4.4 There was then a change in the position of the mental health team following receipt of Dr B's report in November 2002. Its recommendation, that Mr Hardy should be placed in supported accommodation as part of the proposed discharge plan, was adopted by the CMHT. At that late stage, efforts were made to find supported accommodation. But, as members of the mental health team confirmed in their evidence to the Inquiry, it was always clear to them that Mr Hardy would accept supported accommodation only if he was prevented by legal action from returning to his flat.

6.4.5 Mr Hardy's unwillingness to give up his tenancy for supported accommodation put Mental Health Services in a difficult position following receipt of Dr B's report. Dr B's recommended risk management plan included supported accommodation, but once Mr Hardy had been discharged from section 37 the mental health team had no means of bringing that about without his agreement. At the Managers' Hearing on 4th November Mr Hardy had agreed to stay informally only until the 14th November discharge planning meeting and, short of further detaining him under the Mental Health Act, there was no way of preventing him returning to his home. That is what he did.

5. Communication between Housing and Mental Health Services.

6.5.1 The first recorded communication following Mr Hardy's arrest in January was a telephone conversation between Mr R and the Estate Officer on 28th February 2002. This was followed by conversations on 24th April, 1st July and 24th August. In the course of those conversations Mr R kept the Estate Officer informed of Mr Hardy's situation. He also communicated the opinion of the mental health team that should Mr Hardy return to the flat he could pose a risk to other residents and it would therefore be preferable for him to be offered alternative accommodation. It is noteworthy that prior to 1st July, Mental Health Services did not enquire of the Housing Department whether they were intending to take steps to evict Mr Hardy, and still less did they request that proceedings be taken against him. On the contrary, as Mr R told us:

Mr R *It was my role to help Tony to keep his tenancy.*

Q. *You are telling us you would have wanted to persuade the Housing Department not to take possession proceedings?*

Mr R *Yes.*

Q. Presumably that would be your normal response where a client of yours is facing eviction and where your view, and presumably the view of the team, is that the housing is suitable.

Mr R Because we have a duty of care and because he was on enhanced CPA as well.

6.5.2 There was also an exchange of correspondence between the Area Manager and Dr E. On 1st July the Area Manager wrote to Dr E:

“As you are aware, Mr Hardy had been seriously harassing [the victim of the incident of 8th January], another of our tenants, which culminated in an acid attack in February 2002.³⁸ There was also criminal damage to our property. I understand from the Police that a dead body was found at the property and although it cannot be proved it was felt to be murder.

Mr Hardy’s CPN feels that [the victim of the incident of 8th January] would be at risk if Mr Hardy returned to his flat. I feel that the Council has no choice than to implement possession proceedings and injunctive proceedings immediately. It appears that during my absence and due to staff turnover, the case did not receive the urgent attention it should have done.

Can you please confirm your views on this matter, particularly whether Mr Hardy poses any risk to [the victim of the incident of 8th January] or anyone else. Please also advise if he is capable of understanding the terms of any injunction, which may be granted by the court, and possession proceedings.”

Dr E replied on 2nd July:

“As we discussed, there is little information I can give without Mr Hardy’s permission. There would be a risk

³⁸ This is wrong on two counts: the battery acid was poured through a different resident’s letterbox and the incident took place in January.

of a repetition of the incident that you refer to in your letter were Mr Hardy to return to his flat to live. Mr Hardy is capable of participating in legal proceedings in the normal way and I shall advise him to seek legal advice as these proceedings are planned.”(Emphasis added.)

6.5.3 On 29th October, according to a record in the in-patient medical notes, Mr Hardy’s primary nurse spoke to the Estate Officer who

“confirmed that Tony has not been evicted from his flat. However, they are looking to discontinue his tenancy by legal action. [Housing Office] may be offering alternative accommodation.”

If this record is correct, the Estate Officer failed to convey the gist of the legal advice, which she had received by email on 15th October, as to the poor prospects of success in the proposed legal action. On that same date the CHMS co-ordinator spoke to the CMHT manager. According to the record the manager made in the CMHT notes, the CHMS co-ordinator told her:

“Whilst Anthony still has access to his tenancy legally - housing are taking steps i) to get an injunction so he cannot go to the block of flats, & ii) his tenancy is transferred. They have suggested he may require supported accommodation. Anthony should be receiving a letter to this effect from housing soon. Agreed we need CPA/Network meeting soon.”

We have no reason to question the accuracy of the note, but its contents bear very little relation to the reality of the situation. There was no prospect of getting such an injunction and this was not even attempted by the Legal Department. As far as we are aware, the letter referred to by the CHMS co-ordinator was never sent. We note in passing that the suggestion of supported accommodation came from the CHMS co-ordinator, presumably because Mr Hardy was regarded as vulnerable by reason of his mental health problems. As we understand what was proposed, an offer of supported accommodation would have been forthcoming only after Mr

Hardy had been barred from returning to his flat by an injunction granted in the course of the possession proceedings. We also note that on 29th October the CMHT manager recorded a further telephone conversation with the CHMS Co-ordinator:

“Discussion with [CHMS Co-ordinator]. He will ensure some information is sent to Mr Hardy so there is more clarity.”

We do not know whether anything was sent but we note the CMHT manager’s concern about the lack of clarity.

6.5.4 The next significant contact was at the discharge planning meeting on 14th November. We have described at paragraph 6.3.9 above the Housing Department’s understanding of what was agreed at that meeting. The entry in Mr Hardy’s medical records includes the following points in relation to the possession proceedings:

“Housing team to proceed with possession Anthony accepts injunction and understood the proceedings ...has no objection to supported housing if possession order passed... ? Undertaking as opposed to injunction.”

The plan agreed with Mr Hardy at that meeting included:

“Start Comm[unity] Care Assess[ment]... view Supported Housing”.

The implication of this note is that there was a possibility that a possession order would be made and that Mr Hardy would then accept an offer of supported accommodation. A separate entry was made by the community psychiatric nurse in the CMHT records:

“Plan: 1) Tony can go to flat on extended leave, he agreed to an undertaking that he will not harass neighbours. 2) Camden Housing to look into supported accommodation. 3) If Tony gives up his tenancy. Hospital to attempt to find supported accommodation.”

In not referring to the possibility of a possession order, this is closer to the Housing record.

6.5.5 We discuss below the misunderstanding which arose between the Housing Department and Mental Health Services following the meeting on 14th November. Essentially, those in the Housing Department understood that an outright possession order would not be granted but believed that Mr Hardy might be willing to vacate his flat if offered supported housing. The mental health team understood that Mr Hardy would agree voluntarily to give up his tenancy only if offered alternative independent accommodation, but they believed there was a real possibility that an order would be made for possession of his flat and he would then be willing to accept an offer of supported accommodation. Dr E told us:

“My understanding was that he was going to be evicted from the flat and he would not be offered an alternative flat, at least straightaway, and that he would have a period in supported accommodation in the meantime. There were uncertainties about what was happening.”

The true position was that, as Camden’s Legal Department advised, the possession proceedings were not going to result in eviction and, as the mental health team knew, Mr Hardy was not going to leave voluntarily unless offered another flat. We have found no evidence that the legal advice of 15th October, quoted at paragraph 6.3.6 above, was communicated to the mental health team.

6 Discussion

6.6.1 A number of questions arise about how the Housing Department and Mental Health Services handled the matters outlined above. We start with questions affecting the Housing Department, before turning to Mental Health Services. On the Housing side the questions are:

- Did the Housing Department follow their own harassment policy?
- Was there a failure to issue the possession proceedings promptly once the circumstances of the harassment of the neighbours were known; and once the decision had been made to issue proceedings, were they prosecuted expeditiously?
- Was the outcome of the possession proceedings prejudiced by delay on the part of the Housing Department?
- Was the likely outcome of the proceedings communicated clearly to the mental health team?
- Once the history and the concerns of the mental health team were

known, was it reasonable for the Housing Department not to offer Mr Hardy a transfer?

Did the Housing Department follow their own harassment policy?

6.6.2 Our starting point is Camden Council's Housing Harassment Procedure. The following points are relevant:

- The statement that: "The Housing Department is committed to ending acts of harassment and anti social behaviour against all Camden residents. We aim to take legal action against the perpetrator with the victim's consent, and offer support and assistance to victims. To achieve this, and to meet our statutory obligations, we will act quickly, effectively and sensitively ..."
- The definition of Harassment: "Deliberate action designed to cause fear and distress. This includes physical or verbal abuse, abuse of a power relationship e.g. man/woman; white/black and actions are not usually reciprocated. Generally harassment is centred around one or more prejudices. Examples of these prejudices include: Age; Disability; Race/Ethnicity; Religious Belief; Domestic Violence; Gender; Sexuality; Learning Difficulties; Other Vulnerability. Victims of Harassment may suffer from post-traumatic stress disorder. This is characterized by intrusive thoughts, flashbacks, nightmares, drug abuse and increased alcohol consumption."
- The definition of Anti-social behaviour: "This is inconsiderate action, or lack of action, by an individual or a group that prevents other residents from having quiet enjoyment of their home and surrounding area"
- The section on Vulnerability: "When dealing with vulnerable victims or perpetrators the first port of call is the CHMS (Complementary Housing Management Service) Co-ordinator in each DHO (District Housing Office) who can help identify what support service the client is linked to ... In cases of legal action being proposed against a vulnerable person the Vulnerability Panel must give consent and a referral made to Social Services or Tenancy Support for an assessment to be carried out."

6.6.3 In considering how the Council dealt with the incidents of 8th and 20th January, it must be acknowledged that both incidents were serious and constituted harassment, falling within the above definition. The procedures under that policy were initiated by the Housing Department. Under the policy the first step is always to establish the facts. This was attempted in that the victim of the 8th January incident was seen and efforts were made to interview Mr Hardy. The procedure was halted by Mr Hardy's unavailability for interview and at that stage no decision was made on the Council's response to the incidents, of which only the first had been reported. As Mr Hardy was in custody there was no immediate urgency to take action against him.

6.6.4 On 28th February 2002 the Housing Department learned that Mr Hardy, who was still on remand, had been assessed as needing in-patient psychiatric care. In such circumstances, as the above excerpt on vulnerability shows, a number of factors come into play in the Council's response to a tenant's behaviour. The general approach is to take account of any mental health difficulties, particularly in so far as they may have contributed to the housing problems, and to try to resolve matters by meeting the person's needs. In some cases what is required is effective treatment of the mental illness which has contributed to the problems. In others, depending on the assessment made by Mental Health Services, it may be appropriate for additional support to be provided for the tenant or for an offer of alternative accommodation, possibly supported accommodation, to be made.

6.6.5 In Mr Hardy's case, as we have seen, there was discussion between the Housing Department and Mr R. His priority was that Mr Hardy should not lose his flat and be made homeless or forced into unsuitable accommodation. On the other hand, he was concerned for the safety of the immediate neighbours should Mr Hardy return to live at 4 Hartland, and he would have preferred that Mr Hardy be offered alternative accommodation. In looking at the role of the Housing Department, as far as we have been able to ascertain they did not ask the questions necessary to enable them to form a view as to whether Mr Hardy was entitled to be regarded as a vulnerable person in need of support or as someone who was responsible for the behaviour of which his neighbours had complained and who should, accordingly, face the legal consequences of his actions.

6.6.6 It was only in July 2002 that the possible undesirability of Mr Hardy returning to his flat assumed prominence in discussions between Housing and Mental Health

Services. This came about because Mr Hardy had been seen by neighbours when he went home on leave from hospital. The circumstances of the discovery of Sally White's body meant that concern about him returning to live in the flat went beyond the two neighbours whom he had harassed. A petition was started to oppose his return and a local councillor became involved. The Housing Department decided to issue proceedings against Mr Hardy for possession based on the two incidents of harassment. This was not necessarily inconsistent with the general principle of supporting Mr Hardy as a person with mental health needs, as it does not follow from a decision to start proceedings that the Council is seeking an order for outright possession. It appears to us, however, that the decision was made without regard to Mr Hardy's mental health needs, save that supporting evidence was sought from Dr E in relation to the risk of repetition. Although the CHMS co-ordinator was notified of the case, this was not until July. From the information we have received, at no stage was the case referred to the Vulnerability Panel as required under the Harassment Procedure.

6.6.7 Our overall assessment is that there was partial compliance with the Council's harassment policy but that there was a failure to act promptly and effectively in response to Mr Hardy's harassment of two of his neighbours in January 2002. There was also a failure to enquire sufficiently into his circumstances as a person who, in terms of the policy, was vulnerable because of his mental health problems.

Was there was a failure to issue the possession proceedings promptly once the circumstances of the harassment of the neighbours were known, and once the decision had been made to issue proceedings were they prosecuted expeditiously?

6.6.8 No action was taken to instruct the Legal Department until July 2002. The explanation we were offered for this by Ms Z, Assistant Director of Housing at Camden Council, in her written evidence, was as follows:

"On 11 July 2002, a letter from Dr E [dated 2nd July] consultant psychiatrist, was received which stated that there may be a repetition of the incident should ANTHONY HARDY return to the flat.

I believe that this was the reason why legal proceedings and the NOSP [Notice of Seeking Possession] were served

on 11 July 2002, because we had received this expert advice. I believe that this was the quality of evidence required in order to get a result at court. Until July 2002, we had no witnesses to support the injunctive and possession proceedings.”

In our view, this misrepresents the position. Dr E’s opinion was provided, as were the witness statements, shortly after they were requested. The delay arose because Dr E and relevant witnesses were not approached until July. When we asked Ms Z to comment on this, she said:

“My view is that if Mr Hardy was not living at the property there would be no likelihood of him constituting a nuisance. Therefore, although we had these complaints, we had not had an opportunity to interview him about the complaints at that stage and if we were going to take legal action we would need to show that there was an ongoing risk or danger that the incident would occur again. If he was in hospital or in prison he was not living at the property ... Also we needed to know about the likelihood of him returning to the property so that we could be prepared to manage that.”

While we accept that these matters are relevant, we have seen no evidence that they were considered prior to July 2002. The explanation offered by the Area Manager, quoted in paragraph 6.5.2 above, is nearer to the mark: *“It appears that during my absence and due to staff turnover, the case did not receive the urgent attention it should have done.”* When the decision was taken to issue a Notice of Seeking Possession, it was on the basis of information which, had enquiries been made, would have been available in January. We accept that there may be good reasons, particularly where someone has mental health problems and is receiving treatment, for not rushing to issue proceedings in cases of alleged harassment. We also accept that to the extent that enquiries were made of Mental Health Services prior to 1st July, the advice received was equivocal and did not point to an urgent need to obtain possession of Mr Hardy’s flat. However, given the nature of the two incidents and the serious impact on the victims, we can find no justification for the delay until July in sending instructions to the Legal Department. While we accept that, because of Mr Hardy’s history of mental illness, it was entirely appropriate to obtain Dr E’s opinion before taking proceedings, he could have been approached in

April once it was known to the Housing Department that Mr Hardy had been admitted to St Luke's. They were made aware of this on 24th April by Mr R.

6.6.9 So far as the delay after 1st July is concerned, while part of the explanation undoubtedly lies in the Legal Department's concern to ensure that the evidence was in order, it appears to us that there was sufficient evidence available in July to enable the Council to issue possession proceedings against Mr Hardy. Specifically, the 20th January incident, which was the more serious of the two, was evidenced by the statement of one of the police officers who attended on that date. We also consider that Mr Hardy's conviction for criminal damage, arising from his guilty plea, could have been relied on in the possession proceedings. It would no doubt also have been desirable to have taken a statement from the victim of the 20th January incident, and this could have been done at any time after 26th July when her contact details were communicated to the Legal Department. So far as the 8th January incident was concerned, although the victim was unwilling to provide a formal witness statement, the Housing Department had a copy of the offensive letter which Mr Hardy had written to her and this could have been relied on in evidence. What appears to have influenced the way the Legal Department worked on the case was the view they formed early on that the Housing Department's expectation of preventing Mr Hardy from returning to his home was not realistic. Having been instructed to pursue the matter urgently, the Legal Department did not do so. Indeed, proceedings were issued, in November, only after the formal request was made on 10th October, notwithstanding that instructions had been received in early July. Instead of giving clear advice on the evidence and prospects of success, the Legal Department requested additional information and did not act on the instructions they had received in July. Such legal advice as was given, was unpalatable to the Housing Department. But, while not appearing willing to accept it, they did not challenge it or ask for further clarification. On the part of the people responsible within the Housing Department, there was no acknowledgment in their communications with either the Legal Department or Mental Health Services, until possibly as late as November, that Mr Hardy was not going to be evicted from his home as a result of the legal proceedings.

6.6.10 In our opinion, there was within the Housing Department a pervasive lack of focus in the handling of the case. This is illustrated by the failure of those

responsible to ascertain and record the facts about the two January incidents,³⁹ and to adjust their expectations and alter their position in the light of the unfavourable legal advice they received. It is also evident from the involvement of the CHMS co-ordinator, which is described in paragraph 6.5.3 above.

Was the outcome of the possession proceedings prejudiced by delay on the part of the Housing Department?

6.6.11 We accept the evidence we received from the Housing Department that had proceedings been issued at the earliest possible date, it is most unlikely that an outright possession order would have been made. This view is based on a number of considerations: that Mr Hardy had not physically assaulted either victim; that he had not threatened future violence; that he had been living at the property for two years and there had been no previous recorded incidents; that since the two January incidents he had received in-patient psychiatric treatment and been attending alcohol services; that following discharge he would continue to accept treatment and be monitored as an outpatient by the CMHT; and that he was willing to give assurances as to his future behaviour. We believe it is more likely, had proceedings been issued promptly, that he would have been permitted to keep the flat, subject to an order prohibiting him from further harassment of his neighbours. He would therefore have returned to his flat when discharged from detention under the Mental Health Act.

Was the likely outcome of the proceedings communicated clearly to the mental health team?

6.6.12 The first step in the possession proceedings was the service of the Notice of Seeking Possession on 11th July. Mental Health Services were told that it had been served. Particularly given the involvement of Dr E at that stage, it was reasonable for them to assume that the legal proceedings would be issued promptly. As we have seen, there was considerable delay and on 15th October the advice from the Legal Department to Housing was that they were unlikely to get a possession order.⁴⁰ As far as we can tell, this view was not communicated to the mental health team prior to the meeting on 14th November. On the contrary, on 29th

³⁹See footnote 38 above and in the 3rd July email to the Legal Department the same error was repeated, to be subsequently corrected in an email dated 5th July. But in an email sent to the Legal Department on 4th September the Estate Officer states, erroneously, that “*The incident happened in February*”.

⁴⁰ See paragraph 6.3.6

October both the Estate Officer and the CHMS co-ordinator were still holding out the prospect of Mr Hardy being prevented from returning to his flat.⁴¹ We have quoted above from the respective records of the 14th November meeting.⁴² We have also referred to the fact that after the meeting Dr E continued to believe that eviction was still a possibility. Clearly there was a misunderstanding over an important matter. We consider that the Housing Department should have conveyed to Mental Health Services the negative legal advice they had received, preferably in writing. We find it unsatisfactory that this was not done. But we also consider that it was somewhat ingenuous of Mental Health Services not to request information from the Housing Department about the prospects of success in the legal proceedings.⁴³

Once the history and the concerns of the mental health team were known, was it reasonable for the Housing Department not to offer Mr Hardy a transfer?

6.6.13 To have agreed to a transfer would have removed the potential harassment problem from Mr Hardy's immediate neighbours but would have done little or nothing to reduce the potential risk to neighbours in general. There was no evidence that by November 2002 Mr Hardy retained any interest in the particular neighbours whom he had harassed before his arrest in January 2002. On the other hand, to have obtained undertakings or an injunction would have both reduced the risk of further incidents occurring in future and provided a sanction, in the form of enforcement through the Court, if they did occur. We therefore agree with the Housing Department's approach. But we also note that the CHMS co-ordinator appears to have adopted a somewhat different strategy, which we have described in paragraph 6.5.3 above.

6.6.14 On the Mental Health side the questions are:

- Was there clarity and consistency in the approach of Mental Health Services, specifically as to whether they supported Mr Hardy in his wish to return to his home following discharge from hospital?
- Did they adequately inform themselves about the state of the housing possession proceedings?

⁴¹ See paragraph 6.5.3

⁴² See paragraphs 6.3.9 & 6.5.4

⁴³ See discussion at paragraph 6.6.15 below.

- Did they respond adequately to the Housing Department's requests for information?

Was there clarity and consistency in the approach of Mental Health Services, specifically as to whether they supported Mr Hardy in his wish to return to his home following discharge from hospital?

6.6.15 The undesirability of Mr Hardy returning to his flat was one of the factors which supported the case for admitting him to hospital under section 37. Thereafter the potential risk to neighbours was highlighted in risk assessments. However, it is far from clear whether, prior to the meeting on 14th November 2002, there was any plan for Mr Hardy's future accommodation which had been agreed by the multi-disciplinary team. We have seen that the attitude of Mr R towards Mr Hardy's housing situation was ambivalent.⁴⁴ As we have already said, the approach of the team was to wait and see what came out of the actions initiated by the Housing Department.⁴⁵ In our view, the mental health team should have decided very early on, in consultation with Mr Hardy, whether it was desirable, or even acceptable, for him to return to his flat. Had they done so, we believe the decision would have been to look for alternative accommodation. Had enquiries been made in good time, the position would have been much clearer at the Managers' Hearing on 4th November. We do not say that these enquiries would have led to alternative accommodation, acceptable to Mr Hardy, being found. But we criticise the lack of a plan and a clear sense of purpose. We consider that the care planning in this respect did not conform to what is demanded by the Mental Health Act Code of Practice, that discharge planning "needs to start when the patient is admitted to hospital".⁴⁶

Did they adequately inform themselves about the state of the housing possession proceedings?

6.6.16 Uncertainty about accommodation was held out to the hospital managers, particularly in November, as one of the factors justifying Mr Hardy's further detention. But, as we have seen, any uncertainty arose only as a possible consequence of the possession proceedings. There was no uncertainty in Mr Hardy's mind that he wished to return home and, apart from responding to requests from

⁴⁴ Paragraph 6.5.1 above.

⁴⁵ Paragraph 6.4.1 above.

⁴⁶ Mental Health Act Code of Practice, paragraph 27.1.

the Housing Department, nor was there anything the mental health team did, or considered doing, which would have put his housing position in doubt. Given the prominence of this issue, it would have been better had Mental Health Services made greater efforts to inform themselves about the likelihood of the legal proceedings resulting in a possession order. We have in paragraphs 6.3.9, 6.5.4 and 6.5.5 referred to the confusion which arose following the meeting on 14th November. We consider that the mental health team had a clear interest in knowing whether the possession proceedings were likely to result in Mr Hardy being evicted. In our opinion they should have been asking this question as soon as they knew in July of the decision to issue proceedings. However, they were entitled to expect that those responsible in the Housing Department would have kept them informed and have communicated any relevant information. The Legal Department's advice was certainly relevant and should have been conveyed to them. That would have meant that the mental health team could have planned on the assumption that Mr Hardy would be returning to his flat unless he could either be persuaded to change his mind, which no one thought was a serious possibility, or be prevented from returning by the use of powers under the Mental Health Act.

Did they respond adequately to the Housing Department's requests for information?

6.6.17 In the Housing Department's papers, the criticism is made of Dr E that he failed to respond to requests for information received from the Housing Department in connection with the legal proceedings. The specific criticism is that he failed to provide a medical report. What he did, as we have seen,⁴⁷ was to write on 2nd July giving his opinion that there would be a risk to the neighbours if Mr Hardy were to return home. On 8th November a further letter was written, by Dr E's senior house officer, addressed "To whom it may concern":

"Mr Hardy is under the care of Dr E, consultant psychiatrist, and has been attending regularly a project aimed at addressing his alcohol misuse. He is on the following medication for stabilization of his mood: Lithium Carbonate 1.2.mg at night, Sodium Valproate Modified Release 300mg twice a day."

⁴⁷ Paragraph 6.5.2 above

A copy of this letter is on the Housing file but we do not know when it was received. It is not referred to in any of the correspondence on the file.

6.6.18 Following advice from the Legal Department, the Area Manager wrote to Dr E on 22nd November, referring to the legal advice he had received and requesting a medical report for use at the court hearing on 12th December:

*“to include a diagnosis and whether Mr Hardy is able to return to his present accommodation bearing in mind that one of his victims lives next door. Please comment if Mr Hardy poses a threat to his neighbours given his mental condition either current or previous”.*⁴⁸

Dr E explained to us that he had already told the Area Manager, at the 14th November meeting, that he considered Mr Hardy’s entitlement to medical confidentiality precluded the provision of further medical information at that time in connection with the housing possession proceedings, but that he would have been willing to attend court to give evidence if asked to do so. He did not reply to the letter of 22nd November. Dr E explained his position to us:

“They were going to start legal proceedings to evict him and I would have been happy to provide information for the court to make a decision about that. There was no immediate risk. They were doing everything they could in that they were taking legal proceedings to evict him. My breaching his confidentiality would not have produced any benefit to public safety. The legal situation is very different in regard to housing issues and in regard to child protection.

I said in the letter [of 2nd July] there was a risk of repetition of the incident which he had described. The decision to proceed with the eviction was already made. I would breach confidentiality in certain situations but there was no benefit to doing more than that, and I needed to keep them informed of what was happening. There is a balance but in the housing situation the balance was that they said they were doing everything that could be done and that I did not need to reveal anything else at that point”

⁴⁸ This request followed advice from the Legal Department, given by email on 20th November, that “if we do not receive a report from the psychiatrist which confirms that he presents a danger, then we can only go by undertakings and when he does breach those undertakings we can seek possession as the last incident was 9 months ago”.

6.6.19 We consider that in principle this was correct, given that the crucial point about future risk had been made by Dr E in the letter of 2nd July. We also agree with Dr E's assessment that the matter was not urgent, since the Court was clearly not going to be in a position to deal with a contested possession action on the return date of 12th December. However, it appears to us that it would have been better for Dr E to have sought Mr Hardy's consent to disclosure of medically confidential matters. Dr E would have had to explain to Mr Hardy what information he considered it necessary to disclose to the Housing Department and, if Mr Hardy agreed, to have recorded this in the medical notes. In our view it would have been desirable for him to have done this before writing the letter of 2nd July, although we accept that he was entitled, without Mr Hardy's consent, to communicate to the Housing Department his view about the potential risk to neighbours. As it appears to us that Mr Hardy's consent was not sought, either then or subsequently, we are not persuaded that medical confidentiality provided a valid reason for Dr E not to respond to the 22nd November request from the Housing Department. We note that by then Mr Hardy was being advised by solicitors in connection with the possession proceedings and it would have been entirely proper for Dr E to have recommended that he obtain legal advice before consenting to disclosure. We also note that Mr Hardy had spoken openly at the meeting on 14th November in the presence of representatives from the Housing Department. According to their record of the meeting:

“Mr Hardy stated that his behaviour had changed dramatically since January 2002 and [he] had been attending alcohol recovery and attending ‘dual diagnosis’. He said he had met a partner recently. Mr Hardy reported that he was taking two mood stabilisers and where previously he was suicidal, he now felt better”.

We therefore consider that if Dr E had sought Mr Hardy's consent to disclosure in response to the letter of 22nd November, it is possible that he would have agreed. Had Mr Hardy consented to disclosure, the better course would have been for Dr E to have provided the information, given that the request came from the Legal Department. If, not unreasonably, Dr E had doubts about the relevance of the

requested information to the legal proceedings, he could have asked for an explanation.

6.6.20 We therefore conclude that it would have been better for Dr E to have sought Mr Hardy's consent to disclosure in response to the request of 22nd November. Had his consent been forthcoming, we consider that the information should have been provided unless Dr E and the Legal Department had agreed that further medical evidence at that stage would have served no useful purpose. We emphasise that the provision of medical evidence would not have made a difference to what happened at court on 12th December. As soon as it was known that Mr Hardy was defending the possession claim, the court was bound, in the circumstances, to grant the requested adjournment.

7 Conclusion

6.7.1 In respect of both the Housing Department and the mental health team, the general criticism can be made that they did not communicate well with each other and that this gave rise to avoidable confusion and uncertainty. We conclude that there were failures on both sides. On the Housing side, the legal advice on prospects of success in the possession proceedings was not communicated. On the Mental Health side, as part of a discharge planning process insufficient consideration was given to the question of Mr Hardy's future accommodation. This meant that they did not tell the Housing Department what they would have wished to happen in relation to his tenancy.

6.7.2 From our understanding of the case, had Mental Health Services communicated their wishes to the Housing Department shortly after Mr Hardy's admission to St Luke's, they would have requested that he be offered another flat. It seems likely, for the reasons discussed above, that this request would have been refused. Mental Health Services would then have been in a better position to plan on the understanding that, unless a way was found to place him in supported accommodation against his wishes, Mr Hardy would in due course be returning home. We believe this could have been clarified in good time before the Managers' Hearing of 4th November. It was unsatisfactory that uncertainty about accommodation remained at that date.

6.7.3 While better planning would have made for greater clarity, we do not consider that it would necessarily have changed the outcome. We think it likely

that the Housing Department would have maintained their refusal to transfer the problem elsewhere,⁴⁹ and that in due course Mr Hardy would have been discharged from detention and returned home. Even if the mental health team had formed the view at an earlier stage that discharge should be to supported accommodation, we do not consider it likely that this outcome would have been achieved, because Mr Hardy was clearly not willing to agree to it.⁵⁰

6.7.4 It would no doubt be helpful in cases where users of mental health services are subject to legal proceedings for possession brought by the Housing Department if information could be provided to Mental Health Services about the nature of the proceedings, the orders being sought and the likely or preferred outcome. In this case we believe this information could have been provided soon after the Notice of Seeking Possession was served in July.

6.7.5 It also appears to us that there was a failure in the operation of the Housing Department's procedures for protecting vulnerable tenants, which should have ensured better communication with the mental health team. As we have seen, although the CHMS co-ordinator was informed of the possession proceedings and communicated with the mental health team, the case was not referred to the Vulnerability Panel. In common with others, the CHMS co-ordinator was ill-prepared for the situation which arose following the managers' decision to discharge Mr Hardy from section 37. We consider that had the vulnerability procedures operated properly, this outcome could have been anticipated.

⁴⁹ See paragraph 6.3.12 above

⁵⁰ See also the discussion in Chapter 7 Mental Health Act paragraphs 7.5.14 - 7.5.19

Chapter 7 Mental Health Act

1 Introduction

7.1.1 Mr Hardy was detained under the Mental Health Act from his admission to the Huntley Centre on 8th April 2002 until his discharge from section 37, against the advice of the multi-disciplinary team, by the hospital managers on 4th November 2002.

7.1.2 In this chapter we consider the following issues relating to Mr Hardy's detention under the Mental Health Act:

- The reasons for recommending his detention under section 37.
- The justification for his detention thereafter.
- The case put to hospital managers by the multidisciplinary team on 4th November 2002.
- The adequacy of the decision-making process at the Managers' Hearing and the managers' reasons for discharge.
- The role of hospital managers generally in discharging patients from detention under the Act.

2 The reasons for recommending Mr Hardy's detention under section 37

7.2.1 The process by which Mr Hardy was detained under section 37 of the Mental Health Act has been described elsewhere.⁵¹ Once it had been decided that he was not going to be charged with murder, the choice was between discharge home and detention in hospital, as there was no reason to believe he would have been willing to stay in hospital voluntarily. The decision to recommend a section 37 hospital order followed from Dr E's preference for Mr Hardy to have a period of in-patient care before being discharged into the community. He was concerned about the events of January 2002 and the implications for Mr Hardy's future management. There was the particular worry about Mr Hardy returning to his home, where he might continue to harass his neighbours. Dr E also thought it would be desirable to obtain a forensic assessment to inform discharge planning.

7.2.2 We agree that it was preferable for Mr Hardy to be transferred to psychiatric hospital, rather than being discharged home directly from prison.

⁵¹ See Chapter 2 Narrative, paragraphs 2.2.13 - 2.2.14

7.2.3 We accept that the medical recommendations for section 37 accurately conveyed the clinical opinions of the two recommending doctors. They also reflected the medical consensus which had been reached by the forensic psychiatrists over the preceding weeks.

7.2.4 While it is striking, given Mr Hardy's history, that the two medical recommendations referred only to his depressed mental state and the short-term risk of suicide, we accept that it was irrelevant to his future management that at the time of assessment the identified risk was to his own safety rather than to the safety of others. It so happens that at the time Mr Hardy was assessed for section 37 he was found to be depressed and suicidal. Those features provided a sufficient basis for his detention. Thereafter it was for general psychiatric services to treat him and manage the risks, according to their own assessment. Everyone understood that once Mr Hardy was admitted to hospital under section 37, a wider range of factors would come into play in deciding for how long he should continue to be detained.

7.2.5 Accordingly, we make no criticism of the reasons given in the medical recommendations for detention under section 37.

3 The justification for his detention thereafter

7.3.1 By the time he was admitted to hospital Mr Hardy's mental state had improved to the extent that no signs of mental illness were present on assessment by Dr D. But he was not discharged from detention for another seven months despite continuous stability of mental state throughout most of the admission. Using the terminology of the Mental Health Act, it could be said that, taking the two medical recommendations at face value, he was detained primarily because of the *degree* of his mental illness, but it was the opinion of Dr D and Dr E that the illness was also of a *nature* which warranted detention.⁵² This refers to the risk of a deterioration in his mental health and the risk to other people, as summarised in risk assessments.⁵³ We therefore attach no significance to the apparent inconsistency between the clinical grounds stated in the medical recommendations

⁵² In *R v Mental Health Review Tribunal for the South Thames Region Ex p. Smith* [1999] C.O.D. 148, Popplewell J. said that "*nature*" refers to the particular mental disorder from which the patient suffers, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder; and that "*degree*" refers to the current manifestation of the patient's disorder.

⁵³ See Chapter 11 Risk Assessment and Risk Management, paragraph 11.4.10

and the fact that Mr Hardy thereafter remained in hospital under section 37 while not acutely unwell. We consider that it was appropriate to use the Mental Health Act in these circumstances, both at the point of admission and subsequently when it became clear that he was not depressed or suicidal. Once Mr Hardy had been admitted to St Luke's hospital, following the short period of assessment on the Mornington Unit, there was a need to formulate a plan which would minimise the risk of relapse, and the risk to others, when he left hospital.

7.3.2 The justification for detention arose from the following considerations:

- He was suffering from a relapsing mental illness diagnosed as bipolar affective disorder.
- His condition, and vulnerability to relapse, was complicated by his use of alcohol as a mood enhancer. Alcohol was also thought to increase the risk of violence to others.
- He had a history of violence which, taken together with the events of January 2002, required a fuller assessment of risk for the purpose of planning and managing his discharge from hospital.
- There was a risk that if he were to return home he would again come into conflict with neighbours causing them distress and possibly physical injury.

7.3.3 These are mirrored in the interventions during Mr Hardy's period of in-patient care:

- The illness was treated with medication and his mental state was monitored.
- He was referred to the Alcohol Advisory Service and attended other alcohol services. He was required to abstain from alcohol while on leave and was liable to be breathalysed when he returned to the ward, with the sanction of cancellation of leave if he consumed alcohol.
- An assessment was requested from the North London Forensic Service to inform risk management and discharge planning.

- Initially the view was taken that it would be better for him not to return home and there was liaison with the Housing Department.⁵⁴

7.3.4 It is helpful to consider what progress was made during the course of the admission and to what extent treatment in hospital under detention continued to be relevant. This is how matters stood when the managers reviewed Mr Hardy's detention on 4th November:

- Throughout the admission, except possibly for a short period in July, Mr Hardy's mental state had been stable on medication. He was neither depressed nor manic. He was willing to take medication as prescribed both in hospital and as an out-patient.
- Mr Hardy co-operated with the referral to the Alcohol Advisory Service and other alcohol services. He said that he wanted to moderate his consumption, or even to become abstinent, but the realistic assessment was that only after discharge from hospital would it be known whether there had been any change. The opinion of Mr V, as communicated to Dr E in his letter of 30th October 2002, was not optimistic.⁵⁵ As Mr V told us, Mr Hardy's attitude to alcohol had not changed: he drank because he liked its effects. His behaviour as an in-patient was not encouraging. There had been several occasions during the admission when he had returned to the ward having consumed alcohol or had consumed alcohol in his room on the ward. When challenged by nursing staff, he denied that he had been drinking.
- The forensic assessment report, which had been requested by Dr E in June, was sent to Dr E by post on 29th October but had not reached him by 4th November.
- Towards the end of the admission it became apparent that it would be difficult to prevent Mr Hardy returning home but there remained uncertainty about this.⁵⁶

⁵⁴ See Chapter 6 Housing, paragraph 6.5.1 - 6.5.5

⁵⁵ See Chapter 3 Alcohol paragraph 3.2.2

⁵⁶ See Chapter 6 Housing, paragraphs 6.3.6 - 6.3.11

4 The case put to hospital managers by the multi-disciplinary team on 4th November 2002

7.4.1 We confine our discussion to the Managers' Hearing on 4th November because, unlike the Managers' Hearing which took place on 20th June, it affected the subsequent course of events.

7.4.2 The case advanced at the Managers' Hearing for upholding Mr Hardy's detention comprised the following elements:

- There was a mental illness and a history of relapse.
- There was a relationship between his mental illness and his use of alcohol: he used alcohol to elevate his mood and his use of alcohol could lead to non-compliance with treatment and relapse of his mental illness.
- There was a forensic history, including by his own admission the attempted murder of his former wife, albeit he had never been convicted of an offence of violence.
- It was clear that, subject only to remaining for a short time while discharge plans were completed, Mr Hardy would leave hospital if discharged from section 37. There was uncertainty about his accommodation because possession proceedings had been initiated and, in the light of the two January incidents, there was a concern that if he were to return to his flat there would be a risk to his neighbours. However, he had recently been spending some time at home on leave without incident, although he had not yet had any overnight leave.
- There was a need, in order to manage the risks to his own health and to others, for discharge from section 37 to be preceded by increasing periods of leave from hospital during which his mental state and alcohol consumption could be monitored and he could be recalled from leave if there were concerns.

7.4.3 The case was summarised by Dr E in his report for the Managers' Hearing, dated 21st October 2002:

“OPINION

Mr Hardy has a long history of bipolar affective disorder. His mental illness is complicated by alcohol dependence syndrome. There is a serious forensic history, including the attempted murder of his ex-wife. Mr Hardy's mental illness is controlled by treatment, but he is very vulnerable to relapse. He habitually responds to stress by drinking heavily and he also uses alcohol to elevate his mood. His use of alcohol compromises his compliance with treatment and increases his vulnerability to mood symptoms. Non-compliance with treatment, increasing use of alcohol and escalating manic symptoms combine in a vicious circle during relapses of his illness. His illness is of a nature to warrant his detention in hospital in the interests of his health and for the protection of others. I strongly recommend that his discharge should be a gradual process: once his accommodation has been arranged he should have increasing extended leave at home, combined with attendance at an alcohol day programme and regular monitoring of his mental state.”

The social circumstances report supported Dr E's recommendation and also drew attention to the outstanding forensic risk assessment. The nursing report also referred to the forensic assessment. It made no recommendation, but concluded that because Mr Hardy had not been tested with overnight leave:

“it is hard to say whether he would relapse in his mental state and alcohol use without in-patient services. However, these issues appear to be long term risks, that services in [the] community have to deal with as well.”

5. The adequacy of the decision-making process at the Managers' Hearing and the managers' reasons for discharge

7.5.1 The power of hospital managers to discharge patients from detention, which is conferred by section 23 of the Mental Health Act, should not be equated with discharge from hospital. Many people agree to remain in hospital after being discharged from detention, as did Mr Hardy for a further ten days following the Managers' Hearing. Section 23 does not lay down any legal test to be applied by hospital managers in deciding whether to discharge a patient. However, chapter 23 of the Mental Health Act Code of Practice states that "*the essential yardstick ... is whether the grounds for admission or continued detention under the Act are satisfied*". Those grounds are to be found in section 72(1)(b) of the Act, which provides in respect of decisions by Mental Health Review Tribunals that a patient is entitled to be discharged from detention unless the Tribunal is satisfied

"that he is ... suffering from mental illness ... of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment"

and that

"it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment".

7.5.2 Managers' Hearings follow an inquisitorial procedure. The managers are provided in advance with medical, nursing and social circumstances reports. At the hearing they can ask questions of the members of the multi-disciplinary team who are present and also of the patient. The patient is entitled to be represented by a lawyer. The lawyer receives in advance of the hearing copies of the reports and is entitled to question witnesses on the patient's behalf, including the patient's psychiatrist.

7.5.3 In reviewing the decision-making process in this case we have considered the reports and the managers' written reasons for their decision.⁵⁷ We have met two of

⁵⁷ See Chapter 2 Narrative, paragraph 2.5.1

the three hospital managers who made the decision and also Dr E, who attended the hearing and gave evidence. There is no transcript of the hearing.

7.5.4 The points which arise in connection with the Managers' Hearing are:

- On the evidence available to them, was it reasonable for the managers to discharge Mr Hardy from section 37?
- Would it have made a difference to the outcome of the hearing had the forensic assessment report been available and its contents communicated to the managers?
- Were the managers at fault for proceeding with the hearing when they knew that there was a forensic assessment outstanding?

We now consider these questions in turn.

On the evidence available to them, was it reasonable for the managers to discharge Mr Hardy from section 37?

7.5.5 We consider that the hospital managers were entitled to conclude, on the basis of the information that was presented to them, that the treatment of Mr Hardy's mental illness did not require him to be in hospital, because it was more likely than not that he would continue with treatment as an outpatient and remain stable in his mental state. It was also likely that he would co-operate fully with arrangements for monitoring his mental state in the community. This had been the position for many months prior to January 2002 and there was no reason to suppose that in these respects anything had changed since his admission.

7.5.6 As regards the risks associated with Mr Hardy's consumption of alcohol, it does not appear from the written decision of the managers what they thought about this but they must have concluded that further testing of his use of alcohol, by means of leave from hospital, was either not necessary or did not justify the continuation of his detention. This was an understandable conclusion because there was no reason to believe that a longer period in hospital would have changed his attitude to alcohol or his pattern of use. The hope was that, as he claimed, Mr Hardy was sincere in his efforts to control his drinking and was committed to attending alcohol services. When we met two of the managers who made the discharge decision they confirmed that this was their understanding of the position:

“Yes, we were certainly informed that his behaviour and mood were exacerbated when he was drinking. At the time he was attending his alcohol counselling and the fact [was] that there had not recently been any abuse of alcohol, we felt that that particular issue was being addressed and he was addressing himself to it ... at least he gave us the impression he was aware of the effect alcohol was having on him, and he was doing something about it. The staff within the hospital were encouraging him to continue to attend alcohol counselling.”

With hindsight we can see that the managers’ confidence was misplaced. It now appears that Mr Hardy was not sincere. But we do not criticise the managers for the conclusion they reached. They had to consider the totality of the evidence, which included not only Mr Hardy’s history of abusing alcohol but also his recent attendance at the Alcohol Advisory Service, the Alcohol Recovery Project and the Mind dual diagnosis group. They also had to make a judgement about his sincerity based on what he said at the hearing and the impression he made on them. Moreover, it was surely reasonable to conclude that the test of Mr Hardy’s resolve would come only after discharge from hospital and that in this respect a longer period of detention was unlikely to make a difference.

7.5.7 In relation to his accommodation, the way this was presented to the managers was that it would have been better, before discharging him from hospital, to know for certain whether Mr Hardy was going to be able to return home to live. This was countered by Mr Hardy’s willingness both to remain in hospital until the CPA discharge planning meeting 14th November and to consider offers of alternative accommodation if he was not able to return to his flat. We emphasise that the managers were not offered an alternative discharge proposal, to accommodation other than his flat. It was also clear that at that time there was nothing to prevent him returning to his flat if discharged from section 37: the flat was habitable and no orders had been made in the possession proceedings.⁵⁸ The managers were also entitled to take into account the period of stability at his flat between 2000 and 2002 and his stated willingness to co-operate with mental health and alcohol services following discharge.

7.5.8 With regard to the risk to others, it was reasonable for the managers to conclude, on the basis of the information presented to them, that the risk of

⁵⁸ The possession proceedings were only issued in November - see Chapter 6 Housing, paragraphs 6.3.7

violence was associated with alcohol use and elevated mood. This was the predominant view in the risk assessments at the time.⁵⁹ In assessing the risk to Mr Hardy's immediate neighbours, the managers were bound to take into account the fact that he had been back to his flat on leave without incident. They were also entitled to rely on Mr Hardy's assertion, which was probably true, that he did not harbour any animosity towards his neighbours.

7.5.9 In our view, therefore, it was reasonable for the managers, in applying the correct legal test, to conclude that Mr Hardy was entitled to be discharged from section 37. Having heard from two of the three managers it is clear to us that their decision was made after a careful consideration of the available information. Although this is not apparent from the reasons stated in the decision form, on which we comment below, it was a reasoned decision which balanced Mr Hardy's right to liberty against the risks associated with his discharge, taking account of the after-care that would be available when he left hospital. It was reasonable for the managers to conclude, on the basis of the information presented to them, that the risks, whether of relapse or of harm to others, were not so serious as to justify further detention.

7.5.10 We are aware that the discharge decision was received with both surprise and consternation by members of the multi-disciplinary team. Dr E, in his evidence to the Inquiry, drew attention to the statement in his report, "*I strongly recommend that his discharge should be a gradual process*": "*It would be unusual for me to write 'I strongly recommend' in a report. As I said, I strongly recommended that he should stay in hospital; I did think it was important*".

But, for the reasons we have already explained, whatever Dr E's view, we do not consider that the case for continued detention as it was advanced at the hearing on 4th November was particularly strong.

7.5.11 It has been suggested to us that there was an inconsistency between the decisions of the two Managers' Hearings, that of 20th June not to discharge and the discharge of 4th November, in that there had been no significant change in the intervening four months. But in our view a further four months of stability of mental state and behaviour, and of compliance with treatment, together with

⁵⁹ See Chapter 11 Risk Assessment and Risk Management, paragraphs 11.4.1 - 11.4.14

increased leave of absence from hospital, were significant and tended to strengthen the case for discharge from detention.

Would it have made a difference to the outcome of the hearing had the forensic assessment report been available and its contents communicated to the managers?

7.5.12 Had Dr B's report been received by Dr E prior to the Managers' Hearing he would have been able to communicate its contents, including Dr B's conclusions and recommendations, to the managers. Had he chosen to do so, he could also have drawn their attention to those aspects of Mr Hardy's history which Dr B had set out in such vivid detail.⁶⁰ There would have been no need for the managers themselves to have read Dr B's 13 page report, although it would have been available had they wished to do so.

7.5.13 The managers did not see Dr B's report until months after the 4th November hearing - long after Mr Hardy's arrest in January 2003. We asked the two managers whom we interviewed whether Dr B's report would have made a difference to the outcome. One commented as follows:

"If we had had this paper with the police evidence set out like that would we have come to a different conclusion? My answer is yes, we would I am sure. We would have made his withdrawal from hospital more gradual. We had already done it for six months and this was the next one. What was done with the acid and so on was very premeditated. He actually wrote something, four words on her door, and you do not write those four words in a trance."

The other told us:

"All of those things would have changed the whole mood of the hearing, and changed the mood of the managers, and who knows what effect it would have had on Anthony Hardy in that hearing, because his cool composure and wonderful presentation may well have slipped when we started to discuss some of this. It is just impossible for me to say."

These remarks were, of course, made with the wisdom of hindsight.

⁶⁰ See Appendix 3 where the relevant extract from Dr B's report is reproduced.

7.5.14 Our view is that, quite apart from its psychological impact, had the forensic assessment report been available it *should* have made a difference, because of what it said. There were two crucial points in Dr B's analysis. First, that there was a risk of serious violence independent of disturbed mental state and alcohol use; and secondly, that discharge to supported accommodation, such as a mental health hostel, would have reduced the risks associated with discharge. The first point indicated a need for greater caution in planning discharge. The second introduced a new factor into the equation, since the possibility of supported accommodation had not been raised by the multidisciplinary team in the reports provided to the managers.

7.5.15 It has been suggested to us that the desirability, in terms of the management of risk, of Mr Hardy moving to supported accommodation was not relevant to the decision the managers had to make on 4th November. We disagree with this suggestion.

7.5.16 Mr Hardy was detained under the Mental Health Act. His entitlement to discharge from detention depended on a judgment about whether he would remain well if not in hospital and whether the risks associated with his mental disorder could be safely managed in the community.

7.5.17 There are some detained patients who, even though they are well in terms of mental state, continue to be detained until suitable accommodation, for example a supported hostel, is found for them. The legal analysis of this situation is that entitlement to discharge from detention is contingent upon the provision and acceptance of suitable after-care, in the absence of which the patient's detention continues to be justified.⁶¹ It can readily be appreciated that for a patient in this situation there is a considerable incentive to accept the accommodation which is offered.

⁶¹ This proposition can be derived from a number of reported cases. For example, in *R (on the application of H) v Ashworth Hospital Authority*; *R (on the application of Ashworth Hospital Authority) v Mental Health Review Tribunal for West Midlands and North West Region* [2002] EWCA Civ 923, the Court of Appeal upheld an order quashing a Mental Health Review Tribunal's decision to discharge a patient from section 3 without regard to the availability of suitable after-care, on the grounds that "*this was a case in which, if the criteria for discharge were to be met, it was obvious that suitable after-care should be available*".

7.5.18 This is not how the argument for further detention was put in Mr Hardy's case. It was said only that it would have been desirable for the uncertainty about his future accommodation to be resolved, preferably by finding him somewhere else to live, before discharge. Once Dr B's report was received, albeit after the Managers' Hearing of 4th November, the position changed. Dr B's recommendation was for Mr Hardy to go to supported accommodation. This was not put forward primarily with a view to protecting Mr Hardy's neighbours. It arose from concerns about possible deterioration in mental state and excessive alcohol consumption, which could more effectively be monitored in supported accommodation. Dr B's report thus provided some support for the proposition that Mr Hardy would be entitled to discharge from detention if he went to supported accommodation. Had this view been accepted by the managers at the hearing on 4th November the appropriate course would have been to uphold his detention or to adjourn for supported accommodation to be found for him.⁶²

7.5.19 In setting the argument out in this way we do not intend to imply that either the hospital managers or a subsequent Mental Health Review Tribunal would have been bound to accept it. Nonetheless, it would have been deserving of serious consideration.

Were the managers at fault for proceeding with the hearing when they knew that there was a forensic assessment outstanding?

7.5.20 We have considered whether it was justifiable for the managers to proceed with the hearing on 4th November rather than to adjourn until a date when the forensic assessment report would have been available. Although reference was made to the outstanding forensic assessment in two of the reports before the managers, they were not asked to adjourn. But it would have been open to them to have done so, had they decided that they needed to consider the forensic assessment before determining Mr Hardy's application for discharge.

7.5.21 With hindsight we can see that it was unfortunate that the managers decided the case that day rather than adjourning to a date when the forensic

⁶² In *R (on the application of H) v Ashworth Hospital Authority* (ante.) the Court of Appeal endorsed the observations of the first instance Judge: "*If there is uncertainty as to the putting into place of the after-care arrangements on which satisfaction of the discharge criteria depends, the tribunal should adjourn ... to enable them to be put in place, indicating their views and giving appropriate directions*". We consider that this principle applies equally to Managers' Hearings.

assessment report would have been available. But to have justified a decision to adjourn, it would have been necessary to make the connection between the forensic assessment and the legal criteria for detention. The managers told us that their impression, from the way the issue was presented to them, was that the forensic assessment was not going to recommend anything very different from what had gone before.

“In the nursing report on page 3(5) it says ‘forensic risk assessment done last August, waiting for report’, that is a fairly bland statement. In the social circumstances report... it says ‘the forensic report is still outstanding but may give more detailed recommendations’. Now neither of those lines that I have picked out, led us to believe that there was anything crucial about that forensic report. The RMO’s report, which is the one that tends to carry the weight that leads to the most discussion and the most cross-examination (to use a legal term) by the solicitor, made no mention of the forensic report. I have made a little note here saying ‘no mention of requested forensic report’, and if it came up during the hearing there was certainly no emphasis laid on the importance of it. If it was felt to be that important, why was it not pursued from August onwards by the RMO? We should have been informed that this was something that was urgently awaited, had been requested time and time again, and none of that to my recollection came up in the hearing.”.

7.5.22 We accept the managers’ evidence that they were not invited to make a connection between the outstanding forensic report and the decision they had to make about discharge from detention. Moreover, their evidence is corroborated by the view expressed to us in correspondence by solicitors instructed by Dr E:

“The report was not sought to address the issue of Mr Hardy’s detention, which is what the Managers were concerned with. The report was concerned with the question of risk upon Mr Hardy’s release and how this might be managed. Whilst there is often an overlap of these issues, in cases like this a distinction can nevertheless be made.”

While we agree that there is a distinction such that in some cases after-care arrangements may not be relevant to the question whether the patient is entitled

to be discharged, we consider that, as understood by Dr B, this was a case where they *were* relevant. We also note that Dr B's recommendations were accepted by Dr E. We therefore conclude that had Dr B's report been available, its recommendation of supported accommodation would have been a relevant consideration for the managers.

7.5.23 We now turn to the managers' comment that if the forensic report was important this should have been pointed out to them. We accept that Dr E could not have been expected to have anticipated Dr B's recommendation. As such, he was not in a position to argue that it was essential to the managers' decision. The failure, in our judgement, was not to have made efforts in advance of the hearing to chase up the report, or at least to try to find out what Dr B was likely to recommend, so as to be in a position to advise the managers of its contents and possible relevance to their decision.

7.5.24 We do not assert that it was Dr E's responsibility personally to contact Dr B, or Dr C who was supervising the assessment, but we consider that it was his responsibility in advance of the Managers' Hearing to ensure that this was done. In our judgement that responsibility arose from the need for him, as Mr Hardy's responsible medical officer, to put the best and most comprehensive case to the managers. We consider that it should have been apparent to Dr E that in preparing for the Managers' Hearing he would have been assisted by the forensic assessment. We therefore criticise the failure to make such enquiries before the Managers' Hearing.⁶³ This criticism has particular poignancy because had Dr E made enquiries he would have been told that the report had been completed and sent to him on 29th October.

7.5.25 We have two further observations about the information presented to the managers. In common with others, when the managers eventually read Dr B's report, albeit after the shocking events of December 2002, they were struck by its detailed factual descriptions of Mr Hardy's violence towards his former wife and of the events of January 2002 surrounding the discovery of Sally White's body in his flat.⁶⁴ This reinforces our view⁶⁵ that it would generally be desirable to collate in a

⁶³ We comment elsewhere on the length of time taken over preparation of the forensic assessment report - see Chapter 5 Forensic and General Psychiatry, paragraphs 5.3.4 - 5.3.6

⁶⁴ See paragraph 7.5.13 above

⁶⁵ See Chapter 11 Risk Assessment and Risk Management, paragraph 11.5.5

single document what is known about a patient's forensic history and violent behaviour so that those who make decisions affecting a patient's future management, including hospital managers and Mental Health Review Tribunals, have a full and accurate history. The second observation arises from a recommendation made by the Trust's internal inquiry into this case. The recommendation was that the patient's medical notes should be available at Managers' Hearings. We agree with this recommendation but emphasise that normally hospital managers should not need to look beyond the written reports, prepared in advance, and the oral evidence given at the hearing. It is desirable that the medical notes should be available in case there is a need to supplement the reports and oral evidence, or to resolve a disputed point of fact by reference to the notes.

7.5.26 It follows from our discussion that had matters been presented differently to the managers it is possible that Mr Hardy would not have been discharged from section 37 on 4th November. If he had not been discharged from detention on that date he would have remained in hospital longer and any future discharge decision would have been informed by Dr B's forensic assessment. However, given our understanding of what motivated him to commit the two murders of December 2002, we do not believe that in the longer term a further period of detention in hospital would have reduced the risk of Mr Hardy committing murder following his discharge.⁶⁶

6 The role of hospital managers generally in discharging patients from detention under the Act

7.6.1 There are two further aspects of the Managers' Hearing that cause us concern. First, their written reasons fail to convey adequately the factors they took into consideration in reaching their decision. Although it was clear from Dr E's report that in his opinion further detention was justified because of the *nature* of Mr Hardy's mental illness, the decision appears only to deal with its *degree*, with its statement that "*there is nothing at present to convince us that detention in Hospital continues to be necessary*". We are also concerned that in using the phrase "*He has a Natural Human Right to be treated in the surroundings which will encourage and support his own efforts*", the managers were not clear whether they were stating a legal proposition or a humane sentiment.

⁶⁶ See Chapter 1 Introduction, paragraph 1.1.7

7.6.2 We questioned the managers about these matters. They readily conceded that one of the most difficult aspects of the role is drafting the written reasons. They also told us how the reference to human rights came into the decision. It reflected their acceptance of the case put forward by Mr Hardy's solicitor that, under Article 5 of the European Convention on Human Rights, his continued detention was not a proportionate response to the risks associated with his mental disorder.⁶⁷ They had in effect translated a legal proposition into layman's language but in so doing had lost its precise meaning and any reference to Convention rights or case law.

7.6.3 Our second concern arises directly from the managers' lack of legal training. In their evidence to this Inquiry the managers reflected on the role of law and lawyers in these hearings. These are their observations on the subject:

"There is one particular firm of solicitors that represents patients quite often at the different sites which love to quote 'in the case of so-and-so against so-and-so, and so-and-so against so-and-so', and we do not necessarily know the cases she is talking about. But you get the gist of what they are saying. So much depends within a hearing on the skill of the solicitor representing the patient.

The ability of the lawyers being used is higher. We are also aware of the Acts that have come in, in the last two years, and we are also much more aware of the questions that could be asked after our decision. We watch our backs a bit in the legal sense.

The way... it is we are more aware of the likely comeback when we keep someone on section. The solicitor may well take up the case saying that we have made a poor judgment based on information which should have allowed any right-minded person to discharge this patient, so we are careful when we fill in the forms. It is mainly looking from that angle. When we discharge we are not looking at the possible comeback from the consultant."

⁶⁷ See R (on the application of H) v Mental Health Review Tribunal, North and East London Region [2001] EWCA Civ. 415 per Lord Phillips MR at paragraph 33: "We do not believe that Article 5 requires that the patient must always be discharged in such circumstances. The appropriate response should depend on the result of weighing the interests of the patient against those of the public having regard to the particular facts. Continued detention can be justified if, but only if, it is a proportionate response having regard to the risks that would be involved in discharge."

7.6.4 The conclusion we have come to from the evidence we have heard is that the lack of legal training, or any legal assistance, places the managers at a disadvantage to an extent that leads us to question whether decisions about discharge from detention should continue to be made by lay people without legal assistance. We make this observation notwithstanding the considerable support managers in this Trust receive by way of training and information bulletins about case law and other legal developments. Our view is reinforced by the experience of the two members of this Inquiry who sit on Mental Health Review Tribunals. Particularly since the coming into force of the Human Rights Act, legal arguments advanced on behalf of the detained patient play a more prominent role than hitherto in the decision-making of tribunals, not least because the onus is now clearly on the detaining hospital to satisfy the tribunal that continued detention is justified.

7.6.5 On the specific issue of the reasons provided by the managers in this case, the legal position is that the adequacy of the decision-maker's reasons is an essential element of a fair hearing. Case law in relation to the adequacy of the reasons given by Mental Health Review Tribunals establishes that the standard is the same as for a judgement given by a judge:⁶⁸

“The adequacy of reasons must be judged by reference to what is demanded by the issues which call for decision. What is at stake in these cases is the liberty of detained patients on the one hand, and their safety as well as that of other members of the public on the other hand. Both the detained persons and members of the public are entitled to adequate reasons.”⁶⁹

We suggest this applies equally to decisions given by hospital managers. As to what constitutes adequate reasons, the following judicial guidance has been given by the Court of Appeal in a different context:

“...the issues the resolution of which were vital to the judge's conclusion should be identified and the manner in which he resolved them explained. It is not possible to

⁶⁸ R (H) v Ashworth Hospital Authority [2002] EWCA Civ 923, per Dyson LJ at paragraph 79

⁶⁹ Ibid. at para 76.

*provide a template for this process. It need not involve a lengthy argument. It does require the judge to identify and record those matters which were critical to his decision.*⁷⁰

7.6.6 We conclude that the written reasons provided by the managers in this case were not adequate. We doubt whether it is reasonable to expect lay people, without legal assistance, to provide reasons which satisfy the legal standard. We consider that that this is a powerful argument for removing the power of discharge from hospital managers.⁷¹

7.6.7 In conclusion, without criticising the managers in this case, or the decision they made on the information presented to them, we question whether decisions to discharge patients from detention should continue to be made by lay people without legal assistance. We note that the Government's proposals for reform of mental health law dispense with the managers' power of discharge.

⁷⁰ *English v Emery Reimbold & Strick Ltd* [2002] 1 WLR 2409, per Lord Phillips MR at p.2418.

⁷¹ When the system for appealing to the hospital managers for discharge was originally conceived by the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, HMSO, 1957, Cmnd 169, the procedure they had in mind was not a hearing but separate interviews with the doctor responsible for the patient's treatment and with the patient. When the discharge power was introduced by section 23 of the Mental Health Act 1983, initially there was uncertainty about the appropriate procedure to adopt, as is apparent from the following extract from the First Biennial Report of the Mental Health Act Commission, HMSO, 1985, paragraph 8.13: "*In general, it seems necessary to avoid excessive formality, such as any form of court-like or Tribunal hearing, with two sides 'lined up'. But equally the Managers will need to inform themselves of the patient's reasons for his appeal, and this may best be done by interview, unless an interview is inappropriate in the particular circumstances. So too where the appeal requires it, the Managers will wish to inform themselves of the rmo's and other professionals' views, either in written form or by interview.*" The present position is set out in chapter 23 of the Mental Health Act Code of Practice, which was published in 1999. It identifies the following key points in the conduct of contested reviews: the patient should be given a full opportunity, and any necessary help, to explain why he or she wishes to be discharged; the patient should be allowed to be accompanied by a friend or representative of his or her own choosing to help in putting his or her point of view to the panel; the rmo and other professionals should be asked to give their views on whether the patient's continued detention is justified and the factors on which those views are based; the patient and the other parties to the review should, if the patient wishes it, be able to hear each other's statements to the panel and to put questions to each other.

Chapter 8 Mental Illness

1 Introduction

8.1.1 In this chapter we summarise the clinical findings, from Mr Hardy's first contact with psychiatric services until his current admission to Broadmoor hospital, in so far as these are relevant to diagnosis and treatment of mental illness. In the final section we draw some conclusions, with particular reference to the treatment he received in 2002 for his diagnosed mental illness.

2 Diagnosis and Treatment 1982 - 2002

8.2.1 Mr Hardy's first contact with psychiatric services was in Australia. He was admitted to psychiatric hospital there in April 1982 following an attempt to kill his wife. He remained in hospital for 10 days during which time he was assessed by three psychiatrists. He was diagnosed as suffering from a depressive reaction in a cyclothymic personality. A cyclothymic personality denotes a person who suffers from swings of mood as part of their personality rather than in the course of a mental illness. No medication was prescribed during this admission and he was discharged without follow-up.

8.2.2 His next psychiatric assessment was on 1st October 1987. At that time he was on remand in Norwich prison for stealing cars. At the request of his criminal defence solicitors, he was seen by Dr G, a consultant forensic psychiatrist from the Norvic Clinic, the regional secure unit in Norwich. Dr G's assessment on interviewing Mr Hardy was that he could find "*no evidence of major mental illness*". In his opinion, Mr Hardy's offending, and his continuing violent and threatening behaviour towards his wife, resulted from what Dr G characterised as "*personality traits*" which were "*firmly based and likely to be intractable*".

8.2.3 Mr Hardy was assessed on a second occasion by Dr G, again at the request of his criminal defence solicitors, on 11th January 1989. He had again stolen a car, was drinking excessive amounts of alcohol, and was very sociable (for example, spontaneously deciding to drive to Norfolk to collect some friends to bring them back to a party in London). Shortly before his arrest, he had thrown a brick through the door of his former wife's home. In relation to mental illness, Dr G concluded that none was present:

“as the interview progressed it became clear that Mr Hardy showed no evidence of any major mental illness. He was not significantly depressed and clearly is not suffering from mental impairment.”

Dr G concluded that Mr Hardy *“had a very disturbed personality amounting to psychopathy”* and that this condition was untreatable. The records contain copies of some notes and annotations made by Mr Hardy at the time of his arrest, which are suggestive of flight of ideas.

8.2.4 Mr Hardy had no further contact with psychiatric services until April 1995 when he was admitted as a voluntary patient to University College Hospital. At this time he was living in a homeless hostel in London. By his own admission he was drinking heavily and using cannabis. He developed the belief that he was wanted by Special Branch and he was intent on going to a police station. He came across an open police van and got into it. He was taken to the Accident and Emergency department where he was interviewed by a psychiatrist and thereafter was admitted as a voluntary patient to the hospital’s psychiatric unit. When he was seen by the duty psychiatrist he was said to be nearly mute with his head in his hands. When he did speak, his speech was tangential and abnormal in form. The following day he admitted to hearing voices of people saying they would beat him up. He also said he could communicate with the television. He gave a history of heavy drinking. A urine screen was positive for cannabis. This episode was diagnosed as a drug-induced psychosis.

8.2.5 His next admission, also to the psychiatric unit at University College Hospital, was in October 1995. He was brought to the psychiatric unit by the police under section 136 of the Mental Health Act, having taken all his clothes off at a day centre. Abnormalities of mental state on admission included restlessness, distractibility and irritability. He also showed punning speech, for example *“Haloperidol - hello peridol, I’d be laughing if I was on Laffan Ward”*. He had not been sleeping and he believed he was under surveillance. During this admission, Mr Hardy was twice arrested by the police for drunken behaviour and damage to the ward. He was eventually placed under section 3 of the Mental Health Act. It was

considered that his abnormal mental state was due to a hypomanic⁷² episode, and a diagnosis of bipolar affective disorder⁷³ was made. He was treated with a mood stabiliser, carbamazepine⁷⁴, and with anti-psychotic medication. This admission lasted until January 1996.

8.2.6 During the course of the admission he was seen by Dr F, consultant forensic psychiatrist, on 24th November 1995. Dr F's mental state examination included the following: he paced restlessly; he burst into tears when he described his brother's suicide, which had occurred three years previously; and his speech was circumstantial. However, there was no evidence of current psychotic phenomena such as abnormalities of possession of thought, delusions or hallucinations. Dr F concluded that: "*Mr Hardy is undoubtedly suffering from manic depressive psychosis*" (another term for bipolar affective disorder). But he also thought it possible that: "*the break-up of his marriage and his catastrophic social decline since 1986,⁷⁵ as well as the description of auditory hallucinations and persecutory delusions, might suggest the emerging picture of a process schizophrenic illness.*"

Following his initial report, dated 27th November 1995, Dr F read the notes from the Norvic Clinic. In a supplementary report, dated 8th December 1995, he concluded that "*it would appear that in the years since Dr G's assessment, what was thought to be a tendency towards manic depression in 1981 now appears more unequivocally to be a manic depressive illness*".

8.2.7 Following his discharge in January 1996 Mr Hardy took mood-stabilising medication as an out-patient. Because he was placed in temporary hostel accommodation, he was followed up by the Focus Homeless Outreach team. His next

⁷² Psychiatrists distinguish between *hypomania* and *mania*, on the basis of the presenting symptoms. However, for the purposes of this report, this distinction is not important.

⁷³ Bipolar affective disorder (F31 according to the International Classification of Mental and Behavioural Disorders, 10th Edition - ICD-10) is characterised according to ICD-10 by *repeated (i.e. at least two) episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (mania or hypomania) and on others of a lowering of mood and decreased energy and activity (depression).*

⁷⁴ Carbamazepine is used as mood-stabilising medication in bipolar affective disorder. The aim of treatment with mood-stabilising medication is to reduce the likelihood of manic or depressive episodes in people with bipolar affective disorder, or at least to attenuate the severity of episodes if they occur.

⁷⁵ Mr Hardy, who in 1995 was homeless and unemployed, had at an earlier stage of his life graduated from Imperial College London and subsequently been employed as a manager in a large company. In his personal life, he had been married with four children but by 1995 he was single and estranged from his former wife and their children.

psychiatric admission was in May 1998, under section 3 of the Mental Health Act, initially to a private intensive care unit, Abbeydale Court in Walthamstow because there were no NHS beds available at the time. Prior to admission his behaviour had caused concern in a number of ways. He was over-familiar and sexually disinhibited; he punched another resident at his supported accommodation; he was grandiose, confrontational and abusive; he went to a church and handed them his credit card and cash; and he burnt newspapers in his room. Two weeks before his admission, he had been arrested, and was initially charged with rape but the charge was later changed to indecent assault. On admission to Abbeydale Court his mental state examination was described in the following way:

“verbally abusive, uncooperative with interview, no eye contact, his speech was unspontaneous and limited with increased volume and rate; no evidence of formal thought disorder. No access to his mood, he appeared to be intoxicated. No access to the content of his thoughts, except that he wanted to be “left alone”, or to any abnormality of perception. Insight: “Fuck off and let me sleep”.

Three days later, his mental state was described as follows:

“good self-care, wearing dark glasses inside. Over-familiar, conspiratorial manner. Speech: increased volume. Normal rate; no formal thought disorder. No evidence of psychotic phenomena. Compliant with medication. Manipulative of staff and interfering with care given to fellow patients. Extremely litigious.”

He was transferred to local services after eight days at Abbeydale Court. The diagnosis made during his short stay there was one of bipolar affective disorder, with a current hypomanic episode.

8.2.8 He remained as an in-patient at St Luke’s Hospital from 20th May 1998 until 13th August 1998. During the admission it was necessary at one stage for him to be transferred to the locked intensive care unit, Noel Harris ward, because he was threatening towards staff. During the course of this admission he expressed

delusional ideas, believing that he was “a Godfather to Decota’s baby”, and he expressed the belief that a member of staff had attempted to marry a woman whom Mr Hardy regarded as his girlfriend. He improved on medication. The discharge summary, dated 30th August 1998, concluded as follows:

“He then started to improve in his mental state and was started on escorted leave which was increased with time as he continued to be compliant with medication and treatment on the ward. At a multidisciplinary meeting on 13th August 1998 ... he appeared calm with no lability in mood and appropriate behaviour. At this meeting he realised that his aggressive behaviour and threats of violence towards his manager in July 1998⁷⁶ had been part of his bipolar affective disorder. He could not however remember clearly the sequence of events”.

He was discharged on lithium carbonate, which is another mood stabilising medication.

8.2.9 Thereafter, until his admission to the Mornington Unit in April 2002, Mr Hardy was treated as an out-patient and was prescribed lithium. Although he has said that he did not always remember to take the lithium as prescribed, he was generally compliant with the medication. He continued throughout that period to collect prescriptions for lithium from his general practitioner and his blood lithium levels were tested from time to time and indicated that he was taking the medication. He was also in regular contact with his care co-ordinator/key-worker throughout this time.

8.2.10 Mr Hardy has subsequently told psychiatrists that in the period leading up to his arrest on 20th January 2002, he was entering a manic phase of his illness. This is not supported by the psychiatric assessment which took place at that time. When he was assessed by a psychiatrist from the Highbury Magistrates’ Court Psychiatric Diversion Team on 22nd January 2002 he was described as quietly spoken and

⁷⁶ The incident referred to here, which occurred while Mr Hardy was in hospital, was recorded in the Focus Homeless Outreach Team’s notes as follows: “T/c from [the manager at King’s Terrace] saying that a woman called [R] has been living in Tony’s flat for the last few days. Tony left a message on the King’s Terrace answer phone at the weekend saying that the woman called [R] is his fiancée, and to [the manager] ‘If you bother her I will come and throw you through the window, and that’s a threat’.”

answering all questions in a polite and articulate manner. His appearance was downcast and depressed and at times he seemed on the verge of tears. Following remand to Pentonville Prison, he was assessed by Dr A, consultant forensic psychiatrist, on 18th February 2002 who considered that he was depressed and required treatment in a psychiatric hospital. In making a judgement about Mr Hardy's mental state in January 2002, account also needs to be taken of the observations made by his care co-ordinator (a community psychiatric nurse) during this period. On 7th December 2001, his entry in the community mental health team notes is as follows;

“Tony states he feels very well on his scale 0 - 20 he says he is about a 12 but is sleeping 8-9 hours a night and does not feel manic. Rate, tone, and content of speech are normal. Tony requested that I check his lithium levels which are within normal limits”.

On 3rd January 2002, Mr R, the care co-ordinator, met Mr Hardy to discuss the referral which had been made for him to have alcohol detoxification. According to Mr R's note, Mr Hardy gave a coherent account of his drinking and reasons for wanting alcohol detoxification. Mr R commented in the notes *“Tony appeared to be happy with the outcome”*. There is no suggestion that he was manic.

8.2.11 Indeed, throughout the period August 1998 - January 2002, his mental state as assessed by successive care co-ordinators was stable. He was effectively treated with lithium. During the period of community treatment, this was not supplemented by anti-psychotic medication, although this had been used on occasions during in-patient treatment when his behaviour had been challenging and threatening.

3 Treatment and progress in 2002

8.3.1 Mr Hardy was eventually transferred in April 2002 under section 37 of the Mental Health Act from Pentonville Prison to in-patient psychiatric care. While on remand in Pentonville, he had been seen by several psychiatrists, He presented as depressed, and concern was expressed by those assessing him that he might be suicidal. Nevertheless, throughout the course of his in-patient treatment between April and November 2002, there was no evidence of depression. On transfer from Pentonville, no significant abnormality was noted in his mental state. The only

abnormality of mood recorded during the admission was on 22nd July 2002 when he was thought to be showing signs of elevated mood. A second mood stabilising medication, sodium valproate, was prescribed.⁷⁷ If his mood was becoming manic, it appeared to settle quickly. When he was assessed in July and August 2002 by Dr B and Dr C, for the purpose of the forensic assessment which had been requested by Dr E, his mental state was described in the following terms:

“He presented as a physically imposing middle-aged man around six feet tall and stockily built. He was dressed in shorts and a t shirt. He [had] a grey beard which gave him a slightly grizzled appearance. His personal hygiene appeared good. He sat with a relaxed posture and showed little range of emotion during interview. His speech was normal in rate, rhythm and coherence. His speech was measured and at times he appeared to give considerable thought to answers before replying. He described his mood as neither elated or depressed. Objectively he appeared euthymic.⁷⁸ There were no biological symptoms of mood disorder. He denied any suicidal or homicidal ideation. There was no evidence of formal thought disorder or abnormality in the speed of his thought. There was no evidence of delusional or obsessional thoughts. He denied any perceptual abnormalities.⁷⁹ His cognitive state⁸⁰ was normal”.

8.3.2 His mental state remained stable until his discharge in November 2002. Thereafter, there was still no evidence of mental state abnormalities, although there were concerns that he was drinking alcohol. On 2nd December 2002, which was the last time he was seen by Dr E before his arrest on 2nd January 2003, Dr E recorded that *“Tony remains euthymic and with good insight into his previous symptoms. He remains compliant with treatment. . . .”* On 6th December Mr Hardy

⁷⁷ A combination of two mood stabilising medications is most commonly used when it is considered that a single mood stabilising medication does not on its own keep the person free of manic and depressive symptoms.

⁷⁸ Euthymic means that in terms of the observable manifestations of his mood, there was no evidence that he was either depressed or manic.

⁷⁹ Perceptual abnormalities include hallucinations none were present

⁸⁰ This is the term used by psychiatrists to describe aspects of intellectual functioning such as concentration, memory, ability to use and comprehend words, etc.

was seen by the senior house officer, following the report from the occupational therapy department that he had been drinking alcohol during the occupational therapy session that afternoon. On that occasion no abnormalities of mental state were noted.

4 Assessments and treatment 2003 - 2005

8.4.1 Mr Hardy was remanded to Belmarsh prison on 6th January 2003. He was assessed that same day by a consultant psychiatrist, who found him to be suicidal. He was seen on 30th January 2003 by Dr A, consultant forensic psychiatrist, who was of the opinion that he was “*significantly depressed*” and that he should be transferred to a secure psychiatric hospital. He was reviewed again by another consultant psychiatrist on 7th February who agreed with Dr A’s opinion. On 12th March he was assessed by Dr C, consultant forensic psychiatrist who considered that he was depressed. He agreed with the recommendation to transfer Mr Hardy to a secure psychiatric hospital. On 19th March 2003 he was seen by a consultant forensic psychiatrist from Rampton Hospital. He considered that Mr Hardy was suffering from mild to moderate depression. On 15th May 2003 Mr Hardy was transferred to Rampton Hospital. He remained there until 16th July 2003. During that time, no symptoms of depression were elicited. The discharge summary prepared by a consultant forensic psychiatrist at Rampton Hospital included the following observations on mental state:

“there was no evidence of depressed demeanour and he had no morbid beliefs about the world in general but stated that he was tired of having to get up and look after himself and go through other routine daily processes. Mr Hardy settled into the ward well. He attended the on-ward activity programme which takes place every week day. Concentration was noted to be good, for example, he was able to read without difficulty. His mood was observed to be reactive and he took an active interest in events around him. His sleep was good, no early morning wakening and his appetite was normal.”

The discharge summary concluded:

“Mr Hardy did not display any signs of either depressed or abnormally elevated mood during his time [at Rampton Hospital]. He was nursed on one-to-one observation throughout the period of his admission. He participated well in the active on-ward activity programme including sessions at the gym and swimming pool. His sleep and appetite were normal and his concentration was observed to be good as he is a keen reader of newspapers and books.”

8.4.2 In connection with the criminal charges he faced in relation to the deaths of Sally White, Elizabeth Valad and Bridgette Maclennan, Mr Hardy was assessed by a number of clinicians.

Ms J, chartered forensic and clinical psychologist, saw Mr Hardy on 21st August 2003. She described his presentation during interview in the following terms:-

“Mr Hardy was initially mildly irritable and guarded in interview, although quickly settled and appeared to be co-operative thereafter. He maintained poor eye contact, but occasionally showed evidence of a sense of humour, laughing and looking at me. He was able to provide a clear and coherent background, with sufficient detail. There were no symptoms of mental illness in interview.”

Dr I, consultant forensic psychiatrist, saw Mr Hardy on 8th, 22nd, 25th September 2003 and 2nd and 3rd October 2003:-

“Mr Hardy was a calm, cooperative man who was well presented. He was a tall well built man, bearded and spectacled. There were no abnormal movements and no thought disorder. There was relatively little eye contact. He looked sad throughout and became visibly stressed when talking about the victims. He told me that he was neither low or elated in mood. There was no agitation. His energy levels were normal. He was sleeping and

eating normally. His concentration and memory were reported as good. There were no feelings of hopelessness and no suicidal ideation. Mr Hardy denied any persecutory or grandiose ideations. He denied any thought insertion, thought withdrawal or thought broadcasting. He denied any auditory hallucinations or passivity phenomena. His insight was good, he recognised he had a mental illness and that he needed to carry on with treatment.”

Dr K, consultant forensic psychiatrist, saw Mr Hardy on 15th and 29th October 2003. He noted:-

“I interviewed the defendant on 2 occasions for a total of 5 hours. The defendant was polite and cooperative during the interviews and answered questions appropriately. His answers were clear and articulate and sometimes there was a pause whilst he formulated his answer to the questions. The defendant showed no features of anxiety or depression during the interviews and expressed no suicidal thoughts. At times he was cheerful, and on one or two occasions laughed quite loudly, for example when I quoted some of the comments in his ex-wife’s statement. The defendant told me that mentally he feels fine, by which he meant slightly above euthymic. He said that he felt more settled now at Belmarsh prison than he had done at any other time in the last twenty years. There were no psychotic features evident at interview and the defendant appeared of at least average intelligence.”

8.4.3 In March 2004, by which time Mr Hardy was serving his sentence at Wakefield prison, Dr O, consultant forensic psychiatrist, wrote to the admissions panel at Broadmoor Hospital. The letter says that when transferred to Wakefield prison on 4th February 2004, Mr Hardy was being treated with lithium, sodium

valproprate and lorazepam.⁸¹ His manner was described as “*increasingly demanding and abusive*” and he had “*made threats to make a weapon and attack staff*”. He was also refusing to take lithium because he was concerned that his blood lithium level had not been monitored appropriately. Dr O’s letter includes the following:

“He believes he is hypomanic. At times some of his statements are quite grandiose in content, for example, on one of my contacts with him he referred to himself as being St George, the patron saint of England. He told me that St George killed the dragons and he went on to tell me that he had observed his victims smoking crack cocaine and they had the appearance of dragons. . . . Despite the content of some of his speech, objectively he always seems to be in control, although he is irritable. At times he appears manipulative. His behaviour however is increasingly difficult to manage even within the segregation unit”.

8.4.4 In June 2004 he was assessed by a psychiatrist from Broadmoor Hospital who recommended transfer to Broadmoor under sections 47/49 of the Mental Health Act.⁸² He was transferred to Broadmoor on 9th November 2004. On 10th November 2004 he was assessed by Dr H, consultant forensic psychiatrist, when he presented as being “*over-familiar in his behaviour with a flattened affect*”. Dr H found there to be evidence of thought disorder, grandiose delusions and delusions of reference. Mr Hardy spoke to Dr H of being a scientist and referred to “*Dr Who*” stating one of his names was “*Hardy Who*” and speaking about time travel. He said he had four names “*Tony a nice person*”, “*Sinjohn the person who kills*”, “*St George who slays dragons*” and “*Hannibal Lecter*”. He also referred to being Thomas Hardy and said that he had studied the Bible. Dr H found no evidence of obvious cognitive deficits. The mental state abnormalities just described are consistent with a diagnosis of hypomania (which occurs in people who have bipolar affective disorder). Mr Hardy

⁸¹ Lorazepam is used under these circumstances as a sedative, to calm a person who is over-aroused as a result of being manic.

⁸² This is a direction made by the Home Secretary, based on at least two medical recommendations, transferring a sentenced prisoner to a psychiatric hospital to receive in-patient psychiatric care.

told Dr H that he suffered from bipolar affective disorder for which he was willing to take further medication.

8.4.5 On 11th November 2004 he was started on depot antipsychotic medication (antipsychotic medication formulated to be given by injection at intervals of two or more weeks, usually used when a person is unlikely to take oral medication reliably and consistently). By 9th December 2004 he was more settled in his mental state. When seen by Dr H on 6th January 2005 he was “*calmer and more appropriate*”.

8.4.6 When assessed on 6th January 2005 by a specialist registrar (a senior psychiatric trainee) at Broadmoor Hospital he was willing to be interviewed for a period of 45 minutes. The specialist registrar’s summary includes the following:

“Mr Hardy displayed no psychotic symptoms and in particular no formal thought disorder or delusions of reference or grandiose delusions. He spoke clearly about having had ‘bizarre’ thinking when he first came to hospital but this had now settled. He talked about having believed he was five different people, ‘Hannibal Lecter’, a ‘successful doctor/professor’, a ‘religious leader’, a ‘horrible man who is a drunkard and goes around with prostitutes hurting them’ and ‘the man that I am now’. His view was that he can no longer be any of these different people as he no longer has the control that he thought he had and he now realises that he is in fact ‘a failure’ in life. He said this with apparent sadness, regret and insight.”

8.4.7 In January 2005, Mr Hardy was given a working diagnosis of schizophrenia by doctors at Broadmoor. This is not a definitive diagnosis, but one formed on the basis of observations and information collected to date, for the purpose of deciding what treatment would be most appropriate. The following is taken from the admissions summary dated 28th January 2005, prepared at the end of a period of preliminary assessment at Broadmoor:

“The medical team are clear that Mr Hardy has for many years suffered from paranoid schizophrenia and that the

degree of his psychotic disturbance was in the past masked and concealed by his more affective presentation. He has never been treated with sufficient antipsychotic medication and has tended to be treated with mood stabilizers which have only ever been partly effective.”

5 Summary and conclusions on diagnosis and treatment

8.5.1 The working diagnosis of schizophrenia made since Mr Hardy’s admission to Broadmoor opens up the possibility that previously psychiatrists have consistently misdiagnosed Mr Hardy’s mental illness. Under these circumstances, it remains possible that his mental illness has in the past been inadequately or inappropriately treated. However, on the basis of all the evidence we have considered, we reject the possibility, for the following reasons.

8.5.2 First, Mr Hardy has been assessed by numerous psychiatrists in the past, under varying circumstances. Where evidence of mental illness has been elicited during such assessments, this has always been consistent with bipolar affective disorder rather than with schizophrenia. Having scrutinised Mr Hardy’s clinical records, we find no reference to schizophrenia as a possible diagnosis in his case, prior to his admission to Broadmoor, apart from the tentative suggestion made by Dr F which is quoted in paragraph 8.2.6 above.⁸³

8.5.3 Second, we note that the diagnosis of schizophrenia made at Broadmoor is not intended to be definitive, but interim. We have reviewed the records from Broadmoor. Written records may not convey a complete picture of a person’s mental state and changes over time, but the information we have seen is consistent with bipolar affective disorder as the diagnosis.

8.5.4 Third, we consider that during the period 1998 - 2002, Mr Hardy’s mental state was generally stable. There has been some evidence of variability of mood, which is summarised above. However, no evidence was recorded that he was actively psychotic, although during routine mental state assessments, clinicians

⁸³ But Dr F’s diagnosis, which he gave in both his reports, was manic depressive psychosis (bipolar affective disorder): “Mr Hardy is undoubtedly suffering from manic depressive psychosis” (27.11.95); “It would appear that in the years since Dr G ’ assessment, what was thought to be a tendency towards manic depression in 1981 now appears more unequivocally to be a manic depressive illness” (8.12.95).

would undoubtedly have tried to elicit evidence of psychotic symptoms (such as delusions or hallucinations). It is our view that had delusions, hallucinations or other features of schizophrenia been present during the period 1998-2002, these would have been elicited and recorded by mental health professionals.

8.5.5 Fourthly, we consider it likely that that the stability of Mr Hardy's mental state during this period is at least partly attributable to treatment with mood-stabilising medication. In other words, we consider that the treatment of the diagnosed mental illness, bipolar affective disorder, was effective during the period 1998 - 2002.

8.5.6 In conclusion, we are satisfied that Mr Hardy received appropriate treatment for mental illness both as an out-patient and during his 2002 in-patient admission. Our assessment of the evidence is that neither in January 2002 nor in December 2002 was Mr Hardy actively mentally ill. That is to say, he was not significantly depressed or elevated in mood, and he was not experiencing psychosis. We therefore conclude that his mental illness, whether correctly diagnosed as bipolar affective disorder or as schizophrenia, did not contribute to whatever led him to kill three people.

Chapter 9 Multi Agency Public Protection Arrangements (MAPPA)

1. Introduction

9.1.1 The purpose of this chapter is to consider multi-agency public protection arrangements and their relevance in this case. What we refer to here is the role that other agencies, and particularly the police, could have played, in co-operation with Mental Health Services, in protecting people from the risk of violence presented by Mr Hardy. We do this under the following headings:

- The relevance of public protection to this case.
- Multi-agency Public Protection Arrangements.
- Multi-agency Public Protection Arrangements in Camden.
- Patient confidentiality.
- Discussion and conclusions in relation to Mr Hardy.

2 The relevance of public protection to this case

9.2.1 During 2002 an understanding developed that Mr Hardy's assessed risk to others was not attributable only to his mental illness and the effects of alcohol. In the risk assessment of 5th July 2002, the summary of risk included the following statement:

"It is unclear to what extent there is a significant risk of antisocial behaviour and violence independent of mood state."

This was taken further in Dr B's report of 29th October 2002 where he stated that:

"He continues to pose a risk of violent behaviour. It is also my opinion that offending could occur even when his mental illness is well controlled and when not intoxicated with alcohol."

Among Dr B's recommendations for managing risk we find the following:

"a limited disclosure to the Camden Multi-agency Public Protection Panel informing them of his final placement."

9.2.2 Multi-agency public protection was relevant both because of the seriousness of the risk, as assessed by Dr B,⁸⁴ and because there was an assessed risk of violence which was not attributable to mental illness. As such it was reasonable to conclude, as Dr B did, that management of the risk of violence could not be left exclusively to community mental health services.

3 Multi-agency Public Protection Arrangements

9.3.1 The purpose of Multi-agency Public Protection Arrangements (MAPPA) is to provide a framework for inter-agency co-operation in assessing and managing violent offenders in England and Wales: police, probation and the prison service, together with other agencies such as housing, health and social services, work together to manage the risk to the public posed by dangerous offenders. MAPPA's origins are in the Criminal Justice and Court Services Act 2000. The relevant provisions are now to be found in the Criminal Justice Act 2003, which came into force in 2004.

9.3.2 The criteria for inclusion within MAPPA are identical in the two Acts. They require the relevant public bodies to make arrangements for three categories of offender:

- a. registered sex offenders;
- b. violent and other sex offenders sentenced since 1st April 2001; and
- c. *“other persons who, by reason of offences committed by them (wherever committed), are considered by the responsible authority to be persons who may cause serious harm to the public”* (section 67 of the Criminal Justice and Court Services Act 2000 and section 325 of the Criminal Justice Act 2003).

To come within the third category, while it is necessary for the person concerned to have been convicted of an offence, it need not be an offence of violence.

⁸⁴ In his report, Dr B stated that *“there is strong evidence to believe that he is at risk of re-offending and is likely to cause others serious physical or psychological harm”*.

9.3.3 As regards the management of risk, there is a hierarchy of qualifying offenders within MAPPA:

- Level 1: Activity at Level 1 involves a single agency, which could be mental health services, managing an offender without the active involvement of other agencies.
- Level 2: Referral to this level is made where the active involvement of more than one agency is required.
- Level 3: The 'critical few' - those who pose the highest risk or whose management is so problematic that multi-agency co-operation at a senior level is required - are referred to the Multi-Agency Public Protection Panel (MAPP).

In 2004 the percentages of offenders in each of the three MAPPA categories (paragraph 9.3.2 above) referred to MAPP were: a) 5%, b) 6%, and c) 16%.⁸⁵

4 Multi-agency Public Protection Arrangements in Camden

9.4.1 In reviewing the implementation of MAPPA within Camden, it is necessary to compare the situation in 2002 with the arrangements which are now in place. We have heard from a number of people about the absence in 2002 of any procedure, or guidance, within the Trust for identifying patients who fell within the criteria for MAPPA or for referring such patients for multi-agency assessment and management. Our impression is that very little thought had been given to MAPPA at that time. We accept what we were told by Mr X, Senior Manager Camden Mental Health Services, about this:

“At that time the MAPPA arrangements were at an early stage of development and probably poorly understood by members of the Trust and by others.”

As far as we are aware the situation in Camden in 2002 was fairly typical of the picture nationally. Mental Health Services had not yet been integrated into MAPPA. In this context it is important to note that it was only after the 2003 Act was passed that Health Authorities, Primary Care Trusts and NHS Trusts were placed under a statutory obligation to co-operate with MAPPA. Prior to that date, their involvement was purely voluntary. We do not suggest that the Trust in 2002 was

⁸⁵ Home Office Press Release:
<http://www.probation.homeoffice.gov.uk/output/Page241.asp>

unwilling to become involved but rather that it had not yet put in place the necessary practical arrangements.

9.4.2 In contrast to the position in 2002, this is now covered by a written Trust policy: the Camden Multi-Agency Public Protection Arrangements Policy. The policy provides guidance on the three categories of offender referred to in paragraph 9.3.2 above. Decisions about individual referrals to MAPPAs are made within the Trust by the multi-disciplinary care team led by the consultant psychiatrist. The process of referral requires consultation with the Trust's lead officer for public protection, who is also responsible for police liaison.

9.4.3 The policy provides for each of the three MAPPAs levels referred to in paragraph 9.3.3 above.

Level 1: Ordinary Risk Management:

“The majority of patients under the care of the Mental Health and Social Care Trust will be managed routinely under the Care Programme Approach (CPA), which incorporates local risk assessment and management procedures. As part of this process staff can liaise with the JIGSAW team⁸⁶ and involve them in risk management plans as necessary.”

Level 2: Inter-agency Risk Management Meetings:

“The Camden Borough Inter-Agency Risk Management Panel meet monthly ... The meeting is co-chaired by senior officers from the police and probation services and is attended by the following agencies:

- *Camden Police and Probation Service*
- *Social Services, Children and Families Division*
- *Camden Housing*
- *Mental Health and Social Care Trust*
- *North London Forensic Services*
- *Camden Social Services, Youth Offending Team (YOT)*
- *Education Services*
- *Voluntary Housing Providers*

⁸⁶ This is the name of the public protection unit, comprising four police officers and two probation officers, based at Holborn police station.

- *Camden Probation Hostel*

The purpose of this meeting is to help minimise the risk to the public posed by Registered Sex Offenders, violent offenders or other potentially dangerous offenders through the sharing of relevant information, the assessment of risk and the co-ordination and monitoring of inter-agency risk management plans.”

Level 3: Multi-Agency Public Protection Panel (MAPP):

“The MAPP is responsible for the management of the ‘critical few’. The critical few are described as being:-

- (i) As being assessed under the OASys (Offender assessment system) as being high or very high risk of causing serious harm; AND*
- (ii) Presents risks that can only be managed by a plan which requires close co-operation at a senior level due to the complexity of the case and/or because of the unusual resource commitments it requires; OR*
- (iii) Although not assessed as a high or very high risk, the case is exceptional because the likelihood of media scrutiny and/or public interest in the management of the case is very high there is a need to ensure that public confidence in the criminal [justice] system is sustained.”*

9.4.4 We are satisfied that where it is considered that a patient falls within the MAPP criteria, a clear and straightforward referral procedure is now in place. We are also satisfied that relevant people within the Trust, such as consultant psychiatrists, are aware of the procedure. Mr X told us that there is a constant flow of referrals to MAPP. We also heard from Mr P, who is the Crime Manager for Camden and jointly chairs the monthly inter-agency risk management meetings (Level 2 above), that since 2002 *“the relationship between the Mental Health Trust and the police has grown enormously”*.

9.4.5 Multi-agency public protection work in Camden is not constrained by the three MAPP categories described in paragraph 9.3.2 above. As Mr X explained to us:

“We are conscious that there are individuals who are presenting with a high risk who may never go to MAPP ... because there may be [a] complete lack of any

criminal offence or arrest. There may be individuals who are deemed high risk by local clinical teams who need to have significant input from a multi-agency setting including the police ...”

In catering for the risks presented by such individuals, the Trust and other organisations have made arrangements to facilitate inter-agency communication and the development and implementation of agreed plans for managing risk in individual cases. These arrangements are exemplified by the Risk Data Sharing Project which is being piloted in three London boroughs, including Camden and Islington. Together with the Mental Health and Social Care Trust, the other participants are the police, ambulance service and probation service.⁸⁷ The project establishes procedures and criteria for sharing information between agencies. In relation to health information about individuals, the policy document refers extensively to guidance on confidentiality from professional bodies such as the General Medical Council, the British Medical Association, the Royal College of Psychiatrists, the Nursing and Midwifery Council and the College of Occupational Therapists.

9.4.6 Finally, there are informal arrangements in place which support an exchange of information between the Trust and the police. There is a nominated police constable, attached to the JIGSAW team, who takes an interest in individuals with mental health problems who pose a risk to themselves or to others. We heard from Mr P about the work of this officer:

“The main function is to meet with health professionals, develop an understanding of individuals within their care and try to elicit information, on an exchange of information basis, and make sure information is documented on our database for intelligence. ... He’s a police constable who used to be a beat officer and built up contacts with the Mornington [psychiatric intensive care] Unit and maintains those contacts. He provides a single point of contact for police officers around individuals with mental health problems. Again, we are encouraging and developing this two-way exchange of information.”

9.4.7 Approximately two years ago the Trust appointed a retired police officer to

⁸⁷ The 82 page document, which sets out the agreement between agencies on information sharing, has been agreed by the Trust, the police, the probation service, Camden Council, Islington Council, the City of Westminster and the Central and North West London Mental Health NHS Trust.

liaise with the police service. Mr X, on behalf of the Trust, told us that the role of this person, together with the nominated police officer, is: “to perform as a conduit for information and advice to consultant psychiatrists, clinicians, social workers, nurses etc.”. Mr X acknowledged in his evidence to us that the creation of these liaison roles within the Trust and the police service has led to reduced thresholds to seek information:

“It is much easier to access information now, particularly through these arrangements but also through ... our criminal justice consultant ... We have been able to assure police forces that it [public protection] is a reason, and it is a good reason, for accessing that sort of information. There is a much greater exchange of information than a couple of years ago.”

Dr D, who is a consultant psychiatrist on the Mornington intensive care unit, identified easier access to patients’ criminal records as the most important benefit of effective liaison with the police.

9.4.8 Each party to the arrangements regards them as providing better access to information held by others. The relative informality of the arrangements is seen by all parties as advantageous.

5 Patient Confidentiality

9.5.1 We note that the policy documents and the arrangements for information sharing are underpinned by principles of medical confidentiality and give the consultant psychiatrist a pivotal role. We are concerned, however, that there is a risk that these principles will not be adhered to where informal arrangements, based on close working relationships, have developed.

9.5.2 There is a need for constant vigilance to protect patients’ confidentiality, subject to necessary and clearly defined exceptions where disclosure is justified for the protection of the patient or others. We have not looked at how the informal arrangements work in practice in Camden, as this is clearly outside the scope of this Inquiry, but we consider patient confidentiality to be a matter of the greatest importance which deserves to be fully considered when the Risk Data Sharing Project pilot is evaluated.

6 Discussion and conclusions in relation to Mr Hardy

9.6.1 Dr B, in his report of 29th October 2002, included among his recommendations

for managing the risk of violence presented by Mr Hardy,

“a limited disclosure to the Camden Multi-agency public protection panel informing them of his final placement.”

Dr B’s assessment that Mr Hardy was “*likely to cause others serious physical or psychological harm*”, together with the January 2002 criminal damage offence, brought him within the third category of MAPPA offender, as defined in paragraph 9.3.2 above.

9.6.2 The disclosure was not made. This was because, as we have seen, there was at that time no operational policy within the Trust for referring cases to MAPPA. It was also still unclear, in November and December 2002, whether in returning home Mr Hardy had gone to his “*final placement*”, as Dr E was still hoping it might be possible to place him in supported accommodation.⁸⁸ We accept entirely what Dr E told us about his efforts to act on Dr B’s recommendation:

“I was certainly prepared to follow the advice to disclose his final placement and I attempted to find a procedure for making referral to the panel.”

9.6.3 We have seen that inter-agency public protection arrangements have developed considerably in Camden since 2002. If Mr Hardy’s case arose today it is very likely that there would be communication with the police about the potential risk to others as part of the discharge planning process. If, as in this case, a forensic assessment recommends a referral to MAPPA, we are satisfied that the procedures are now in place to ensure that this happens.

9.6.4 We asked a number of witnesses with knowledge and experience of MAPPA what difference a reference to the Camden Multi-agency Public Protection Panel or to the Inter-agency Risk Management Meeting could have made to the risk management arrangements in this case. The most positive response we received was from the police. They told us that had Mr Hardy been referred to MAPPA, urgent consideration would have been given to his case and appropriate measures, in the form of an action plan, would have been agreed and implemented. As to what those measures might have been, Mr P answered as follows:

“First and foremost it would be an opportunity to share information among all the

⁸⁸ See Chapter 6 Housing, paragraph 6.5.5.

agencies and to alert all the agencies [to] the potential risk he poses, the fact that the public protection unit has an interest in that individual and to ensure that any information, no matter how small, would be brought to that public protection unit so we can review any risk assessment. In addition to that we have a whole raft of practical options we could have considered, including a home visit ourselves to assess risk, alerting a warden who may or may not have been available at the time, considering re-housing with our housing colleagues if appropriate. We could have considered surveillance as an option; we could have alerted the particularly vulnerable group we have connections with, about any potential risk this individual could pose to them.⁸⁹ We could never rule out a limited disclosure to certain individuals if it helped minimise that risk, but that would only be done in consultation with our partners [in other agencies].”

9.6.5 Mr X said that in his opinion:

“If the MAPPAs were to have [had] a proper discussion about Anthony Hardy and if they were to take into account the very special concerns that were around following the death of [Sally White] in his flat, I am sure extra measures could have been taken to provide additional checks. Whether that would have resulted in anything it’s impossible to tell ...I very much doubt if any surveillance activity would have taken place ... Additional visits and additional checks could have been made which may have resulted in something, but this is very speculative.”

He went on to say:

“I wouldn’t diminish the ability of MAPPAs through its joint agency approach ...to come up with another action plan. We will never know, of course.”

9.6.6 We consider that MAPPAs was relevant in this case. On the basis of the risk assessment made by Dr B, Mr Hardy was regarded as representing a serious risk which was not associated with a formal psychiatric illness. The management of that element of risk was therefore not amenable to therapeutic interventions by Mental Health Services. Within the resources available to them, those services were not able effectively to monitor Mr Hardy’s behaviour when he was living at home. For these reasons, it would have been appropriate to involve other agencies, and particularly the local police, in assessing and managing the risks following

⁸⁹ This is a reference to women working as prostitutes.

discharge from hospital. We think it likely that Mr Hardy would have agreed to disclosure of information to the police, had he been asked, as he would have wanted to give the impression of co-operating with any arrangements.

9.6.7 This is not to imply that a referral to the MAPP would have changed the course of events. With the benefit of hindsight, we conclude that Mr Hardy was strongly motivated to pursue sexual encounters which placed the women with whom he came into contact at grave risk. We do not think it likely that a referral to the MAPP, and any feasible action plan that could have been put in place to monitor him in the community, would have deterred him from committing further offences.

Chapter 10 Personality Disorder

1 Introduction

10.1.1 In this chapter we consider the following issues:

- The nature and diagnosis of personality disorder.
- The assessment of Mr Hardy's personality.
- If there were abnormalities of personality present, how did Mental Health Services respond to these?
- What would have been the implications of managing Mr Hardy's abnormal personality differently?
- If the abnormalities of Mr Hardy's personality had been taken into account differently in formulating the management plan, how might this have affected the outcome?

2 The nature and diagnosis of personality disorder

10.2.1 According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR), all the following criteria have to be met in order to diagnose the presence of a personality disorder:

A. *“An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. The pattern is manifested in two (or more) of the following areas:*

- (1) cognition (ie ways of perceiving and interpreting self, other people, and events)*
- (2) affectivity (ie the range, intensity, lability and appropriateness of emotional response)*
- (3) interpersonal functioning*
- (4) impulse control.*

B. *The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.*

C. *The enduring pattern leads to clinically significant*

distress or impairment in social, occupational or other important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (eg a drug of abuse, a medication) or a general medical condition (eg head trauma”.

10.2.2 The International Classification of Mental and Behavioural Disorders, 10th Edition (ICD-10) offers a very similar classification of personality disorders, with even greater emphasis than DSM-IV on the onset of the personality disorder in early life: “*the .. .manifestations [of disharmonious attitudes and behaviour] always appear during childhood or adolescence and continue into adulthood.*”

10.2.3 There are two main reasons why it is important to diagnose personality disorders when they are present. First, as noted above, one of the key criteria for diagnosing a personality disorder is that its presence leads to significant distress, either for the individual or others, and/or impairment in personal and social functioning. Consideration should therefore be given to treating the personality disorder. However, effective treatment of personality disorders usually requires specialist expertise and substantial resources, and is not widely available within the NHS. Moreover, the nature of some personality disorders is such that the individuals concerned see no need for any treatment, or indeed any need to change. People with these types of personality disorder can therefore be difficult to engage in treatment.

10.2.4 The second main reason why it is important to diagnose personality disorders is that, where a person has a mental disorder like schizophrenia, bipolar affective disorder or even alcohol problems and also has a co-existing personality disorder, research evidence clearly indicates that this tends to makes the outcome less favourable. At least in part, this is because, as noted above, the presence of a

personality disorder make it harder to engage the person in treatment for the other mental disorder.

10.2.5 Psychiatrists distinguish between mental disorders (like schizophrenia and affective disorders) and personality disorders. In DSM, they constitute separate axes of psychiatric diagnosis. In what follows, we will make this same distinction, with references to mental illness or mental disorder being concerned with Mr Hardy's bipolar affective disorder.

3. The assessment of Mr Hardy's personality.

10.3.1 On several occasions during his psychiatric history Mr Hardy was described by doctors as having a personality disorder. The first of which we are aware was in 1989 when Dr G assessed him as having "a very disturbed personality amounting to Psychopathy".⁹⁰ In 1998 at the time of an in-patient admission to St Luke's Hospital he was diagnosed as suffering from bipolar affective disorder "with underlying dissociative personality disorder". Dr D, in the discharge summary prepared in April 2002 on Mr Hardy's transfer to Cardigan Ward, recorded a diagnosis of "dissociative personality disorder: F60.2". This refers to the World Health Organisation ICD-10 classification of mental and behavioural diseases.⁹¹

10.3.2 Doctors also referred to personality traits, using this phrase descriptively rather than diagnostically. For example, Dr F in his report of 8th December 1995 mentions "his underlying personality traits which are disinhibited by mental illness and intoxication".

10.3.3 Dr B's forensic assessment in 2002 included a consideration of whether Mr Hardy was suffering from a personality disorder. This was in the context of his overall assessment of the risk to others and his proposals for managing risk. The

⁹⁰ Dr G did not define psychopathy with reference to diagnostic criteria.

⁹¹ F60.2 Dissocial (Antisocial) Personality Disorder - "*Personality disorder, usually coming to attention because of a gross disparity between behaviour and the prevailing social norms, and characterized by at least 3 of the following: callous unconcern for the feelings of others; gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations; incapacity to maintain enduring relationships, though having no difficulty in establishing them; very low tolerance to frustration and a low threshold for discharge of aggression, including violence; incapacity to experience guilt and to profit from experience, particularly punishment; marked proneness to blame others, or to offer plausible rationalizations, for the behaviour that has brought the patient into conflict with society. There may also be persistent irritability as an associated feature. Conduct disorder during childhood and adolescence, though not invariably present, may further support the diagnosis.*"

diagnostic view expressed in Dr B's report was:

“His behaviour is characterised by impulsivity, a lack of forethought as to the consequences of his actions, seriously irresponsible behaviour, inability to learn from past experiences and a lack of concern for others' feelings. The cause of this behaviour could be due to a number of possible factors.

It could be the result of deeply ingrained ways of thinking, feeling and reacting that have been present all his adult life (personality disorder). However, there is little evidence of disturbed functioning until he was in his mid twenties. He may also have some personality change as a result of suffering a severe psychiatric illness or from prolonged alcohol misuse (although these features appear to have been present in the early 1980's when his alcohol use was not severe). Acute intoxication with alcohol will also have had an influence on his behaviour. His affective illness may also have had an influence on his behaviour. It is my opinion that his behavioural problems are a combination of these factors.”

Dr B went on to say that an element of Mr Hardy's risk to others was independent of his mental illness and intoxication with alcohol. This would appear to carry the implication that a risk of violence arose from abnormal personality traits. But he did not make a diagnosis of personality disorder.

10.3.4 Dr C, who supervised Dr B's assessment, explained why he and Dr B concluded that Mr Hardy did not have a dissocial personality disorder:

“We did not think he met the criteria for dissocial personality disorder under ICD-10 or DSM IV. He didn’t have the trajectory through adolescence and young adulthood of somebody with a personality disorder and Dr B teased it out by suggesting there may have been a combination of personality traits, the effects of episodes of illness and alcohol. It is obviously very different now knowing what he has gone on to do and with hindsight the diagnosis looks different.”

10.3.5 When Mr Hardy was assessed by psychiatrists and a psychologist in 2003 in connection with the criminal proceedings, there was a consensus that he had an abnormal personality but disagreement both as to whether this amounted to a personality disorder and, if it did, as to the type of personality disorder.

Dr L, consultant forensic psychiatrist, 2nd April 2003:

“... some abnormal personality traits which have particularly expressed themselves in his behaviour towards his ex-wife and which one might assume are concerned with sexual jealousy in one form or another. There is, from his own account, little evidence that any such personality traits emerged before he was well into his adult life and at this point it is not easy to discern where such behaviours may have originated. I do not therefore believe that he would meet a formal diagnosis of personality disorder on the evidence currently available to me.”

Dr A, consultant forensic psychiatrist, 11th April 2003:

“He has attracted a variety of diagnoses but more recently appears to be considered as suffering from bipolar affective disorder and to possess certain maladaptive personality traits.”

Dr I, consultant forensic psychiatrist, 6th October 2003:

“There is evidence of personality abnormality on structured testing. This needs further evaluation together with any abnormal psychosexual characteristics.”

Ms J, chartered clinical and forensic psychologist, 13th October 2003:

“...he appears to be an individual who suffers from a personality disorder, predominantly of a schizoid type, with passive-aggressive features, most notably sadistic ...the personality characteristics appear to have been evident since late adolescence/early adulthood, prior to significant mood changes and heavy alcohol use, and are also evident more recently at times when Mr Hardy’s mood has been thought to be relatively stable.

Schizoid personality disorder - as defined by the ICD-10 Classification of Mental and Behavioural Disorders - is characterised by some or all of the following: few activities providing pleasure, emotional coldness and detachment, limited capacity to express warm, tender or angry feelings towards others, apparent indifference to praise/criticism, little interest in having sexual experiences with another person, preference for solitary activities, excessive preoccupation with fantasy and introspection, lack of confiding relationships, and marked insensitivity to prevailing social norms.”

Dr K, consultant forensic psychiatrist, 6th November 2003:

“at the time of the killings[he] was suffering from a personality disorder which has been identified on psychological testing by GJ, and shows features of emotional coldness, hostility and sadistic sexual fantasy.”

10.3.6 More recently, since his admission to Broadmoor Hospital in November 2004, the initial assessment did not come to any conclusions about his personality:

“His personality cannot really be understood until he has been fully treated in terms of his mental illness.”

10.3.7 Our own view is that, to put it no higher, any adequate description of Mr Hardy's psychopathology would have to say something about his abnormal personality traits, whether or not these provide a sufficient basis for a diagnosis of personality disorder. We agree with Dr C's analysis in relation to a diagnosis of dissocial personality disorder: there is an insufficient history, particularly in childhood and adolescence, to support such a diagnosis. As noted above, both ICD-10 and DSM-IV stipulate that in order to make a diagnosis of personality disorder, there must be evidence of its presence no later than early adulthood. It is likely that the absence of such evidence has led to the uncertainties and inconsistencies noted above.

10.3.8 Thus applying standard diagnostic criteria rigorously, a diagnosis of personality disorder cannot be made. On the other hand, there is substantial evidence that Mr Hardy has abnormalities of personality entirely consistent with those expected of a personality disorder.⁹² Furthermore, there is no evidence from his history of any cause or event likely to have been responsible for a personality change in adulthood (see DSM-IV definition, above). It is often difficult to distinguish between the behavioural manifestations of a mental illness and those of a personality disorder except that, over time, beliefs and behaviours attributable to a mental disorder would be expected to fluctuate with the other mental state abnormalities associated with that disorder and its treatment, while behaviours attributable to personality disorder would be expected to show no such fluctuations. With the benefit of hindsight, it is clear that Mr Hardy's most conspicuous beliefs and behaviours are attributable to abnormalities in his personality rather than to his bipolar affective disorder.

4 How did Mental Health Services respond to Mr Hardy's abnormal personality?

10.4.1 During the period with which we are mainly concerned, January - December 2002, there was no psychological assessment of Mr Hardy's personality, of the kind later carried out by Ms J, and no formal consideration was given to the potential impact of his personality on the management of his bipolar affective disorder, or on the assessment and management of risk. No formal consideration was given to whether appropriate treatment could be made available for his personality problems, although this is perhaps not surprising, given the difficulties noted above

⁹² Such evidence is to be found, for example, in his behaviour towards his former wife which, as described by Dr B, is reproduced in Appendix 3.

in treating such problems and the difficulties finding appropriate expertise and resources to carry out such treatment within the NHS.

10.4.2 He was admitted to an acute mental illness ward. The interventions, both there and in the community, were designed to treat and manage his mental disorder (bipolar affective disorder). Interventions were also made to help him change his pattern of alcohol use. This was of interest to mental health professionals because alcohol interacted with his mental illness and was seen as increasing the risk of relapse and as contributing to the risk of violence. None of those involved in 2002 found the notion of personality disorder to be relevant to the task of treating and managing Mr Hardy as a psychiatric patient. As already noted, a contributing factor to this was probably the absence of any evidence of personality abnormalities until he was in his mid-20's, which precluded a formal diagnosis of personality disorder according to ICD-10 or DSM-IV. Yet when we consider now what is known about Mr Hardy's state of mind and motivation when he committed the three murders, abnormality of personality provides a better basis than mental illness, or the effects of alcohol, for understanding his actions.

10.4.3 What characterised the response of services to Mr Hardy's personality was pragmatism. This was put to us by Dr E in the following terms:

"We have to recognise our limitations and our role is managing mental disorder,⁹³ not other problems that people face. However, you cannot always separate out what is caused by mental disorder and what is not and then there is the complicating factor of psychopathic disorder. We cannot control behaviour that is not related to mental illness."

10.4.4 This reflects the realities of psychiatric practice, which necessarily works with the resources available to it. The clinical expertise of the team which cared for Mr Hardy both in hospital and in the community was in the treatment and management of mental illness. The team's resources and methods were designed for this purpose. There was also an understanding of his use of alcohol, and interventions and resources were available to try to manage that as a clearly identified risk factor which was understood to be related to abnormalities of mental state and behaviour. But as far as we are aware there was nothing the team could have offered Mr Hardy for his problems of personality. The pragmatic

⁹³ In this part of his evidence Dr E used mental disorder synonymously with mental illness.

response was for the multi-disciplinary team not to interest themselves clinically in that which they could not treat or manage. This was despite the widely shared perception that Mr Hardy's personality was abnormal.

10.4.5 On the other hand, as Dr E acknowledged in his evidence, if the emphasis shifts from the treatment of a medical condition to the management of violent or other anti-social behaviour, the distinction between mental illness and personality disorder is of less importance. There is an acceptance within psychiatry that behaviour which carries risks is properly a matter of concern, and this is true whether or not it can be linked to a treatable mental disorder. Dr E put it like this:

“If people have long-term mental illness it is impossible to have a category of behaviour you are not concerned with and another category of behaviour that you are concerned with.”

Dr B made a similar point, with reference to the role of forensic psychiatry:

“the offending of many of the patients we look after is sometimes very loosely related to their mental state and yet we are still held to be responsible in some way for their behaviour. In this case we felt we had to do the most that could be reasonably expected to protect the public ...”

10.4.6 When one considers what was done in 2002 to manage Mr Hardy's behaviour, the first intervention was to detain him in hospital. From the outset this was seen as reducing the risk of a repetition of what had happened in January 2002, when he had harassed neighbours on the estate where he lived. Detention in hospital thereafter was said at the time to be justified in part by concerns about the risk to others. When he was discharged from detention and chose to leave hospital, after-care arrangements were put in place which provided for monitoring of his mental state and alcohol use. Those arrangements, which we describe in the chapter on risk,⁹⁴ were framed in terms of relapse in mental state but by implication required those involved to interest themselves in Mr Hardy's behaviour in the community in so far as it gave cause for concern. As Dr E's remarks show, if the mental health team had become aware of antisocial or violent behaviour, it would not have been open to them to disregard it simply because it was not related to the diagnosed mental illness. There is, however, a paradox here. While the mental health team

⁹⁴ See Chapter 11 Risk Assessment and Risk Management, paragraph 11.5.22.

clearly recognised that they could not ignore anti-social or violent behaviour that could not be attributed to Mr Hardy's mental disorder, they had no means of effectively managing such behaviour. The only course open to them was to attempt to reduce this risk by continuing his detention under the Mental Health Act and thereafter by maintaining contact with him when he was discharged into the community.

10.4.7 In conclusion, the response was not to diagnose and treat Mr Hardy's abnormal personality, but to manage the behaviour associated with it in so far as this could be done within the resources available to the mental health team. This was within the framework of an overall plan for treatment and management of his diagnosed mental illness.

10.4.8 In our opinion what was missing from this plan was an explicit acknowledgement and understanding of Mr Hardy's abnormalities of personality, whether or not these amounted to a personality disorder. The personality traits we have in mind include manipulativeness. This was manifested in the way Mr Hardy controlled the information he gave people about Sally White's death by claiming to have suffered an alcoholic blackout at the time. More generally, there was a pervasive sense of Mr Hardy as someone who was controlling and who enjoyed 'getting one up' on others. There were also instances of dishonesty. It is of particular note that on those occasions when he lied to nursing staff, in denying he had been drinking alcohol, or when he attempted to steal a CD from the occupational therapy department, he showed no apparent concern about the breach of trust and did not see fit to apologise. Yet at the same time he appeared to value his relationships with staff. He participated willingly in therapeutic activities while in hospital and also made use of mental health resources when in the community. From the evidence we have heard we consider that these abnormalities of personality did impinge on Mr Hardy's management, both because of the wariness with which he was regarded by staff and because they did not feel equipped to challenge his behaviour. This is not to say that the abnormalities of personality were treatable, but merely that they existed and needed to be taken into account.

5. What would have been the implications of managing Mr Hardy's abnormal personality differently?

10.5.1 If, as we believe, Mr Hardy's aberrant behaviour can be better understood in terms of abnormality of personality than as being associated with mental illness, why did the psychiatrists who assessed and treated him in 2002 not interest themselves more in his personality? We have been given a number of possible explanations.

- i. That a diagnosis of personality disorder does not in itself point to a need for a psychiatric intervention and it would not be practicable to offer treatment to everyone with a personality disorder. If a generic definition is used, such as that in ICD-10, "*a severe disturbance in the characterological condition and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption*", the prevalence of personality disorder in the adult population is in the range 10 - 13%.⁹⁵ There is a much higher prevalence among the prison population. Psychiatry, with its limited resources, must therefore be rigorous and selective in diagnosing personality disorder in circumstances where a diagnosis would carry an expectation that treatment would be offered.
- ii. Specifically, as we have seen, Mr Hardy was assessed as not meeting the relevant diagnostic criteria for antisocial or dissocial personality disorder, which is the form of personality disorder most usually associated with serious violence and which in law most frequently attracts the classification psychopathic disorder in relation to people

⁹⁵ See Personality Disorder: No longer a diagnosis of exclusion (2003) National Institute for Mental Health in England p. 11.

who have committed acts of violence.⁹⁶ It follows from the fact that Mr Hardy did not in the opinion of those who assessed him meet the relevant diagnostic criteria, that there would have been no justification for detaining him under the classification psychopathic disorder.

- iii. There was no evidence that Mr Hardy's abnormal personality traits were susceptible to any form of clinical intervention. The opinion that he was untreatable was first expressed by Dr G in 1989 when he said: "*... he is not amenable to psychiatric treatment at the present time. Indeed, some of his comments seemed to have a somewhat manipulative element with the implication that if he did not receive help and continued to behave in an irresponsible, criminal and violent fashion, it would be the fault of those who denied him treatment. I personally do not have much to offer Mr Hardy at the present time and believe he should be faced with the consequences of his actions.*" None of those who assessed Mr Hardy after his arrest for the two murders of December 2002 expressed the opinion that he was suffering from a treatable personality disorder. The Inquiry's expert witness, Professor Maden, who specialises in the treatment of violent and dangerous people with personality disorders, told us that in his opinion Mr Hardy's abnormalities of personality were untreatable. This amounts to saying there was probably nothing that psychiatric services could have offered Mr Hardy to ameliorate his problems of personality.
- iv. While, notwithstanding the diagnostic problems discussed above, it may be correct to describe Mr Hardy as suffering from a personality disorder, we were told by Professor Maden that the description of him as a serial killer is more

⁹⁶ Psychopathic disorder is defined in the Mental Health Act 1983 as "*a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned*".

apt.⁹⁷ In psychiatric terms there was nothing particularly remarkable about Mr Hardy's personality. What was unusual about him, but beyond the reach of psychiatry, was that he was a serial killer. Professor Maden told us:

“serial killer is not a psychiatric diagnosis and it doesn't equate to any such diagnosis in DSM - IV or anything like that; no one has tried to put it into a diagnostic framework. Serial killers might have a range of psychiatric diagnoses but they are peripheral to the main issue ... It follows that one would not expect psychiatric treatment to change a person's identity as a serial killer ... One should in principle not expect the killings of a serial killer to be explicable in terms of mental disorder. The state of our current knowledge is that they are not.”

10.5.2 If these points are accepted, the conclusion which follows is that Mr Hardy could not have been detained under the Mental Health Act classification psychopathic disorder because he was not suffering from a relevant form of personality disorder and because his abnormal personality traits, however described, were not amenable to treatment. Even if it had been possible to overcome these legal obstacles to his detention in hospital under the classification psychopathic disorder, it would not have been a sensible use of scarce resources to detain him on a mental illness ward for treatment of his personality problems, without any therapeutic benefit.⁹⁸

⁹⁷ There is no single accepted definition of a serial murderer, with different definitions even disagreeing on the number of victims required to qualify. However, one widely quoted definition (Egger, S. A. (1984). A working definition of serial murder and the reduction of linkage blindness. *Journal of Police Science and Administration*, 12 (3), pp. 348-357) includes the following criteria: (a) at least two murders; (b) no relationship between perpetrator and victims; (c) murders separated in time with no direct connection one to another; (d) the murders are frequently committed in different places; (e) murders are not committed for material gain; (f) the victims may share common characteristics. According to this definition, Mr Hardy can be described as a serial murderer.

⁹⁸ We asked Professor Maden if Mr Hardy would in 2002 have been a suitable candidate for the Dangerous Severe Personality Disorder Service of which he is the Clinical Director. In his opinion Mr Hardy would not come within their admission criteria because they require a link between a diagnosed personality disorder and violent offending. He told us that: *“the DSPD service, which is now going to be a service rather than anything in legislation hinges pretty heavily on the concept of psychopathy and it also is very much couched in terms of mental*

10.5.3 Had there been an assessment in 2002 and the conclusion been reached that there was no therapeutic intervention available to modify the enduring abnormal features of Mr Hardy's personality, we would have no reason to question that. This was the point made by Dr G, which we quote in paragraph 10.5.1 iii above. However, it is our view that an assessment of Mr Hardy's personality, in the context of the management of his diagnosed mental illness, might well have helped those involved in his care and treatment to have understood him better and to have been clearer about what they could achieve.

10.5.4 Professor Maden suggested that an assessment of Mr Hardy's personality by a specialist personality disorder team, even if it concluded that he was untreatable, would have informed the care team's management:

"It is unfortunate that Ms J's assessment of his personality came after these events. People knew beforehand that they were worried about his personality and yet there wasn't a systematic assessment of it. A team like that could advise, and it is a specialised business and I would not expect a general mental health team to be able to do that ..."

10.5.5 In Professor Maden's opinion better training on personality disorder would also have assisted staff who were in contact with Mr Hardy because it would have given them a conceptual framework for understanding how he interacted with them:

" ... people might benefit sometimes from better teaching on personality disorder because this was somebody with a schizoid or schizotypal personality characteristic. The feeling [expressed by members of the care team] you are describing is people picking up[on this] ... it would allow a better vocabulary for talking about those sorts of feelings if there were more explicit teaching about personality disorder and people became more skilled in those categories."

10.5.6 We would go slightly further than Professor Maden. The vulnerability of staff resulted from the nature of the therapeutic relationship, based on trust and respect for the individual. The difficulty staff experienced in responding to some of

disorder. I don't want to repeat myself too much but if this is a serial killer and if therefore his behaviour is not explicable in terms of mental disorder, it is unrealistic for a service that is couched very much in terms of severe mental disorder to be dealing with him and with his risks".

Mr Hardy's behaviour, most notably his way of managing and controlling his relationships with professionals, arose primarily from their perception that the behaviour was not part of the pathology of his mental disorder. It thus fell outside their sphere of competence and was regarded as an essentially private matter, to be respected as such. For example, they were aware that Mr Hardy was not trustworthy but this was not seen as something on which they could properly and relevantly comment because it was neither part of an illness nor something which had been assessed as relevant to the future management of risk. By way of contrast, the attitude of staff to his use of alcohol was quite different because it had been incorporated into the clinical formulation.

10.5.7 Had the nature of Mr Hardy's abnormal personality traits been better understood, they could have been incorporated into a clinical formulation. This would have provided a clinically legitimate framework for staff to record and raise matters which, in the absence of such a framework, were regarded as subjective impressions. We cannot say to what extent such an approach would have led to changes in Mr Hardy's management. But one matter which we think is relevant is that had his personality been better understood, less importance would have been attached to his compliance with care plans. Such compliance would have been seen as consistent with a description of his personality as manipulative, rather than as evidence that he could be trusted. We do not wish to suggest that clinical staff were unaware of these aspects of Mr Hardy's personality. We are mindful that none of the clinical staff we have met regarded Mr Hardy as trustworthy. Dr E told us that he always regarded Mr Hardy as untrustworthy and unreliable. Mr R, with whom Mr Hardy had established a generally good relationship, described him as follows:

"He could manipulate if he wanted to and he could show you one side of himself when he was meeting you, and as soon as you turned your back he would be walking into one of the bars."

Our point is that these insights were not formulated and to that extent were not incorporated into Mr Hardy's clinical management.

10.5.8 We did raise with Professor Maden the question whether in his opinion there would have been any benefit in challenging Mr Hardy, based on an understanding of his attitudes and behaviour as features of his abnormal personality. Professor

Maden did not think so:

“I wouldn’t like to predict what would happen. It is not a straightforward business because on some level it is very important to him that he feels superior. Presumably it feeds into the whole thing: the offending was getting one over on the world and fooling other people. I imagine on some level he gained a lot of gratification out of manipulating the system and staff. It is not the sort of thing that is easily corrected in a person. I would say it is a very fundamental aspect of his personality, so if one said, ‘I can see through you’ and made it clear one did, he would have the option of avoiding that member of staff and going off somewhere else to get his reinforcement or going further in his manipulation. It would be a challenge: ‘You might think that you see through me, but just wait until you see what I’ve done.’ It is unpredictable.

This is his way of relating to the world, he is used to it and you would have to be careful about challenging it without a lot of precautions around that. Certainly an acting out of one form or another would be a high risk in challenging.”

10.5.9 We are aware of initiatives, both locally in Camden and nationally, which are intended to increase the likelihood of people with personality disorders being assessed and offered appropriate treatment if any such is available. We have read the paper produced by the National Institute of Mental Health in England, *Personality Disorder: No longer a diagnosis of exclusion*,⁹⁹ and have noted its recommendation, echoed in Professor Maden’s remarks quoted above, that:

*“Trusts may wish to consider the development of a specialist personality disorder team to meet the needs of those with personality disorder who experience significant distress or difficulty”.*¹⁰⁰

Among the proposed criteria for referral to the specialist team are risk of harm to others, and the presence of co-morbid mental illness and/or addiction. The specialist team would take referrals for assessment as well as for treatment and would also provide consultation, supervision and training. In Mr Hardy’s case, the existence of such a team, had he been referred to it, might have made a

⁹⁹ See footnote 95 ante

¹⁰⁰ Ibid. p.30.

difference in the ways we have already described.

10.5.10 The general tenor of *Personality Disorder: No longer a diagnosis of exclusion* is that such teams would be dealing with personality disordered patients who make considerable demands on health and social care resources, including general practice. Even without the diagnostic problems to which we have referred above, this would not make Mr Hardy a high priority. The only sense in which he could have been regarded as a high priority was by reason of his potential dangerousness, and the considerable impact which concerns about him had on the professionals involved in his care. It may be that the appropriate mode of referral for such a patient is to forensic services. We note that *Personality Disorder: No longer a diagnosis of exclusion* comments on the paucity of personality disorder services in forensic psychiatry.¹⁰¹ We consider it would be desirable for forensic outreach services to offer structured personality disorder assessments as part of the service they provide to general psychiatric teams.

10.5.11 In Camden there is already a personality disorder service, the Oscar Hill Service, which accepts referrals from general psychiatry. It is a small specialist service which sees people in an intensive way. As such it would probably not have been suitable for Mr Hardy. As it happens, the service was not taking referrals in 2002 and was therefore not available to the team during the period with which we are mainly concerned. We understand that consideration is now being given to using the expertise within the Oscar Hill Service to provide advice to community teams on ways of dealing with people who present special problems.¹⁰² We support this approach. It cannot be assumed that Mr Hardy would meet the criteria for referral for assessment by this specialist service, and we do not presume to prescribe criteria for referral to such a service on the basis of one highly unusual case. However, we consider that where a patient is causing particular concern to staff, and where that concern arises from a perception that the patient's personality is abnormal, the team should be able to refer the patient to a specialist personality service for assessment.

¹⁰¹ Ibid. p. 17.

¹⁰² This information came from Mr X, Senior Manager, Camden Mental Health Service.

6. If the abnormalities of Mr Hardy's personality had been taken into account differently in formulating the management plan, how might this have affected the outcome?

10.6.1 While we think it possible that a clinical formulation of Mr Hardy's personality would have changed his management as an in-patient, we do not believe this would have modified his personality or his behaviour. We accept, however, that a clearer formulation of the relationship between his personality traits and the management of the risks associated with his mental illness could have led to a more cautious approach to his discharge. Such an approach is to be found in Dr B's forensic assessment and his proposals for Mr Hardy's management in the community. It is therefore possible that had more attention been paid to Mr Hardy's personality, his detention, albeit under the legal classification of mental illness, would have been further prolonged. To go further than this would be too speculative.

Chapter 11 Risk Assessment and Risk Management

1. Introduction

11.1.1 In this chapter we consider the assessment and management of Mr Hardy's risk to others. We start by restating some essential principles of risk management in psychiatry, because the assessment and management of risk in this case must be understood in the context of risk management in general. We then describe the Trust's policies, before going on to look at how in practice risk was assessed and managed. In the final section we discuss the issues raised by the case with reference to the six questions which are set out in paragraph 11.5.1 below.

2. Risk Assessment and Risk Management in Psychiatry

11.2.1 Risk assessment in mental health care aims systematically to identify the risks of adverse outcomes, to the patient and to others. The risks thus identified should be incorporated into a management plan, the main purpose of which is to minimise the likelihood of adverse outcomes occurring. Four observations crucial to risk management are summarised below.

11.2.2 First, while unsystematic, inadequate or flawed risk assessments may increase the risks of adverse outcomes, satisfactory outcomes cannot be guaranteed even with detailed management plans based on thorough and appropriate risk assessments. In other words, a tragic outcome is not necessarily indicative of unsatisfactory risk management.

11.2.3 Second, in a retrospective review of the management of risk where very serious adverse outcomes have occurred, as in Mr Hardy's case, care must be taken to avoid placing too much reliance on the benefit of hindsight. Looking back, from a position of 100% certainty of an adverse outcome, is liable to distort the analysis of the actions that were taken before the adverse outcome occurred.

11.2.4 While health care professionals understand these two principles, others might have some difficulties with them. It might be suggested, given the exceptional nature of the outcomes in this case - with three women murdered, that surely whatever drove Mr Hardy to commit these murders should have been obvious

to those looking after him. This argument is fundamentally flawed for two reasons: first, because it relies on hindsight; and secondly, as will be elaborated below, because it assumes that all the risk factors relevant to being able to predict that Mr Hardy would commit murder are attributable to Mr Hardy's mental disorder, or at least to aspects of his behaviour or personality that mental health professionals should have been able to understand and interpret predictively. Because Mr Hardy was diagnosed as having a mental illness and was under the care of Mental Health Services, it might be assumed that his mental illness was a major contributing factor to the murders. However, this assumption needs to be supported by evidence.

11.2.5 Murder is always a tragedy for the victim's family and friends. But thankfully murder is a rare event, and the third important observation concerns the prediction of **any** rare event. In medicine in general, and in the social or behavioural sciences in particular, it is hardly ever possible to make predictions with absolute accuracy. No matter how sophisticated the method of prediction, there is always a margin of error, usually expressed in terms of 'false positives' (those predicted to have a particular outcome but in whom that outcome does not occur) and 'false negatives' (those who experience a particular outcome despite being predicted not to be at risk of that outcome). It is a property of all predictive tests that there is an inverse relationship between false positives and false negatives: if a test is designed to minimise the rate of false positives, the rate of false negatives will inevitably rise. This applies to a putative test to predict future homicide: ideally, such a test should have as few false negatives as possible, in order not to miss any individuals who are likely to commit homicide. If a particular outcome has a very low prevalence rate (that is, rate of occurrence), as is the case for homicide committed by people with mental health problems, prediction becomes extremely unreliable because of the effect of the false positives. National statistics indicate that there were approximately 150,000 in-patient psychiatric admissions in England during 2001-2. The Confidential Inquiry into Suicides and Homicides reported that 9% of homicide perpetrators had been in contact with Mental Health Services during the 12 months prior to the homicide.¹⁰³ Using this and other data from the Confidential Inquiry, it can be estimated that approximately 30 people convicted of homicide in 2001 had had an in-patient

¹⁰³ Safety First: Five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, Department of Health (2001).

psychiatric admission in the preceding 12 months. Assuming that a test to predict future homicide were available and was nearly perfect, with a 1% false negative rate and a 5% false positive rate, such a test could successfully identify all the individuals likely to commit homicide; but for every one of these individuals correctly identified, there will be 218 people whom the test incorrectly identifies as likely to commit homicide who will not do so (false positives).¹⁰⁴ In practice, very few predictive tests perform this well, so that for each person correctly identified as likely to commit homicide, the number of people incorrectly identified as likely to commit homicide will be even greater than 218.¹⁰⁵ To reiterate, this is an intrinsic property of any predictive test which aims to predict rare events.

11.2.6 The calculations above assume that there is a valid and reliable predictive test for homicide among those in contact with Mental Health Services. In fact, no such test exists. However, the figures clearly show that were such a test available, it would have very limited value even at its best. This is because of the fundamental problems inherent in predicting rare events, and cannot be overcome by enhancing the skills or training of mental health professionals or others.

11.2.7 It could be argued that the results just presented underestimate the accuracy of prediction of the risk of homicide, because in clinical practice it is common to apply not just a single predictive test but a series of tests. Applying a series of tests sequentially can under some circumstances allow the accurate prediction of even rare events.¹⁰⁶ However, there is no evidence that such circumstances apply in the prediction of homicide.

11.2.8 It therefore remains extremely difficult to predict future homicides. This is not to say that *all* homicides are unpredictable, but the majority remain so. This is confirmed by the Confidential Inquiry into Suicides and Homicides, which found that among those people who had been in contact with Mental Health Services

¹⁰⁴ See Appendix 4, for further elaboration.

¹⁰⁵ The principles outlined here are certainly not new, and have been well recognised by clinical epidemiologists and clinicians. See, for example, Sackett DL, Haynes RB, Guyatt GH & Tugwell P. *Clinical Epidemiology - A Basic Science for Clinical Medicine*. Boston: Little, Brown, 1991.

¹⁰⁶ For further discussion of this point, see Gill CJ, Sabin, L and Schmid CH. Why clinicians are natural bayesians. *BMJ* 330, 1080-1083, 2005.

prior to committing homicide, very few had been predicted as at high risk of committing homicide at their last contact with services.

11.2.9 Nevertheless, despite these limitations, or more particularly because of them, it is essential for mental health professionals to carry out rigorous risk assessments and formulate thorough risk management plans, because only in this way can the risks of adverse outcomes be minimised.

11.2.10 Risk management plans in psychiatric practice use expertise and resources to manage risks associated with mental disorder. Our final observation is that where this association is not present, Mental Health Services may find themselves having to provide care for an individual who presents risks which are not amenable to psychiatric interventions.

3 Trust Policy and Procedures on Risk Assessment and Risk Management

11.3.1 The practice and procedure for risk assessment and risk management is to be found in the Trust's document "Policy and Guidelines on Clinical Risk Assessment and Risk Management".¹⁰⁷ This is linked to the Trust's policy on the Care Programme Approach (CPA).¹⁰⁸

11.3.2 The Trust's policies require that anyone such as Mr Hardy who is assessed as being entitled to enhanced CPA and whose needs indicate a high level of risk, must have a full assessment of risk documented on the Trust's Full Assessment of Risk Form.

11.3.3 The Full Assessment of Risk Form is a self-contained document which conveniently gathers information from a number of sources and includes the opinion of the clinician who completes the form. For practical purposes it is relied on as telling the reader what needs to be known about risk. In this Trust, as in others, the use of standard forms for risk assessments is not intended to replace clinical judgment.

11.3.4 After an initial full risk assessment has been completed the policy requires it to be updated at CPA reviews, which should take place at least every six months.

¹⁰⁷ Camden and Islington Mental Health and Social Care Trust, 1st April 2001

¹⁰⁸ Care Programme Approach Operational Policy, Camden and Islington Mental Health and Social Care Trust, 1st April 2001.

11.3.5 The risk assessment and risk management policy includes in its introduction the following cautionary words:

“Even with the best risk assessment practice, suicides and violent incidents will still occur. Teams must identify suitably qualified and experienced practitioners able to carry out risk assessments. What matters is that professionals use their knowledge to the best of their ability, and are able to demonstrate that they have done so. It is important that a thorough assessment of risk is made and a clear and reasoned judgement developed and documented which shows that the best practice has been followed.”

11.3.6 The policy contains detailed guidance on the clinical assessment of risk, including a section on the assessment of risk of harm to other people.

11.3.7 As regards management of risk, the policy requires the following six questions to be considered:¹⁰⁹

- *How serious is the risk?*
- *Is the risk specific or general?*
- *How immediate is the risk?*
- *How volatile is the risk?*
- *What specific treatment and interventions can best reduce the risk?*
- *What plan of management is needed to reduce the risk?*

We note in passing that these questions are reproduced in the Full Assessment of Risk Form: the first four in the part of the form where the risk factors are summarised, and the other two where the risk management plan is described.

¹⁰⁹ These questions, and other parts of this document, are exactly the same as those in Royal College of Psychiatrists guidance - The Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk: *Assessment and clinical management of risk of harm to other people*. Council Report CR 53. Royal College of Psychiatrists, London, April 1996.

11.3.8 The policy goes on to suggest “*some helpful general Risk Management Strategies*” of which the following are of particular interest:

- *Consider who might be harmed, why and how;*
- *Evaluate whether current arrangements adequately address the risk and decide whether further measures need to be taken;*
- *Record in writing exactly what risks are thought to be present, what action has to be taken and by whom and what level of risk is being accepted for an individual, bearing in mind the practical constraints, resources available and the rights of the individual to be treated in the least restrictive manner compatible with minimal risk.*

11.3.9 The policy deals specifically with home visiting:

“If it is predicted there will be a high risk of violence during a visit, workers should visit in pairs or ask the service user to attend appointments at the office base.”

11.3.10 The policy envisages that the assessment and management of risk is multi-disciplinary and it comments on problems which can arise within multi-disciplinary teams:

“To date, much risk assessment has been ad hoc and unsystematic. Generally speaking differences in beliefs and knowledge about risk assessment between disciplines has led to poor levels of agreement and disputes between staff. All staff are expected to engage with multi-disciplinary team work and multi-disciplinary team decision-making processes.” (Emphasis in the original.)

11.3.11 It concludes with a paragraph on clinical supervision:

“There are many reasons why clinical supervision is crucial for mental health workers. It can provide emotional support in the face of difficult and stressful work. It is a means by which workers can continually

grow and develop in expertise and also help managers ensure that agreed policy is being followed and professionals standards being maintained. The content of clinical supervision sessions is mostly about service user care. The supervisor can contribute to higher standards of care and safer practice by making sure that risk and its assessment is a regular aspect of discussion on service user care.”

4 Assessment of risk and risk management in Mr Hardy’s case

11.4.1 Under the changes that were introduced nationally to CPA in 1999, Mr Hardy was assessed as qualifying for the enhanced, as opposed to the standard, level of care under CPA. Prior to that he had been on the supervision register, as someone who was “*known to be at significant risk or potentially at significant risk of committing serious violence or suicide or of serious self-neglect*”.¹¹⁰

11.4.2 At the beginning of the period with which we are mainly concerned there was in existence a completed Full Assessment of Risk Form in respect of Mr Hardy dated 7th August 2001. Further full risk assessments were completed on 2nd May 2002 and 5th July 2002. The first was completed by Ms U, who was then Mr Hardy’s care co-ordinator. The second and third were completed by Dr E personally. All three completed assessments were signed by Dr E. A new risk assessment form was not produced following the CPA meeting on 14th November 2002, but a management plan was formulated and recorded in a document dated 18th December 2002. That plan took account of Dr B’s forensic assessment report which had included new information about Mr Hardy’s history and a detailed analysis of the risk of harm to others.

Comparison of full risk assessments dated 7.8.01, 2.5.02 and 5.7.02

11.4.3 The three risk assessments identified a risk of violence and a risk to others. These risks are recorded on the form by ticking the appropriate boxes on the first page of the form.

¹¹⁰ These words are taken from HSG(94)5, *Introduction of supervision registers for mentally ill people from 1 April 1994*. Supervision registers were abolished when changes were made to CPA in 1999.

11.4.4 Each of the three assessments recorded Mr Hardy's history of criminal and violent behaviour, but there were differences. In the 2001 assessment the history was prefaced by the statement *"Risk behaviour is associated with hypomanic behaviour"*. The history of violence was summarised as:

- *Serious assault on ex-wife (1981) - no charges*
- *Kidnap of wife (1983) - no charges*
- *Numerous assaults, violent and intimidating behaviour towards hostel workers and residents (1992-1999)*
- *Indecent assault and sexual assault (1998).*

The history in this and the subsequent risk assessments also included a record of other offences such as theft and driving under the influence of alcohol.

11.4.5 In the history section of the May 2002 assessment, the prefatory remark has been removed and replaced by the statement:

"Most violence has been associated with mania and alcohol intoxication. Most recent episode was associated with alcohol use but only equivocal mood symptoms."

Some additional information is provided in the history:

- *1981 Serious assault (?attempted murder) of wife*
- *1982 Kidnap of wife*
- *1992 - 1999 Numerous assaults, violent and intimidating behaviour towards hostel workers and residents*
- *1998 Indecent assault and sexual assault*
- *Jan 2002 Poured battery acid through female neighbour's door after probable other incidents of harassment*
- *20.1.02 Police found naked body of a woman in Tony's flat - post-mortem revealed death by natural causes - body found when police investigated harassment of neighbour.*

11.4.6 The July 2002 assessment contains the same statement that while most violence had been associated with mania and alcohol intoxication only equivocal

mood symptoms were associated with the most recent episode. It further elaborates the history of violence:

- *1981 Attempted murder of wife. Froze water in bottle and hit over the head in the bath, attempting to drown her. Planned for at least some days.*
- *1982 Kidnap of wife*
- *1992 - 1999 Numerous assaults, violent and intimidating behaviour towards hostel workers and residents*
- *1998 Indecent assault and sexual assault*
- *Jan 2002 Poured battery acid through female neighbour's door after probable other incidents of harassment*
- *20.1.02 Police found naked body of a woman in Tony's flat - post-mortem revealed death by myocardial infarction - body found when police investigated harassment of neighbour. Tony unable to account for the body, unable to remember what happened.*

11.4.7 All three risk assessments recorded a number of other matters of possible relevance to the potential risk of violence:

- Compliance with medication had been good since 1998 but in the past non-compliance had been linked with rapid deterioration in mental state and aggressive or violent behaviour.
- An association between increased alcohol consumption and manic episodes. The risk assessment of July 2002 noted "*three episodes of heavy binge drinking when on leave from the ward since transfer to Cardigan*".
- In the two assessments completed in 2002 the behaviour towards his former wife and the harassment of his neighbour were noted in the part of form which refers to sexually inappropriate behaviour. The risk assessment of July 2002 also noted that he was "*sexually disinhibited during manic episodes*".
- In the two 2002 risk assessments, precipitants of risk-taking behaviour were recorded as manic symptoms, increasing alcohol use, threatening behaviour and preoccupation with sexual matters.

- In the assessment of July 2002, under the heading “*Recent loss events or any threat of loss*” it is recorded that he was “facing eviction from his flat”.
- Where the form refers to potential victims, the 2001 assessment records previous threats against care staff and the community psychiatric nurse who had initiated his admission in 1998. It says “*in the past felt to be high risk*”. The two 2002 assessments additionally refer to the neighbour. The May assessment simply says “*neighbour is at risk*”, while the July assessment adds “*... if he returns to flat to live*”. Both the 2002 assessments refer to “*conflict with neighbour*” as a risk factor associated with his accommodation.
- In relation to mental state and symptoms of mental disorder, the assessments include entries under the heading which deals with “*difficulties gaining access to the service user’s mental state*”. In the 2001 assessment this reads: “*Client can be quite reticent and finds it difficult to express feelings. However, when well (as at present), meets regularly with key worker (at resource centre or coffee shop)*”. In the two 2002 assessments this is replaced by the following statement: “*Mr Hardy has not given a frank account of his behaviour over the past year. He is unlikely to be able to conceal severe mood symptoms - he may conceal minor symptoms and alcohol use*”.
- Where the form asks about specific threats to others, the three assessments refer only to a threat made in 1998 to throw a mental health worker through a window.¹¹¹
- All three assessments record that he was not currently expressing any plan to harm himself or others. The 2001 assessment says he had made such plans in the past, and the 2002 assessments record “*details of 1980’s risk behaviour not available*”.

11.4.8 The part of the form which deals with risk assessment concludes with a summary. The person who completes the form is directed to “*collate and summarise all the available risk information*” and is asked the first four questions in paragraph 11.3.7 above:

- *How serious is the risk?*
- *Is the risk specific or general?*
- *How immediate is the risk?*
- *How volatile is the risk?*

11.4.9 The 2001 assessment states:

“There is a risk of serious violence when manic. Non-compliance with medication or treatment with anti-depressants may cause manic episodes. The public and professionals are at risk. Alcohol misuse is a complicating risk factors (sic) Relapses may be gradual or sudden.”

11.4.10 The two 2002 assessments summarise the risks as follows:

“Risk of violence

High risk of violence when manic to professionals and members of the public. Women with whom he is in a relationship may be at particular risk.

Risk modifiers

Non-compliance with treatment, increasing use of alcohol, relapse of manic symptoms all increase risk; these individual risk factors combine in a vicious circle as he relapses. Treatment with anti-depressants or use of stimulant drugs increases the risk of mania.¹¹¹

Rate of escalation of risk

This may be gradual or sudden.

Risk of suicide

The lifetime risk of suicide in bipolar affective disorder and alcohol dependence syndrome is estimated at 15%. Severe depression and the period following a manic relapse are particular risk periods.

Influence of personality disorder

¹¹¹ Although there had been concerns in the past about Mr Hardy’s use of drugs, we have seen no evidence that during 2001/2002 he was using drugs.

It is unclear to what extent there is a significant risk of antisocial behaviour and violence independent of mood state.

Immediate risk

The immediate risk is low. There are no manic symptoms and treatment is supervised in hospital. Alcohol consumption when on leave from the ward is the main factor to monitor in the short-term. Monitoring of mental state remains important.”

We note in passing that this assessment of the immediacy of risk, which refers to symptoms of mental illness, does not take account of risks arising from what the form refers to above as *“Influence of Personality Disorder”*.

11.4.11 The final part of this section of the form invites *“a summary of the service user’s positive potential and resources available”*. All three assessments refer to Mr Hardy’s understanding of his illness. The 2002 assessments record *“an understanding of his mood symptoms and the relation of these to risk behaviour”*. The assessments refer to the informal contract with his care co-ordinator to manage risk behaviour.¹¹²

11.4.12 The final section of the form requires details of the risk management plan to be entered. The fifth and sixth questions from paragraph 11.3.7 above appear here:

- *What specific treatment and interventions can best reduce the risk?*
- *What plan of management is needed to reduce the risk?*

11.4.13 The 2001 assessment has three headings: prevention of relapse, management of relapse and safety of staff. The emphasis is on the risks associated with a manic relapse. The safety of staff is to be safeguarded by *“joint home visits with at least one male member of staff”*.¹¹³

¹¹² See Chapter 4 Community Mental Health Services, paragraphs 4.3.1 - 4.4.8 for a discussion of this issue.

¹¹³ This was not strictly adhered to because on one occasion Mr R visited alone. He told us that he did not have concerns for his own safety in visiting Mr Hardy at home at that time.

11.4.14 The 2002 assessments are much fuller. The following points are of particular interest:

“Risk to neighbour

Housing department should be asked to contact care co-ordinator immediately if neighbour makes any complaints about Mr Hardy’s behaviour to her. (May 2002)

Housing department, police and neighbour (via police) have been asked to contact ward staff immediately if Tony makes any threats to neighbour or if there are any other concerns. Leave must be stopped immediately if any threats are made. (July 2002)

Referral to alcohol services

This has been made. The aim is to help Mr Hardy minimise his alcohol use. (May 2002)

This has been made. The aim is to help Tony minimise his alcohol use. A structured day programme is being developed. (July 2002).”

The two 2002 assessments also provide for the management of crises, whether associated with manic symptoms or with escalating alcohol use. They also say that leave from the ward is to be suspended if there is evidence of alcohol use or of manic or hypomanic symptoms. The July 2002 assessment includes a reference to the referral for a forensic psychiatric assessment.

11.4.15 A further full risk assessment was not completed following receipt of Dr B’s report in November 2002. However, the management plan which was formulated at the CPA meeting on 14th November 2002, and recorded in the document dated 18th December 2002, included the following point of relevance to the management of risk to others:

“If there are indications that he is relapsing i.e. using alcohol or not keeping in contact with services, the situation should be reviewed urgently i.e. discussed with Dr E, Cardigan [ward] and Mr R and decision about

what action needs to be taken.” (Emphasis in the original.)

5 Discussion and Conclusions

11.5.1 In the discussion which follows we consider the assessment and management of the risk to others in the light of the Trust’s policy and the information available at the time. We have asked ourselves the following questions:

- Were the Trust’s policies and procedures for assessing and managing risk followed in Mr Hardy’s case?
- Could the assessment of risk have been more comprehensive?
- How best could Sally White’s death be included in the risk assessment?
- Was the risk management plan sufficiently robust?
- If risk assessment and risk management had been more comprehensive and robust would the outcome have been different?
- Were there features of this case that made risk management particularly difficult, and how, with the benefit of hindsight, could these have been better managed?

Were the Trust’s policies and procedures for assessing and managing risk followed in Mr Hardy’s case?

11.5.2 As we have shown, there was formal compliance with the policy, in that risk assessments were recorded in the correct form, which was fully completed on each occasion. One possible criticism would be that a further Full Assessment of Risk Form was not completed following the CPA meeting on 14th November. If that had been done some of the additional information obtained by Dr B could have been included, for example in relation to Mr Hardy’s harassment of his former wife. It is possible also that the emphasis on manic symptoms and alcohol would have been modified to take account of Dr B’s conclusion that there was a risk to others unconnected to those two factors.

11.5.3 The information and analysis included in the 2002 risk assessments conveyed what was known and believed by the treating team and reflected views expressed in previous psychiatric assessments, for example those of Dr F. The forms referred to the relevant factual matters in Mr Hardy’s history and highlighted the uncertainty about the death of Sally White. The forms clearly identified the risk of violence to others. Regarding management of risk, the forms refer to the main risk

factors and how they are to be monitored and managed. The plan dated 18th December 2002 provided further reinforcement.

Could the assessment of risk have been more comprehensive?

11.5.4 We have a number of observations. First, many of those who gave evidence to us commented on the impact of reading Dr B's report.¹¹⁴ This confirmed our impression that the formal risk assessments did not fully convey either the seriousness of the risk or its nature, as understood by Dr B, as including a significant element which was not attributable to mental illness and/or alcohol. While this is partly explained by the simple fact that Dr B's analysis of the risk differed from what had gone before, it is above all else the very full and detailed information concerning Mr Hardy's history that strikes the reader of his report. But, as Dr E told to us, most of that information was not new: "*the most important elements of it were known to us*". It just had not been written down in one place before.

11.5.5 There is not space on the form for the kind of detailed forensic history which in Dr B's report covered five pages. But, even before Dr B's report had been received, it would have been a relatively straightforward matter to summarise in a couple of pages what was known about the arrest in January 2002, together with some of the history relating to Mr Hardy's violence towards his former wife and the incident in 1998 when he was accused of sexual assault by an 18-year-old woman.¹¹⁵ Such a summary would, for example, have highlighted those features of the circumstances in which Sally White's body was found that gave rise to suspicion. We believe that such a document would have been useful in providing a fuller and more accurate picture. It would also have drawn attention to uncertainties, particularly in respect of Sally White's death. In that context the statement, which appeared in the July 2002 Full Risk Assessment, that Mr Hardy was "unable to account for the body, unable to remember what happened", would

¹¹⁴ The relevant section of Dr B's report is reproduced as Appendix 3.

¹¹⁵ It is interesting to note that although Dr B reported his understanding that the prosecution did not proceed because the victim "*refused to press charges*", this is not apparent from the police print-out. It shows that the allegation was made on 24th April 1998 and Mr Hardy was interviewed on the same day. On 13th May the police received information that he had been detained under section 3 of the Mental Health Act. On 18th May the victim confirmed her wish to proceed with the case, stating that "*during the assault he appeared in very sound mind and fully aware of what he was doing*". The file was passed to the Crown Prosecution Service in early June. On 24th July advice was received from them "*that having considered all the facts and statements of this case that no further action is intended*".

have been demonstrably inadequate, it being clear that he had lied to the police and that his claim not to be able to remember was unconvincing.

11.5.6 Our second observation is that the use of standard form risk assessments militates against what is described in the policy as the need to develop “*a clear and reasoned judgment*”. We find this in Dr B’s report but it is much less evident in the completed risk assessment forms. It is interesting to note, for example, how over the course of the three assessments described above, the emphasis on the link between manic symptoms and violence became attenuated but no corresponding analysis of the implications is apparent. Had the reasoning process been exposed, it is likely that further questions would have been asked which might have led to the conclusion, subsequently reached by Dr B, that some or all of Mr Hardy’s violent behaviour was attributable neither to intoxication with alcohol nor to mental illness. Even where doubts were raised in the form, as in the statement that “*it is unclear to what extent there is a significant risk of antisocial behaviour and violence independent of mood state*”, this did not lead to a consideration of the implications for risk assessment and management. This was presumably what Professor Maden had in mind when in his evidence to this Inquiry he spoke of the need for members of the mental health team to categorise “*what they are worried about, why they are worried about it and what they ought to be doing about it*”. Clearly, there is a balance to be struck between producing a document which is of practical value and something which is so discursive that it is of no use to anyone. Our judgment is that in this case the standard risk assessment form served to mask the shortcomings in the formulation of risk.

11.5.7 In a case where there are significant areas of uncertainty in the history, or in the understanding of the patient’s mental disorder, which have a direct bearing on the risk analysis, there is a danger that the use of a standard form conveys a false impression of certainty. There is no space on the form for highlighting uncertainty, for example where the information is incomplete; and the document by its very nature does not encourage the reader to look further into the matters it covers. We believe that a simple and desirable change would be to add to the form a section which invites the person making the assessment to answer the specific questions which are set out in paragraph 11.3.7 above and then to ask:

- What are the areas of uncertainty in the assessment of risk?
- What can be done to reduce uncertainty?
- What are the implications for risk assessment and risk management of those uncertainties?

The identification of areas of uncertainty should not be seen as something of only academic interest. As happened in Mr Hardy's case, following Dr B's report, the uncertainties about risk, together with a shared perception that the effect of uncertainty was to increase the risk, led to the formulation of a management plan which was tighter than anything that had gone before.

11.5.8 Our third observation relates to what is said in the policy about supervision, which is quoted in paragraph 11.3.11 above. We found no evidence that supervision had been used in this way. Yet we were told by a number of people how concerned they were about the potential risk of violence which, by implication, was not adequately conveyed in the risk assessments. Had their concerns been discussed in supervision, as part of the process of risk assessment and risk management, it is possible that further consideration would have been given to matters which, while they were referred to in the formal risk assessment, were not well understood and had not been sufficiently thought through. Of these, the most important relate to the circumstances in which Sally White's body was found and certain features of Mr Hardy's personality. People were very troubled by what they knew and believed but they did not find a way of feeding their concerns into the risk assessment process. Supervision sessions, as stated in the policy, are capable of performing this purpose. In essence, staff clearly had concerns about Mr Hardy's past and current behaviour, but their reasons for being concerned remained only vaguely formulated and to a large extent implicit in the expressed feelings of staff, rather than explicitly described and monitored. The translation of implicit to explicit knowledge is essential in developing adequate care plans in general, and in risk management in particular.

11.5.9 A fourth observation concerns multi-disciplinary working. In general, we have been impressed by the good working relationships and mutual respect within the Trust among professionals from different disciplines. Nonetheless, some individuals encountered difficulties in, or felt excluded from, contributing to the risk assessment process. We were told by an occupational therapist that the

observations she and her colleagues made and recorded were not routinely taken into account in discussions during ward rounds. While she acknowledged that part of the explanation lies in the pressure of work on acute wards, it appears to us that she has identified a specific weakness in the procedure. We believe that it should always be part of the process of risk assessment to consult with colleagues in other disciplines and to invite comment on the risk assessment document before it is finalised.

How best could Sally White's death be included in the risk assessment?

11.5.10 A number of witnesses to the Inquiry spoke about the difficulty of incorporating the circumstances of Sally White's death into the risk assessment. The difficulty arose because while the circumstances were suspicious, there was no evidence, on which mental health professionals felt able to rely, to prove that Mr Hardy had been responsible for the death of Sally White. Moreover, because there was a post mortem finding that she died of heart failure and a Coroner's verdict that her death was due to natural causes, mental health professionals felt constrained not to attribute responsibility to Mr Hardy. The way in which they dealt with this difficulty was to inform themselves about and record the facts surrounding Sally White's death, but not expressly to rely on those facts in the formulation of risk.

11.5.11 For example, Dr D told us:

"It [Sally White's death] should be factored in somehow, one cannot disagree with that. This may be a more general comment but I don't know that it is not almost asking whether the mental health system or the psychiatrists involved in this case could have somehow redressed the decisions made in the Coroner's court. That cannot be, so that is the difficulty I have with that."

Dr C, consultant forensic psychiatrist, who supervised Dr B in the preparation of the forensic report, told us:

"I just want to make the point that a great deal of this case stems from that [post mortem]... clearly everything that followed took that post mortem in good faith that here was somebody who died of natural causes and all our interpretations were based very much on that."

He went on to say:

“Our recommendations were based on the assumption that he hadn’t killed Sally White, that he may have been deceptive or lied about exactly what had gone on in that room, and that there was something suspicious - “suspiciousness” is the word that was used - that there was something suspicious about his failure to give an account, suggesting that something may have gone on that contributed to her dying of natural causes.”

11.5.12 During the course of our discussions we have returned time and again to this issue. We are now able to formulate it in two questions. First, whether and, if so, how the circumstances of Sally White’s death were relevant to the assessment of risk? Secondly, assuming they were relevant, how could they be factored into the risk assessment without making an assumption about Mr Hardy’s culpability, or asserting without sufficient evidence that he had caused Sally White’s death? (A further difficulty here is that in 2002 to take a view on his culpability would have required a consideration of the degree of his involvement and culpability, ranging from death by heart failure in the course of consensual sex to, at the other end of the scale, premeditated murder.)

11.5.13 Having ourselves considered these questions we have formulated our own risk assessment, which factors in the known circumstances of Sally White’s death. The table in Appendix 5 is our assessment of the risk to others, based on what was known in December 2002.

11.5.14 The table relies on the circumstances of Sally White’s death not merely as evidence of Mr Hardy’s unreliability or dishonesty or callousness, but as a positive risk factor in the assessment of the potential risk of violence associated with sexual activity. We need to explain and justify this.

11.5.15 Our analysis is as follows.¹¹⁶

- The circumstances were suspicious.
- Given that Sally White was known to have worked as a prostitute, it was reasonable to infer that her presence in his flat was for the purpose of sexual activity.
- Mr Hardy failed to offer any explanation to allay the suspicions to which the circumstances gave rise. In fact he lied in claiming that he did not

¹¹⁶ See also Appendix 5 Risk Assessment Procedures.

know Sally White was in his flat and he thus fuelled the suspicion that he had something to hide.

- His history showed he was capable of sexual violence against women, in the past against his former wife and the woman who alleged he indecently assaulted her in 1998.
- Therefore it was reasonable to take into account the circumstances surrounding Sally White's death as a risk factor predictive of violence associated with sexual activity.¹¹⁷

11.5.16 We overcome the difficulties, referred to above, arising from the lack of sufficient evidence to make a positive finding of culpability, by including within the table an assessment of the probative value of the evidence in prediction of violence associated with sexual activity. In relation to Sally White's death, we acknowledge that its probative value was low. It was far too low, for example, to have secured a criminal conviction; and, almost certainly, too low to have satisfied a Coroner that she had been unlawfully killed. But it is our view that the circumstances were such that they did have some probative value in prediction. We consider this could have been reflected in a risk assessment in December 2002. We consider that we have succeeded in doing this in the table in Appendix 5.

11.5.17 We emphasise that by factoring in Sally White's death we have not demonstrated that it was possible to predict that Mr Hardy would commit homicide. On the contrary, the table and the analysis on which it is based reinforces our conclusion that the risk of future homicide was not predictable.

Was the risk management plan sufficiently robust?

11.5.18 In January 2002, prior to Mr Hardy's arrest, there was in place a care plan which achieved the main purpose of enabling mental health professionals to maintain regular contact with him. This took the form of fortnightly meetings with his care co-ordinator, Mr R. An important part of Mr R's role was to monitor Mr Hardy's mental state. This was done by a combination of self-reporting, on a scale of 0 - 20, and Mr R's assessment. Mr R's entries, and those of his predecessor, show that Mr Hardy's mental state had been generally stable for many months prior to his arrest in January 2002. The regular meetings with Mr R also provided an opportunity for discussion of matters of concern, for example any increase in Mr

¹¹⁷ Another way of expressing this would be to say that it would have been unreasonable to disregard the circumstances in assessing the risk of violence.

Hardy's alcohol consumption or personal difficulties. The arrangement had worked well. Mr R commented on the period since he took over in October 2001:

"He was amenable towards me. He was always polite and proper and I never had any concerns about him; he was that well."

11.5.19 One aspect in measuring the success of such arrangements is the engagement of the service user. An example of how well the arrangements appeared to be working in this case is that, according to Mr R's contemporaneous note, in December 2001 Mr Hardy telephoned him

"saying he wanted to see me urgently as he had been drinking very heavily over the Christmas period due to feeling physically unwell. Appointment arranged ..."

The point here is not that Mr Hardy had started drinking heavily but that he had informed Mr R and sought his help.

11.5.20 During the period of in-patient care in 2002, risk was managed by monitoring Mr Hardy's mental state and alcohol use. There was no significant disturbance of mental state throughout the admission, with the possible exception that in July 2002 Dr E thought he might be becoming hypomanic and sodium valproate was prescribed as an additional mood stabiliser. There were occasions when Mr Hardy drank alcohol while in his room or on leave. The sanction of revocation of leave was used on some of these occasions. At the same time Mr Hardy was being seen by the Alcohol Advisory Service and attending other alcohol services.

11.5.21 What should have happened during the 2002 admission was the formulation of after-care plans to manage risks following discharge. It appears to us that, prior to receiving the forensic assessment in November 2002, the assumption was that the arrangements would be much the same as those that had been in place prior to January 2002, with the addition of attendance at alcohol services. However, this was not formulated in a care plan prior to the managers' decision to discharge the section 37 hospital order.

11.5.22 Following the discharge from section 37, the team had to draw up an after-care plan to manage risk. The plan was agreed at the CPA meeting on 14th November and formally recorded in the document of 18th December. It specified

weekly meetings with Mr R, attendance at Cardigan ward every Friday and regular attendance at Tottenham Mews. It also provided that:

- *If there are indications he is relapsing i.e. using alcohol or not keeping in contact with services, the situation should be reviewed urgently i.e. discussed with Dr E, Cardigan and Mr R and decision about what action needs to be taken.*
- *'Contacts' to liaise with Mr R if there are any concerns.*
- *ASW Duty/EDT should be informed if necessary.*
- *If Tony presents on Cardigan and appears to be relapsing, he can be detained under section 5(2)[of the Mental Health Act].¹¹⁸*

11.5.23 Apart from placing Mr Hardy in supervised accommodation, it is difficult to see what more could have been provided in the community to monitor his mental state and alcohol consumption and to respond quickly and effectively if problems arose. In saying this, we acknowledge that there were risks which were not managed by the management plan. But we consider that these were risks beyond the reach of psychiatric services. We concur with Professor Maden's comment:

"I thought what they did was fine. They were stuck with a difficult problem in that they admitted someone because of mental illness but then were aware at some level that when you treated the mental illness you hadn't got rid of the risk and they took steps to try and sort that out. That is the personality problem in many ways but in this case the risk may not have been due entirely to personality disorder. Whatever, there were background risks that the treatment of mental illness was not addressing and what they did to try and sort that out was eminently sensible. I can't suggest anything different."

11.5.24 The same point was made by Dr A, who told us that in planning discharge one has to be solution-focused and resist *"the temptation and the tendency ... to be extremely risk averse"*.

¹¹⁸ This last point is probably not a correct understanding of section 5(2) which applies only to *"a patient who is an in-patient in a hospital"*.

If risk assessment and risk management had been more comprehensive and robust would the outcome have been different?

11.5.25 It might be suggested that had the risk assessment process been done differently the risk that Mr Hardy would commit murder would have been understood and steps could have been taken to prevent that happening. The argument is that Mr Hardy's history of violence, taken together with the suspicious circumstances in which Sally White's body was discovered in his flat, showed that there was a risk that he could kill women with whom he engaged in sexual activity.

11.5.26 We have already commented on this, but we take this opportunity to refer to some of the evidence we received on the point. The view of all the psychiatrists we heard from, including Professor Maden, was that the risk that Mr Hardy would commit murder was not predictable. There are three elements to this analysis. First, it could not be said prior to his discharge in 2002 that he had killed Sally White. To that extent the factual basis for predicting similar violence in future was simply not present. Second, the attempted murder of his wife in 1981 did not indicate a risk of violence to others, except to those with whom he was in an intimate relationship. Professor Maden commented as follows:

“the implications for future risk in a general sense of the assault on his wife were not that major. They were certainly important in the context of intimate relationships ...”

Third, even with the benefit of hindsight, the murders in December 2002 are not explicable in terms of his psychiatric diagnosis and history. Professor Maden put it this way:

“The picture he presented to services throughout most of 2002 was common everyday inner city psychiatry. He had emotional or affective symptoms associated with alcohol dependence and features of personality disorder,¹¹⁹ so it is a complicated picture because it is all mixed up together. There is alcohol, personality disorder, mental illness, but it is common and I guess the psychiatrist dealing with him deals with these sort of issues every day. There is also a context, which again is not that uncommon in the inner city, of previous violent offending,

¹¹⁹ Although here in his evidence Professor Maden uses the expression “*personality disorder*”, his overall view was that there was in 2002 no clinical basis for a diagnosis of dissocial or antisocial personality disorder. This is discussed in Chapter 10 Personality Disorder.

the more serious of which was associated with difficulties in intimate relationships. There is also aggression to the neighbour and the possibility of psychosis in the background of all this. That is just bread and butter inner city psychiatry. Therefore I would expect the service to manage those problems and the associated known risks adequately, but I would not have any expectation that they could manage unknown risks. I would also have no expectation that, just because they did their job properly and provided safe and satisfactory treatment for those problems, it would have any impact whatsoever on the core difficulty and therefore the killings.”

We concur with Professor Maden that the risk that Mr Hardy would commit murder if released from detention was not predictable and therefore not a risk that Mental Health Services could have been expected to manage. This view is reflected in the discussion of risk management which follows.

11.5.27 Notwithstanding that the risk that Mr Hardy would commit murder was not predictable, it could still be argued that a more comprehensive and robust approach to risk management would have led to a different outcome.

11.5.28 As compared with Dr B’s recommendations, the risk management plan agreed and implemented on 14th November lacked two elements: supported accommodation and a referral to MAPPA. We consider the recommended referral to MAPPA in Chapter 9, paragraphs 9.6.1-9.6.7 where we conclude that it is unlikely that arrangements that would have been made under MAPPA would have prevented Mr Hardy committing the two murders in December 2002. We now discuss the role of supported accommodation in managing risk in this case.

11.5.29 When we asked Dr B about his recommendation of supported accommodation he told us:

“It was in part because, in addition to his mental illness, Mr Hardy had a number of other difficulties with alcohol, and my opinion was that some support would perhaps enable that to be better addressed and he may get more support from that. Also, were his mental state to be deteriorating it would be picked up a lot quicker than were he to be living on his own.”

We agree with these observations. They follow from the fact that in Mr Hardy's history some anti-social and aggressive behaviour was associated with deterioration in mental state and increased alcohol use.

11.5.30 We acknowledge that had Mr Hardy not returned to his flat, but instead been discharged to supported accommodation, there would not have been the same opportunity to take women home. However, we think it likely that women would have been at risk even if Mr Hardy did not have his own flat to which he could take potential victims. We base this first, on the fact that he had in early December assaulted a woman in circumstances which we believe to have been very similar to those in which Sally White, Elizabeth Valad and Bridgitte Maclennan were killed.¹²⁰ Secondly, we agree with the view expressed by Professor Maden that, to the extent that Mr Hardy's psychopathology can be understood by psychiatrists,¹²¹ there is no reason to believe that psychiatric intervention would have made any difference. This is what Professor Maden said with reference to the sexual dimension of the three murders:

"I know there is a lot of debate about the treatment of personality disorder and it gets very complicated, but the evidence on primary sexual preference is unequivocal. . . . Even within the context of personality disorder services, where we have fairly low expectations of treatment, sexual sadism is notoriously resistant to any form of treatment."

We understand the implication of this statement to be that whatever could have been provided, whether by way of treatment or after-care, would not have had an impact on Mr Hardy's motivation to behave as he did. It seems to us that, short of detaining him indefinitely, the opportunity would have presented itself for him to pay women to engage in sexual acts with the consequential risk that he would kill them in the course of sadistic sexual activity.

Were there features of this case that made risk management particularly difficult, and how, with the benefit of hindsight, could these have been better managed?

11.5.31 In paragraph 11.5.23 we quoted Professor Maden:

¹²⁰ See Chapter 12 Sally White's Death, paragraph 12.2.2.

¹²¹ See discussion in Chapter 10 Personality Disorder, paragraph 10.5.1 iii.

“Whatever, there were background risks that the treatment of mental illness was not addressing and what they did to try and sort that out was eminently sensible. I can’t suggest anything different.”

These remarks take us to an important feature of the case. The essence of the problem of trying to manage what we now understand to be the full extent of Mr Hardy’s risk to others was that there was an important element which arose from features of his personality that were not amenable to psychiatric interventions. The question could be asked whether it was the business of Mental Health Services to manage what Professor Maden referred to as “background risks”, which were not connected to mental illness or any other treatable mental disorder.

11.5.32 As far as can be ascertained, at the time Mr Hardy committed each of the three murders his mental state was clinically normal: he was neither manic nor depressed nor psychotic. The offences cannot be attributed to the mental illness, bipolar affective disorder, for which he was being treated and by virtue of which he was detained under the Mental Health Act and received community mental health services under CPA. Although there appears to have been an association between alcohol use and the offences, the association between alcohol and violent offending is well known. There is no evidence that the effect of such alcohol as Mr Hardy had consumed at the time of these offences was to trigger symptoms of mental illness.

11.5.33 The “background risks” to which Professor Maden referred arose from Mr Hardy’s personality. The argument could be made that since personality disorder is recognised by psychiatry as a form of mental disorder, it is properly the business of Mental Health Services to manage the risks associated with abnormality of personality, at least in respect of a person, such as Mr Hardy, who is being looked after by those services because he also happens to suffer from a mental illness.

11.5.34 We discuss elsewhere the role of Mental Health Services in the diagnosis and treatment of personality disorder.¹²² What we say here follows from that discussion. A distinction needs to be drawn between those mental disorders, in Mr Hardy’s case bipolar affective disorder, which are treatable, and those which are not. Treatability is a function both of the availability of interventions and of resources which are capable of modifying the disorder and its associated risks. In

¹²² See Chapter 10 Personality Disorder.

Mr Hardy's case we are satisfied that within general psychiatric services his abnormal personality was untreatable. In so far as the risk he presented could be said to have arisen from his abnormal personality, the only intervention which would have significantly reduced that risk was detention in conditions which would have denied him access to potential victims.

11.5.35 There are no doubt some individuals who are believed to present such a serious and immediate risk to others, usually evidenced by previous offences of serious violence, that this justifies prolonging their detention in hospital, even where therapeutic benefit cannot be demonstrated. On the basis of what was known about Mr Hardy in 2002, we do not consider that he fell into this category. However, had it been predictable that he would offend as he did, there would then have been clear justification for continuing his detention, and in conditions of greater security than an open general psychiatric ward.

11.5.36 It is unfortunate that the unrealistic expectation has been fostered that Mental Health Services can protect the public from all risks, whatever their nature, presented by people with mental health problems. For example, we find the following statement in government guidance on the discharge of psychiatric patients:

*“Those taking individual decisions about discharge have a fundamental duty to consider both the safety of the patient and the protection of other people. No patient should be discharged from hospital unless and until those taking the decision are satisfied that he or she can live safely in the community, and that proper treatment, supervision and support and care are available.”*¹²³

The problem in this case was that one could not be “satisfied” that Mr Hardy could live safely in the community, but because those features of his personality which gave rise to concern about risk were not susceptible to interventions by Mental Health Services they could not be relied on to justify his further detention in hospital.

11.5.37 The view that the role of Mental Health Services is to treat and manage those forms of mental disorder that are amenable to psychiatric interventions is, in our opinion, compatible with a pragmatic approach to risk management. Such an

¹²³ NHS Executive HSG (94)27 (1994) Guidance on the discharge of mentally disordered people and their continuing care in the community, paragraph 2.

approach makes use of the available resources, without the need to distinguish risks which are attributable to a treatable mental disorder from those which are not. But there is still a need to be clear in a case such as this that there are uncertainties and risks which are not amenable to psychiatric interventions. This is precisely the point being made in the Trust's policy where it says:

“Record in writing exactly what risks are thought to be present, what action has to be taken and by whom and what level of risk is being accepted for an individual, bearing in mind the practical constraints, resources available and the rights of the individual to be treated in the least restrictive manner compatible with minimal risk.”

11.5.38 In Mr Hardy's case, stating what risks were thought to be present, and what level of risk was being accepted, would have had two important consequences. First, it would have made clear that risks which were not attributable to his mental illness, or to the interaction between his illness and alcohol, were not being accepted by services as risks which they could effectively manage. Secondly, in so far as any such risks might be reduced by the monitoring and supervision arrangements which were in place for managing his mental illness and alcohol use, it would have been stated that those arrangements might also have the effect of reducing the risk of violent or other criminal behaviour not attributable to his mental illness. This would have reflected the reality of what could be achieved while avoiding the attribution to Mental Health Services of responsibility for those risks which fell outside the scope of psychiatric intervention and which, accordingly, they had no means of managing.

Chapter 12 Sally White's Death

1. Introduction

12.1.1 The death of Sally White in January 2002 and the discovery of her body in Mr Hardy's flat is central to this Inquiry. At the time of those events Mr Hardy had been managed by community mental health services as an outpatient since his last hospital admission in 1998. He was questioned by the police but did not provide any information about Sally White's death. In February 2002, after a pathologist concluded that she had died of natural causes, it was decided that there was insufficient evidence to charge him. In April 2002 a Coroner's inquest recorded a verdict of death by natural causes. Sally White's death presented a challenge to Mental Health Services. They were faced with a situation in which the criminal justice system and the Coroner had not found Mr Hardy to have been responsible for killing Sally White, and yet because of the suspicious circumstances surrounding the discovery of her body, and the inconsistencies in his account of what had happened, Sally White's death was not something that could be disregarded in planning and managing his future care. It heightened the concerns which already existed about the risk he represented to others.

2 The circumstances of Sally White's death

12.2.1 Mr Hardy has never said how Sally White died in January 2002. The inference from his guilty plea in November 2003 is that she died in circumstances similar to those in which Elizabeth Valad and Bridgette MacLennan were killed in December 2002. It is known that all three victims were working as prostitutes at the time of their deaths and that this is how each of them came to be with Mr Hardy in his flat.

12.2.2 We know, from the account Mr Hardy gave to psychiatrists who assessed him in 2003, that the sexual activity with Elizabeth Valad and Bridgitte MacLennan included bondage, specifically tying them to the bed. Evidence we received from a woman, who met Mr Hardy in December 2002 through an advertisement she placed in a contact magazine, throws further light on Mr Hardy's sexual practices. She told us about their meeting at her home when Mr Hardy paid for what was advertised as a massage. According to her account, Mr Hardy forced her to submit to sexual intercourse. He appeared to find sexual gratification in crushing her with the bulk and weight of his body:

“I couldn’t speak because I could not breathe ... it was like he was pushing me right down into the bed ...His whole face was just like that [close to face], his whole chest was crushing right up into here [under neck] and my head was back. I physically couldn’t move and couldn’t speak ...He got a kick knowing I couldn’t breathe...The most kick he got was at the point when I was literally not able to breathe and I was crushed in such a position.”

12.2.3 We believe that Sally White died in the course of a similar sexual encounter with Mr Hardy, but we are not able to say whether he intended to kill her or whether her death was an accident.¹²⁴ Whatever may have been his state of mind at the time of Sally White’s death, when the police came to his flat on 20th January he was sober and we are in no doubt that he was fully aware that she had died and that her body was in the bedroom. Indeed, a short time before the police arrived he had been in the bedroom with a bucket of warm water. It is not clear what he was intending to do when he was interrupted but it seems possible that, as he later did with Elizabeth Valad and Bridgitte Maclennan, he was going to pose Sally White’s naked body and take photographs.

3 Questions prompted by the circumstances.

12.3.1 The highly suspicious circumstances in which Sally White’s body was found, including Mr Hardy’s complete denial of any knowledge of her presence in his flat, have been described in the Narrative.¹²⁵ We have considered how Mental Health Services responded to the discovery of Sally White’s body in his flat.

12.3.2 It is helpful to start by identifying a number of important features which were known to the police and Mental Health Services at the time:

- There was no evidence that he was actively mentally ill, either psychotic or manic, at the time Sally White’s body was found in his flat.
- The presence of a bucket of warm water in the room where her body was found shows that he had been in the room shortly before the police entered his flat.
- His claim that he had suffered an alcohol-induced blackout, and therefore

¹²⁴ Since his admission to Broadmoor Hospital Mr Hardy has told a doctor that he strangled Sally White but he has not provided any further information. As far as we are aware, this is the first time he has admitted to anyone that he even knew of Sally White’s presence in his flat before the police discovered her body.

¹²⁵ See Chapter 2, paragraphs 2.2.1 - 2.2.6.

could not remember how she came to be in his flat, was almost certainly false.¹²⁶ This is not to say that his claim that he had been drinking heavily on 19th January was false.

- He lied to the arresting police officers in claiming that he did not know that Sally White's body was in his flat. Subsequently, he did not tell all that he knew either to the police or to psychiatrists and other mental health professionals.
- If, as he claimed, he knew nothing, his reaction was unusual in the extent to which he dissociated himself from something that one would have expected to have been extremely troubling and preoccupying. He showed neither curiosity about how Sally White died; nor any apparent concern about the possibility that he had contributed to her death; nor, as presumably the last person who had seen her alive, did he express any grief or sympathy.

12.3.3 We accept that mental health professionals were not in a position to know how Sally White died and that they were most unlikely to get any further information or explanation from Mr Hardy himself. But the circumstances were undoubtedly suspicious and disturbing. They raised a number of questions:

- What credence was to be given to his claim to have experienced an alcoholic blackout with associated memory loss? If he was not telling the truth about this, what followed?
- How were his immediate reaction to the discovery of Sally White's body in his flat, and his subsequent dissociation from her death, to be understood?
- How were mental health professionals to understand and respond to his unwillingness or inability to say anything about Sally White's death?
- How were the events of January 2002 to be placed and understood in the context of Mr Hardy's known psychiatric and forensic history?

12.3.4 The purpose of asking such questions, to which there were not straightforward answers, would have been to provide mental health professionals

¹²⁶ For example Dr D expressed his scepticism thus: "*This enterprise [the criminal damage of 20th January 2002] therefore required some degree of planning and his memory for those events makes his amnesia for the other relevant events of that night all the more strange.*"

with an understanding of the relevance of Sally White's death to Mr Hardy's care and treatment, both while he remained in hospital and following his discharge. It was important to consider whether the circumstances called for different therapeutic interventions and whether they affected the assessment of risk to others and the management of that risk.

4 The relevance of the pathologist's findings and the Coroner's inquest

12.4.1 We were told by a number of witnesses that the conclusion of the pathologist that Sally White had died of natural causes, which led to the prosecution for murder being discontinued, when taken together with the inquest verdict of death by natural causes, effectively precluded further consideration of the circumstances of her death. Their view was that for mental health professionals to go into these matters would have been to step outside their area of competence and responsibility. This point was put most forcefully by some of the forensic psychiatrists whom we interviewed.¹²⁷ We were also told by Dr C and Dr B that the circumstances in which Sally White died were not relevant to their assessment of risk.¹²⁸

12.4.2 We accept that mental health professionals were bound to give weight to the opinion of the pathologist and the Coroner's verdict. The Coroner's verdict was a judicial finding that Mr Hardy had not caused the death of Sally White.

12.4.3 We agree with the mental health professionals that, in the absence of new evidence, they would not have been justified in concluding that Mr Hardy had killed Sally White. If new evidence had emerged it would have been their responsibility to pass it on to the police. It is not the job of mental health professionals to investigate criminal allegations. However, in our view it would have been legitimate, in planning and managing Mr Hardy's care, to take into account the circumstances of Sally White's death. For this purpose it was not

¹²⁷ For example, Dr A told us: "One can be criticised, and often is criticised, for taking on other people's role, be it the role of a police officer, a jailer or whatever. If you receive information that the offence initially being investigated has not been committed, my own view is that there is a need to think very carefully about whether or not there is any utility or whether it is necessary to explore that much further."

¹²⁸ Dr B told us: "At the time we couldn't come to any conclusion other than go along with what had been found and decided by the police and by the Coroner. We certainly felt that the circumstances were suspicious and in light of previous behaviour regarding allegations made by a prostitute, there was always a very small niggling doubt that perhaps somehow a terrible mistake had been made. Ultimately we felt there wasn't the evidence there at all to say that Mr Hardy had done anything untoward in causing her death."

necessary for those involved to reach a conclusion about his culpability.¹²⁹

5 Questions asked and perceptions of Mr Hardy arising from what was known and believed about Sally White's death.

12.5.1 Questions were asked. As soon as he assumed responsibility for Mr Hardy's care on admission to the Mornington Unit, Dr D made his own enquiries and was quickly able to gather the essential points. Although he thought it relevant to make these enquiries Dr D told us that he considered himself bound by the pathologist's findings and the Coroner's verdict. In his opinion, it would not have been proper for him to have assessed and managed Mr Hardy on the assumption that he was in some way responsible for Sally White's death.¹³⁰ Nonetheless, he concluded that the circumstances were highly suspicious, that Mr Hardy had probably lied to the arresting officers and that his claim that he could not remember the events because of the effects of alcohol was untrue. Dr D commented to us that when he spoke to Mr Hardy about these matters, it appeared to him that Mr Hardy knew that Dr D knew he was not telling the truth, and he was watching Dr D as if to observe how he was dealing with this uncomfortable situation:

"When talking to him particularly about the events surrounding his arrest, there was the strong sense that he was not telling the truth, but more than that, that he knew we knew he was not telling the truth and he was reflecting on that as you were talking to him. I don't say necessarily he was enjoying it or that he was manipulating us, but that is unusual. Many patients minimise or deny but they do so in quite a frank way in as much as they are sometimes trying to deceive, but with him there was an added level of reflection that made people very uneasy."

12.5.2 When Mr Hardy was transferred to St Luke's Hospital under Dr E's care, the team was thus in possession of most of the facts relating to the circumstances in which Sally White's body had been found and they also knew that Mr Hardy had not offered any explanation. It was clear to members of the team, including those who had previously known Mr Hardy, that he was not willing to discuss the matter. He continued to deny any knowledge of how Sally White's body came to be in his flat, attributing the gap in his memory to the effects of alcohol. At St Luke's the fact

¹²⁹ We develop this point further in Chapter 11 Risk Assessment and Risk Management, paragraphs 11.5.14 - 11.5.17.

¹³⁰ *"I don't know that it is not almost asking whether the mental health system or the psychiatrists involved in this case could have somehow redressed the decisions made in the Coroner's court. That cannot be, so that is the difficulty I have with that."*

that Sally White's body had been found in Mr Hardy's flat in unexplained circumstances was recorded in risk assessments, but not in such a way as to imply that he was responsible or that the circumstances gave rise to identifiable risk factors requiring further assessment or management.¹³¹

12.5.3 In summary, general psychiatric services considered that Sally White's death was a relevant matter but not one that they could take further. As appears from Dr E's letter of 27th June 2002 to Dr C requesting a forensic assessment, the discovery of Sally White's body was one of the matters he had in mind when planning Mr Hardy's discharge.¹³²

12.5.4 It became clear from our interviews with a number of people who were involved in Mr Hardy's care during 2002 that what was recorded in the risk assessments did not convey the full extent of the concerns they felt at the time. They did not believe in his claimed memory loss. They thought he had something to hide. This made them extremely uneasy. What follows are extracts from evidence given to us by four of those who were closely involved.

Mr R - community psychiatric nurse and care co-ordinator

With me it was just a gut feeling I had about him, so I wouldn't really put that in [a report prepared for the managers' review in June 2002].

Q. ...are you confident in telling us that your gut feeling, say in June when you wrote this report, was the gut feeling you have expressed to us? Or is it possible that the gut feeling came later?

A. It's the same gut feeling I had because I spoke to another member of the team, . . . , when we were talking in the office about it and I always had my concerns that he had done it.

The whole team had a gut feeling about him that he had done it. I don't think it was mentioned that much.

Ms M - psychiatric nurse and ward manager

He was always considered to be a very serious risk history, but we had to work to

¹³¹ See Chapter 11 Risk Assessment and Risk Management, paragraphs 11.4.5 - 11.4.6 and 11.5.4 - 11.5.5

¹³² He wrote: "When the police came to Mr Hardy's flat they found the body of a dead naked woman in the bedroom. Post-mortem examination revealed she had died from a myocardial infarction, although this was not immediately apparent and Mr Hardy was initially arrested for her murder. He had not given any account of how she came to be in his flat, claiming he couldn't remember because of his drinking problem."

some extent with what the courts had found or what the coroner had found. It is a very difficult issue and it brought up a lot of discussion on the ward among the whole team, not just the nursing team. He was brought up almost weekly in our staff support group as a patient who on the surface was incredibly compliant with his treatment and did all the right things, but he had this huge history and it was very difficult to get access.

Ms W - occupational therapist

It was hard to talk in an impressionist fashion in a ward round but, having said that, informally with his primary nurse, with Mr R, I often used to talk about the impressionist things. There again the consensus was that this man poses a threat. I know Mr R felt that very strongly.

I used to get second-hand feedback from the nurses and I am very aware his name came up time and time again. There were lots of fears surrounding his placement on the ward.

I think there was a general consensus with the multi-disciplinary team that they were dealing with a very strange character.

Ms T- Kentish Town CMHT Manager

Q. Presumably at a certain point you heard that the murder charge had been dropped. Do you remember being told that and how you reacted to that and how others around you reacted to that?

A. I do. I remember a number of reactions. One was, that's daft, how does the body of a woman get into somebody's flat? Then there was relief, and it was a mixture of, that's all right then, he hasn't murdered somebody, but hang on a minute, it's not all quite right. It was a mixed reaction.

Q. In your own mind, putting it at its lowest, it remained for you a possibility that it was murder and that he had got away with it.

A. Yes.

Q. Did that always remain a possibility in your mind in the succeeding months?

A. Yes, it did.

Q. ... when his position is being looked at in 2002, as you rightly say, there is this concern about risk. So the man we were managing well enough previously ...we are now looking at him differently and we are asking ourselves whether we are comfortable with managing him in the community. Is that a fair way of putting it? There is an unease that has entered into this.

A. Yes, there was unease.

Q. It is qualitatively different from the kind of unease that was around even before.

A. Yes.”

12.5.5 These people did not keep their anxieties to themselves but spoke to each other both individually and at weekly staff support meetings, which were also attended by Dr E. Their perceptions of Mr Hardy arose not only from what they knew of the circumstances of Sally White’s death, but also from their interactions with him and from their knowledge of his personal and forensic history, including the attempted murder of his former wife. Significantly, Mr Hardy never offered any explanation or reassurance. Nor did he choose to mention Sally White’s death as something which was troubling for him. Indeed, he succeeded in closing off all attempts to discuss the matter.¹³³ It is clear from what a number of people have said to us that Mr Hardy was discussed extensively at staff support meetings. These discussions did not allay people’s fears. There was a disconnection between on the one hand the belief of some of those most closely involved in his care that Mr Hardy had probably killed Sally White, and on the other hand an approach to his management which resisted speculation about how she had died.

12.5.6 The only occasion of which we are aware when he drew attention to Sally White’s death was during an occupational therapy session when he decorated a glass bottle with a design which included the words “Sally Rose White - R.I.P”. This was seen by Ms W, the occupational therapist, as a matter of concern. She told us:

“He decorated a glass bottle and put the inscription ‘Sally Rose White RIP’. He did maintain later on - because he had a penchant for decorating glass bottles - that what he was doing was recycling because he was trying to give up alcohol and it was his way of recycling the bottles he used. I didn’t question him about the inscription at all; I didn’t feel it was appropriate at the time. . .

¹³³ Ms M told us: *“In terms of the death of [Sally White] he always said he could not remember what happened and that was his standard answer to that question. However, on a number of occasions he did say to the nurses, particularly his primary nurse when she would ask him about it, that if he felt he was responsible he would kill himself. That is what he always said, and that was pretty much a standard answer he gave to that particular incident.”* It may be that this response made it even more difficult for staff to pursue this with him subsequently.

After the group I was quite concerned that he had done it and I re-read his notes and his risk assessment and I had an inkling. The name rang a bell and I discovered that Sally Rose White was the name of the woman who had been found in his flat ...in the ward round on the Monday Dr E asked me if there was any other feedback I had about any other patients and I said, 'Yes, I want to feed back about Anthony Hardy. He has been doing some very bizarre drawings in occupational therapy and he has also decorated a bottle with 'Sally Rose White RIP' and I have concerns about him.'"

12.5.7 When Dr B's detailed forensic assessment was received in November 2002 it had the effect of heightening anxiety. This was in part because of its conclusion that Mr Hardy presented a risk of serious harm which was independent of mental illness and his use of alcohol. But its impact was increased for those who read it at the time by the detailed descriptions of the circumstances in which Sally White's body was found and also the history of Mr Hardy's sustained harassment and violence towards his former wife.¹³⁴ For those who were already disposed to suspect the worst, the report tended to confirm their suspicions. Its impact was greater because of its timing, as it was first read by those responsible for Mr Hardy's care shortly after the managers' decision to discharge him from section 37.

6 The assessment and use of the available information by Mental Health Services.

12.6.1 Having reviewed the way services responded to Sally White's death, we draw the following conclusions. First, for the purpose of managing Mr Hardy's care it would have been wrong in principle to have assumed that he had killed Sally White. Secondly, no new evidence emerged during the course of 2002 which would have warranted referral back to the police for further investigation. Thirdly, we accept that there was nothing anyone involved in Mr Hardy's care could have done to have got him to talk about how Sally White died. This appears from his refusal at the time and subsequently to give an account of the circumstances; and is explained, we believe, by the fact that he was determined not to disclose any information which would have provided evidence of his responsibility for her death. Fourthly, we share the understanding, which we find in the approaches of both the general psychiatric services and the forensic psychiatrists, that Sally White's death could not simply be disregarded in planning Mr Hardy's future management, as the suspicious circumstances raised serious concerns about risk.

¹³⁴ The relevant extract from the report is reproduced as Appendix 3.

12.6.2 We have seen that members of the care team discussed their concerns. But the discussion was taking place in staff support group meetings rather than as part of the normal process of multi-disciplinary care planning. We believe that people's observations and impressions of Mr Hardy, some of which we have quoted above, should have been taken into account in this process. The challenge was to decide what information was relevant and reliable and to analyse it in a way that would assist in planning Mr Hardy's care and future management.

12.6.3 We are left with the question about how the information arising from the circumstances of Sally White's death should have been recorded and used. We are referring here both to the factual circumstances, so far as these were known, and to people's observations of Mr Hardy and their feelings that it was possible he had killed Sally White.

12.6.4 The distinction we draw is between information which was relevant to the assessment of risk and that which was relevant to Mr Hardy's management. We deal with the former in the chapter on Risk Assessment and Risk Management.¹³⁵ The position we state there is that the circumstances, taken together with his history of violence, provided a sufficient basis to bring Sally White's death into the risk assessment.

12.6.5 We now consider the relevance of people's interactions with Mr Hardy and their impressions of him to his management both as an in-patient and in the community.

12.6.6 The first point to be made is that the explicit inclusion in the risk assessment of the circumstances in which the body of Sally White was found would in itself have had an impact on his management. It would have provided a clinically legitimate basis for speaking to him about the concerns arising from her death and for explaining that the account he had given was not accepted as true. But it is our view that he would not have provided any further information however the question had been framed. His unwillingness to say anything about Sally White's death or to acknowledge that the circumstances were troubling to others was in itself a matter of concern. Examples of this are what Dr D told us (quoted in paragraph 12.5.1 above) and the sense of unease he created in the minds of the occupational therapist when he decorated the glass bottle. Another point was his

¹³⁵ See Chapter 11, paragraphs 11.5.14 - 11.5.17.

anxiety in connection with the forensic assessment. This was observed and recorded at the time but was not seen as worthy of particular note.¹³⁶ People were able to describe these things accurately and articulate them to us in ways which went beyond subjective impressions. We consider that this information about Mr Hardy could have been used in making a formulation.

12.6.7 The starting point should have been to record the uncertainties surrounding the death of Sally White. The next step would have been to acknowledge that there were concerns, and the nature of those concerns. To some extent this would have been achieved by including Sally White's death in the risk assessment in the way we propose. But it would have been seen that it was not simply an anxiety that Mr Hardy had killed Sally White. There were features of his personality which became apparent to members of the multi-disciplinary team because of his response to Sally White's death and their interactions with him in relation to that matter. Had these been articulated in ward rounds, and other multi-disciplinary meetings, they could have explicitly informed his continuing assessment and management.¹³⁷

12.6.8 Some of those from whom we have taken evidence might comment on the discussion in the preceding paragraph that in terms of assessing and managing risk no useful purpose would have been served by adding to or highlighting information which would have got the team no nearer to being able to draw inferences about how Sally White died. After all, they all were aware that Mr Hardy was dishonest and manipulative. It might be suggested that the effect would merely have been to heighten anxiety about risk. We do not accept this view. On the contrary, we believe that the reluctance of the mental health team to discharge Mr Hardy from hospital came from their concerns about risk, which arose from the uncertainties surrounding Sally White's death. The problem they had was in articulating and formulating those concerns.

12.6.9 Professor Maden in his advice to us made the general observation that while psychiatrists are good at identifying risks:

“what they are not good at is taking that further and categorising precisely what they are worried about, why they are worried about it and what they ought to be

¹³⁶ See Chapter 2 Narrative, paragraphs 2.4.27 - 2.4.35.

¹³⁷ See also the discussion in Chapter 10 Personality Disorder, paragraphs 10.5.4 - 10.5.8.

doing about it”.

The circumstances surrounding Sally White’s death provided important and relevant information about Mr Hardy’s personality, for example his emotional detachment and untrustworthiness. It was not necessary to speculate on how Sally White died in order to derive this information from the circumstances. Had a formulation been made that took account of his personality traits, it would not only have been more comprehensive than the care plans which were prepared, but it would also have reflected more accurately what people were feeling and discussing among themselves.

12.6.10 In conclusion, if the question asked about Sally White’s death was what was known about Mr Hardy’s involvement, little if any useful information would have been forthcoming during his admission in 2002. If instead the question was what could be learned of relevance to Mr Hardy’s management from the circumstances surrounding Sally White’s death, a considerable amount information would have become available.

Chapter 13 Recommendations

Chapter 4 Community Mental Health Services		
	Problem	Recommendation
1.	Paragraph 4.4.12 There were no procedures followed regarding exchange of information (notably of risk) between Mental Health Services and voluntary sector resources attended by Mr Hardy.	While it remains important to all concerned that voluntary sector resources are independent of the local mental health service, all CMHT's should meet with their local voluntary sector resources to develop protocols for regularly recording and sharing information about individuals in contact with them, especially that relevant to risks to the patient or others. This is particularly relevant when Mental Health Services refer patients to voluntary sector resources as part of their care plan, and/or fund such placements.
2.	Paragraphs 4.4.4 - 4.4.8 The multi-professional team caring for Mr Hardy did not visit him at home.	In some instances, the decision not to see a patient at home may be justifiable, but this decision needs to be based on careful and documented consideration, and regularly reviewed as part of his care plan. The threshold for avoiding all home visits should be high, because in many instances, seeing the home (and the individual in his/her home setting) can give valuable clues regarding the person's functioning and mental state.
Chapter 5 Forensic and General Psychiatry		
3.	Paragraphs 5.3.4 - 5.3.6 There was a substantial delay in completing the forensic report while Mr Hardy was an in-patient.	Complex reports involving consultation about, or specialist assessment of, patients should be prepared according to a timescale agreed in advance. Failure to meet a deadline should always require those preparing the report to contact the person who commissioned it to discuss the delay and agree a revised deadline.

	Problem	Recommendation
4.	Paragraph 5.4.10 In monitoring and assessing risk, the in-patient care team would have benefited from ongoing advice from a specialist forensic team.	General psychiatry teams in every Trust should liaise with a multi-professional forensic specialist service offering ongoing advice and support regarding clinical management, in addition to a basic consultation service. It would be helpful to pair particular forensic and general psychiatric teams.
Chapter 6 Housing		
5.	Paragraph 6.5 During the 2002 admission, there was uncertainty regarding Mr Hardy's housing until shortly before his discharge.	Contact with the Housing Department should be with a named individual whose post (a) gives him/her the responsibility to be the key contact within Housing, and (b) is at a sufficiently senior level to allow him/her to represent all elements of the Housing Department in liaising with Mental Health Services.
6.	Paragraph 6.5 The Housing Department did not convey to Mental Health Services how pessimistic their Legal Department were about the likelihood of evicting Mr Hardy from his flat.	As with risk assessment, all information relevant to decisions about a patient's placement needs to be shared in a timely manner between all those involved with the patient.
7.	Paragraph 6.7.1 The multi disciplinary team did not decide whether it was desirable or even acceptable for Mr Hardy to return to his flat.	Good practice would indicate that discharge planning (including housing) should begin at admission.
Chapter 7 Mental Health Act		
8.	Paragraphs 7.5.15 - 7.5.19 In the way the case was presented to the managers by the multidisciplinary team, insufficient weight was given to the relevance of after-care.	Clinicians need further training to improve their understanding of the criteria used in decision-making by Managers' Hearings and Mental Health Review Tribunals.
9.	Paragraph 7.6.4 The hospital managers who heard Mr Hardy's appeal against his detention section 37 reported that they considered that they were not qualified to discuss or contradict the legal opinion offered by Mr Hardy's solicitor at the Managers' Hearing. This case illustrates the enormous difficulties in the role of the hospital managers in hearing appeals, without automatic access to their own legal advice.	While hospital managers retain the power to discharge patients from detention, they should have access to legal advice on the conduct of hearings and the formulation of reasons for their decisions.

Chapter 9 Multi-Agency Public Protection Arrangements (MAPPA)		
10.	Paragraph 9.4.2 Limited disclosure to MAPP was recommended, but there was no explicit procedure for doing this.	Every Trust should have a protocol for Trust liaison with the Multi Agency Protection Panel, including referrals and seeking advice.
11.	Paragraphs 9.4.5 - 9.4.6 Although the risk posed by Mr Hardy to others was considered to be significant, a substantial element of that risk was not attributable to mental illness or alcohol use, and therefore beyond the scope of any interventions Mental Health Services could provide.	Under such circumstances, the Multi-Agency Protection Panel (MAPP) is the most appropriate forum to discuss the risks of a person to others. Trusts and MAPPs need to agree procedures to determine how a case like this could best be brought to MAPP.
12.	Paragraphs 9.4.5 - 9.4.6 If Mr Hardy's case had been referred to MAPP, this would have permitted appropriate shifting of responsibility away from Mental Health Services for those elements of risk not attributable to mental illness, although it is unclear how MAPP could have intervened to reduce the risk.	MAPPs should use this case as an example to explore how multi-agency consideration of the risks within the MAPP would contribute to their management.
Chapter 10 Personality Disorder		
13.	Paragraphs 10.5.5 - 10.5.7 Most reports on Mr Hardy conveyed little if any information about his personality, and the possible personality factors relevant to risk. This was probably complicated by the reluctance of clinicians to diagnose Mr Hardy as having a personality disorder because there was no known history of personality problems until he was in his mid 20's.	Psychiatrists and other mental health professionals should receive further training in understanding and describing features of personality, independent of the specific process of diagnosing particular personality disorders.
14.	Paragraph 10.5.11 Had greater account been taken of Mr Hardy's personality, his in-patient and discharge care plan would have been more comprehensive.	General psychiatry teams in every Trust should have liaison with a specialist service offering advice and support (that is, not exclusively a consultation service) in the treatment of people with mental disorder in whom personality is considered to be an important element in their care.

Chapter 11 Risk Assessment and Risk Management		
	Problem	Recommendation
15.	Paragraphs 11.5.4 - 11.5.9 Some important details relevant to risk assessment and risk management were inadequately recorded or appear to have been lost over time (such as those related to Mr Hardy's attempted murder of his wife).	All Trusts should ensure that information directly relevant to risk management is easily available and easily accessible (for example, by storing such information in a specifically designated part of the clinical records). The design of electronic patient records must allow for this also.
16.	Paragraph 11.5.8 The in-patient risk assessments did not adequately reflect the level of concern among staff about Mr Hardy's risk to others.	Trusts should review their supervision procedures concerning patient care to ensure that (a) regular clinical/professional supervision happens and (b) it gives staff the opportunity to reflect on concerns about individual patients and to formulate these concerns into risks that can be monitored and that can be incorporated into care plans
17.	Paragraph 11.5.8 Some concerns among those in the mental health team about Mr Hardy's current and future risks to others were not explicitly formulated and documented, but remained largely implicit, as a result of which they could not be taken fully into account in the care plan, nor systematically monitored.	All mental health staff should have training in translating implicit into explicit knowledge. It would be appropriate for this to be considered specifically in training and supervision.
18.	Paragraph 11.5.9 Some staff considered that they were not given adequate opportunity to express their concerns about Mr Hardy's risk to others during ward rounds.	Ward rounds have become increasingly complex, and the aims they attempt to meet have increased. Every team should try to make dedicated time to reflect (probably once a year) on how their ward rounds and other meetings are used, and on changes that might improve the team's work.

	Problem	Recommendation
19.	Paragraph 11.5.9 The structure and format of the risk assessment forms provided little if any help in appraising risk, focussing mainly on cataloguing risk factors.	Trusts should review their risk assessment forms to determine whether improvements can be made so that forms can contribute optimally to assessment and appraisal or risk. This should include consideration of a facility to record estimated levels of prediction and certainty - rather than omitting a risk because it is uncertain. Recording it in the risk assessment should help the multi-professional team to focus on any further evidence relevant to that risk that becomes available after the risk assessment has been completed.

Chapter 14 Summary

1. Background

14.1.1 Anthony Hardy pleaded guilty to, and was convicted of, the murders of three women. His first victim¹³⁸ died in January 2002. She was discovered by police behind a locked door in Mr Hardy's flat when they came to interview him for harassing a neighbour and damaging her property. Mr Hardy denied any knowledge of the dead woman's presence in his flat, claiming that he could remember nothing because he had had an alcoholic blackout. Shortly after the discovery of the woman's body, a pathologist concluded that she had died through coronary artery disease, and in April 2002 the Coroner recorded a verdict of death by natural causes.

14.1.2 Mr Hardy was charged with criminal damage to his neighbour's flat and remanded in custody. He was known to local mental health services, with a diagnosis of bipolar affective disorder. He was assessed by psychiatrists while on remand, and in April 2002 he was transferred to a psychiatric hospital, under section 37 of the Mental Health Act, having pleaded guilty to the criminal damage charge. While in hospital, there was very little evidence of any mental state abnormalities, although Mr Hardy continued to drink alcohol on occasions when allowed out of hospital on leave. In November 2002, he successfully appealed to the hospital managers and was discharged from the section 37. He returned to his flat. At the end of December 2002, he murdered two other women within a very short space of time.

14.1.3 This chapter highlights the key points from the report and then draws some conclusions. The summary follows the order of the chapters in the report.

¹³⁸ Because this Summary may be read without reference to the full report, we have deliberately chosen not to name Mr Hardy's victims in the summary. While we are very much aware that three people lost their lives, and that their families mourn for them, we considered that naming them in the Summary risked their being regarded as 'names' rather than as people.

2. Chapter 1: Introduction

14.2.1 It is well recognised that when faced with tragic events, people try to make sense of them. Events like the three murders which led to this Inquiry demand explanations in order to restore confidence that day-to-day living is indeed safe. More particularly, there is a strong urge to find someone to blame. If someone can be blamed for not recognising what was going to happen, this could go some way to reassuring those most directly affected by the tragic deaths, as well as the public, that something similar would never happen again.

14.2.2 When someone who murders has a history of mental illness, the media commonly attribute the former to the latter, even in the absence of any clear evidence. This problem is compounded by the well-meaning but potentially misguided efforts of pressure groups seeking to use such tragedies to argue the case for better care for the mentally ill. Both reporting in the media and the action of pressure groups serve to reinforce the notions that mental illness was responsible for the murders, and that, were it not for inadequacies in the treatment the individual received, the tragic outcomes would have been averted. Clearly, each case must be considered separately, but overall, it remains true that most murders are committed by people who do not have any mental illness, and those with mental illness are much more likely to be the victims of violence than its perpetrators.

14.2.3 Having investigated the circumstances of Mr Hardy's care in great detail, our conclusion, even with the benefit of hindsight, is that Mr Hardy alone was responsible for his actions. We acknowledge that this conclusion provides a very limited answer to the questions which are in people's minds.

3. Chapter 3 Alcohol

14.3.1 Mr Hardy had longstanding problems with alcohol. This is evidenced by Dr F's report of 29th November 1995 where he recorded: "Mr Hardy admitted that in recent years he had been prone to binges of heavy drinking, cider or vodka, though he denied symptoms of physical addiction".

14.3.2 The most important point is that appropriate and timely referrals were made to the specialist alcohol services and that the in-patient care plan included interventions designed to monitor Mr Hardy's alcohol use and to support him in his avowed intention of moderating his drinking. We consider that any failings in the enforcement regime while Mr Hardy was an in-patient are of secondary importance. The aim of modifying his pattern of alcohol use when he left hospital was not, in our view, going to be achieved by more efficient policing of his alcohol use as an in-patient.

14.3.3 We consider that Mental Health Services, in conjunction with the Trust's alcohol services, did all that could reasonably have been expected of them in 2002 to manage Mr Hardy's problems with alcohol. With hindsight it can be seen that the interventions made little, if any, difference.

4. Chapter 4 Community Mental Health Services

14.4.1 During 2001/2002, when he was not in hospital, Mr Hardy was a client of the Kentish Town Community Mental Health Team (CMHT). They managed his care within the framework of the Care Programme Approach (CPA). He also made use of resources in the community which were not managed by the CMHT.

14.4.2 The first year following the transfer of his care to the CMHT in September 2000 went well. His mental state remained stable. His behaviour gave no cause for concern. He appeared not to be drinking excessively, for example reporting to his key-worker in September 2001 that he had cut down and was then only drinking two pints a day. The general picture was reassuring, and contrasted markedly with the situation in 1995. There had been considerable progress. He was being effectively managed in the community.

14.4.3 It is our view that, from what was known at the time, the events of January 2002 did not provide a basis for changing fundamentally the way that Mr Hardy was managed. We consider that the plan, following his arrest and subsequent detention under the Mental Health Act, that Mr Hardy would be discharged back into the community was reasonable.

14.4.4 The CMHT took the deliberate decision, following discussions with Mr Hardy, not to visit him at home, but rather to arrange meetings with him elsewhere. We have considered whether, following discharge in November 2002,

home visits would have provided the mental health team with information which would have enhanced their ability to manage the risk of violence. Our conclusion is that they probably would not have done so. Home visits would have been by prior appointment and, as was the case on the one occasion he was visited at home (in November 2001), there is no reason to believe that Mr Hardy's domestic circumstances would have given rise to particular concern. We accept that a home visit in late December 2002, after Mr Hardy had murdered one or both of the women he killed at that time, would have been a very different matter. But he would surely have cancelled any such visit. In the absence of information that he was relapsing or behaving in ways that gave cause for concern, such a cancellation would not of itself warranted an unscheduled visit, particularly if Mr Hardy indicated a willingness to meet on another date.

14.4.5 From our meetings with the people directly involved in Mr Hardy's management during 2001/2002, and from reading the contemporaneous notes, we are satisfied that staff were conscientious in implementing the care plan and in recording relevant information. Although we heard from several people about the considerable pressures on CMHT staff during this time, we have seen no evidence that Mr Hardy's management in the community was compromised either by pressure of work or by other problems within the team. We consider that the way the team functioned in this case was satisfactory.

5. Chapter 5 Forensic & General Psychiatry

14.5.1 Mr Hardy was assessed on a number of occasions by forensic psychiatrists. No proposal was made to transfer his care to forensic services. It is clear from the evidence we have heard that once the decision had been made not to prosecute Mr Hardy for any offence in connection with Sally White's death, there was no possibility of his care being transferred to forensic services. This was because Mr Hardy had no convictions for serious offences of violence or sexual offences. There was therefore no basis, applying the criteria for admission to forensic services, for his psychiatric care and management to be transferred to the North London Forensic Service.

14.5.2 If one goes back to the process by which Mr Hardy was initially admitted to local mental health services under section 37 of the Mental Health Act, it appears to us that the actions of local services can best be understood as a

response to the assessed risk to others. Thereafter, the interventions available to the team were effective in treating Mr Hardy's mental illness but had little impact on his use of alcohol and did not touch those features of his personality which were associated with an increased risk of violence. He was discharged from the section 37 following a hearing by the Hospital Managers. It is clear from the reaction to the managers' decision that most, if not all, members of the multi-disciplinary team believed that the risk to others was as high after seven months in hospital as it had been at the beginning of the admission. The situation which arose in November 2002, when Mr Hardy went home in circumstances which caused considerable anxiety to members of the team, was perhaps the inevitable consequence of the initial decision to admit.

14.5.3 Our concern is that general psychiatric services, who in terms of physical and human resources are less well endowed than forensic services, are not in a position to exclude someone like Mr Hardy. He came to them by default and they had to do their best. It is not simply that people were anxious. In our view, there were features of the case which made it unusually complex and difficult for general adult services to manage. These included, but were not confined to, the problems of assessing risk because of the combination of the serious history of violence against his former wife and the unanswered questions surrounding the discovery of the first victim's body. Our view is that it was these features, although they were not fully articulated at the time, that caused such unease. With the benefit of hindsight, we can say that this unease was well-founded and that the risk that he would commit further acts of serious violence was unrelated to his mental illness and therefore not amenable to any intervention that general adult psychiatric services had available to them.

14.5.4 Our view is that the expertise and resources of forensic services could have been of assistance to those with responsibility for managing Mr Hardy. We consider there would be considerable benefit in a more collaborative approach to the management of patients who are assessed as presenting serious risks to others.

6. Chapter 6 Housing

14.6.1 There were two incidents in January 2002 where neighbours accused Mr Hardy of harassment. In considering how the Council dealt with these incidents, it must be acknowledged that both incidents were serious and constituted harassment.

14.6.2 Our overall assessment is that there was partial compliance with the Council's harassment policy but that there was a failure to act quickly and effectively in response to Mr Hardy's harassment of two of his neighbours in January 2002. There was also a failure to enquire sufficiently into his circumstances as a person who, in terms of the policy, was himself vulnerable because of his mental health problems.

14.6.3 Having been instructed to pursue the matter urgently, the Legal Department did not do so. Indeed, proceedings were issued, only in November, after the formal request was made on 10th October, notwithstanding that instructions had been received in early July. Instead of giving clear advice and asking for further instructions, they requested additional information and did not act on the instructions they had received in July. Such legal advice as was given, was unpalatable to the Housing Department. But, while not appearing willing to accept it, they did not challenge it or ask for clarification.

14.6.4 In our opinion, there was, within the Housing Department, a pervasive lack of focus in the handling of the case. This is illustrated by the failure of those responsible to ascertain and record the facts about the two January incidents, and to adjust their expectations and alter their position in the light of the unfavourable legal advice they received.

14.6.5 We accept the evidence we received from the Housing Department that had proceedings been issued at the earliest possible date, it is most unlikely that an outright possession order would have been made. This view is based on a number of considerations: that Mr Hardy had not physically assaulted either victim; that he had not threatened future violence; that he had been living at the property for two years prior to the two incidents and there had been no previous complaints about his behaviour; that since the two January incidents he

had received in-patient psychiatric treatment and been attending alcohol services; that following discharge he would continue to accept treatment and be monitored as an outpatient by the CMHT; and that he was willing to give assurances as to his future behaviour. We believe it is more likely, had proceedings been issued promptly, that he would have been permitted to keep the flat, subject to an order prohibiting him from further harassment of his neighbours.

14.6.6 We find it unsatisfactory that the Housing Department did not convey, preferably in writing, to Mental Health Services the negative legal advice they had received. But we also consider that it was somewhat ingenuous of Mental Health Services not to request information from the Housing Department about the prospects of success in the legal proceedings.

14.6.7 In our view, the mental health team should have decided very early on, in consultation with Mr Hardy, whether it was desirable, or even acceptable, for him to return to his flat. Had they done so, we believe the decision would have been to look for alternative accommodation. Had enquiries been made in good time, the position would have been much clearer at the time of the Managers' Hearing on 4th November. We do not say that these enquiries would have led to alternative accommodation, acceptable to Mr Hardy, being found. But we criticise the lack of a plan and a clear sense of purpose. We consider that the care planning in this respect did not conform to what is demanded by the Mental Health Act Code of Practice, that discharge planning "needs to start when the patient is admitted to hospital".

14.6.8 While better planning would have made for greater clarity, we do not consider that it would necessarily have changed the outcome. We think it likely that the Housing Department would have maintained their refusal to 'transfer the problem elsewhere', and that in due course Mr Hardy would have been discharged from detention and returned home. Even if the mental health team had formed the view at an earlier stage that discharge should be to supported accommodation, we do not consider it likely that this outcome would have been achieved because Mr Hardy was clearly not willing to agree to it.

14.6.9 It would no doubt be helpful in cases where users of Mental Health Services are subject to legal proceedings for possession brought by the Housing

Department, if information could be provided to Mental Health Services about the nature of the proceedings, the orders being sought and the likely or preferred outcome. In this case we believe this information could have been provided soon after the Notice of Seeking Possession was served in July.

7. Chapter 7 Mental Health Act

14.7.1 While it is striking, given Mr Hardy's history, that the two medical recommendations, made while he was on remand, for the section 37 hospital order, referred only to his depressed mental state and the short-term risk of suicide, we accept that it was irrelevant to his future management that at the time of assessment the identified risk was to his own safety rather than to the safety of others. It so happens that at the time Mr Hardy was assessed for section 37 he was found to be depressed and suicidal. Those features provided a sufficient basis for his detention. Thereafter it was for general psychiatric services to treat him and manage the risks, according to their own assessment. Everyone understood that once Mr Hardy was admitted to hospital under section 37, a wider range of factors would come into play in deciding for how long he should continue to be detained.

14.7.2 Regarding the hearing in November 2002, we consider that the hospital managers were entitled to conclude, on the basis of the information presented to them, that the treatment of Mr Hardy's mental illness did not require him to be in hospital, because it was more likely than not that he would continue with treatment as an outpatient and remain stable in his mental state. It was also likely that he would co-operate fully with arrangements for monitoring his mental state in the community. This had been the position for many months prior to January 2002 and there was no reason to suppose that in these respects anything had changed since his admission.

14.7.3 A detailed forensic assessment had been carried out, but at the time of the Managers' Hearing, the report had still not been received. With hindsight we can see that it was unfortunate that the managers decided the case that day rather than adjourning to a date when the forensic assessment report would have been available. But to have justified a decision to adjourn, it would have been necessary to make the connection between the forensic assessment and the legal criteria for detention. The managers told us that their impression, from the way

the case was presented to them, was that the forensic assessment was not going to recommend anything very different from what had gone before.

14.7.5 In this context, we recognise that Mr Hardy's consultant psychiatrist did not consider that there was an urgent need to ensure that the hospital managers saw the forensic report. Nevertheless, in our view, as Mr Hardy's Responsible Medical Officer, he needed to present the hospital managers with the best case to justify the continuation of Mr Hardy's detention, and we consider that he would have been greatly assisted by the forensic report. We criticise the failure to make the necessary enquiries before the Managers' Hearing. In our view, it was the consultant's responsibility to ensure that this was done.

14.7.6 Had matters been presented differently to the managers, it is possible that Mr Hardy would not have been discharged from section 37 on 4th November. If he had not been discharged from detention on that date he would have remained in hospital longer and any future discharge decision would have been informed by the forensic assessment. However, given our understanding of what motivated Mr Hardy to commit the two murders of December 2002, we do not believe that in the longer term a further period of detention in hospital would have reduced the risk of Mr Hardy committing murder following his discharge.

14.7.7 Regarding the Managers' Hearing, our key conclusion from the evidence we have heard is that the lack of legal training, or any legal assistance, places the managers at a disadvantage to an extent that leads us to question whether decisions about discharge from detention should continue to be made by lay people without legal assistance. We make this observation notwithstanding the considerable support managers in this Trust receive by way of training and information bulletins about case law and other legal developments.

14.7.8 We have concluded that the written reasons provided by the managers in this case were not adequate. We doubt whether it is reasonable to expect lay people, without legal assistance, to provide reasons which satisfy the legal standard. We consider that that this is a powerful argument for removing the power of discharge from hospital managers. We note that the Government's proposals for reform of mental health law dispense with the managers' power of discharge.

8. Chapter 8 Mental Illness

14.8.1 During the period 1998 - 2002, Mr Hardy's mental state was generally stable. There had been some evidence of variability of mood, but no evidence was recorded that he was actively psychotic, even though during routine mental state assessments, clinicians would undoubtedly have tried to elicit evidence of psychotic symptoms (such as delusions or hallucinations).

14.8.2 We consider it likely that that the stability of Mr Hardy's mental state during this period is at least partly attributable to his treatment with mood-stabilising medication. In other words, we consider that the treatment of the diagnosed mental illness, bipolar affective disorder, was effective during the period 1998 - 2002.

14.8.3 In conclusion, we are satisfied that Mr Hardy received appropriate treatment for mental illness both as an out-patient and during his 2002 in-patient admission. Our assessment of the evidence is that neither in January 2002 nor in December 2002 was Mr Hardy actively mentally ill. That is to say, he was not significantly depressed or elevated in mood, and he was not experiencing psychosis. We therefore conclude that his mental illness did not contribute to whatever led him to kill three people.

9. Chapter 9 MAPPA

14.9.1 In reviewing the implementation of MAPPA within Camden, it is necessary to compare the situation in 2002 with the arrangements which are now in place. We have heard from a number of people about the absence in 2002 of any procedure, or guidance, within the Trust for identifying patients who fell within the criteria for MAPPA or for referring such patients for multi-agency assessment and management. Our impression is that very little thought had been given to MAPPA at that time. However, these panels were only becoming established and it is likely that the same situation applied at this time in other mental health Trusts.

14.9.2 We are satisfied that where it is considered that a patient falls within the MAPPA criteria, a clear and straightforward referral procedure is now in place. We are also satisfied that relevant people within the Trust, such as consultant psychiatrists, are aware of the procedure.

14.9.3 We note that the policy documents and the arrangements for information sharing are underpinned by principles of medical confidentiality and give the consultant psychiatrist a pivotal role. We are concerned, however, that there is a risk that these principles will not be adhered to where informal arrangements, based on close working relationships, have developed.

14.9.4 We consider that MAPPA was relevant in this case. On the basis of the risk assessment in the forensic report, Mr Hardy was regarded as representing a serious risk which was not associated with a formal psychiatric illness. The management of that element of risk was therefore not amenable to therapeutic interventions by Mental Health Services. For these reasons, it would have been appropriate to involve other agencies, and particularly the local police, in assessing and managing the risks following discharge from hospital. We think it likely that Mr Hardy would have agreed to disclosure of information to the police, had he been asked, as he would have wanted to give the impression of co-operating with any arrangements.

14.9.5 This is not to imply that a referral to MAPPA would have changed the course of events. With the benefit of hindsight, we conclude that Mr Hardy was strongly motivated to pursue sexual encounters which placed the women with whom he came into contact at grave risk. We do not think it likely that a referral to MAPPA, and any feasible action plan that could have been put in place to monitor him in the community, would have deterred him from committing further offences.

10. Chapter 10 Personality Disorder

14.10.1 Applying standard diagnostic criteria for personality disorder rigorously, a diagnosis of personality disorder cannot be made in Mr Hardy's case, because these criteria require evidence of personality disorder to be present from adolescence or early adulthood, and we found no evidence of this in Mr Hardy's case. On the other hand, there is substantial evidence that Mr Hardy has abnormalities of personality entirely consistent with those expected of a personality disorder.

14.10.2 During the period with which we are mainly concerned, January - December 2002, there was no psychological assessment of Mr Hardy's personality, and no formal consideration was given to the potential impact of his personality on the management of his bipolar affective disorder, or on the assessment and management of risk. No formal consideration was given to whether appropriate treatment could be made available for his personality problems, although this is perhaps not surprising, given the acknowledged difficulties in treating such problems and the difficulties finding appropriate expertise and resources to carry out such treatment within the NHS.

14.10.3 The clinical expertise of the team which cared for Mr Hardy both in hospital and in the community was in the treatment and management of mental illness. The team's resources and methods were designed for this purpose. There was also an understanding of his use of alcohol. Interventions and resources were available to try to manage that as a clearly identified risk factor which was understood to be related to abnormalities of mental state and behaviour. But as far as we are aware there was nothing the team could have offered Mr Hardy for his problems of personality. The pragmatic response was for the multi-disciplinary team not to interest themselves clinically in that which they could not treat or manage. This was despite the widely shared perception that Mr Hardy's personality was abnormal. In our opinion what was missing from this plan was an explicit acknowledgement and understanding of Mr Hardy's abnormalities of personality, whether or not these amounted to a personality disorder.

14.10.4 Had there been an assessment in 2002 and the conclusion been reached that there was no therapeutic intervention available to modify the enduring abnormal features of Mr Hardy's personality, we would have no reason to question that. However, it is our view that an assessment of Mr Hardy's personality, in the context of the management of his diagnosed mental illness, might well have helped those involved in his care and treatment to understand him better and to be clearer about what they could expect to achieve.

14.10.5 Had the nature of Mr Hardy's abnormal personality traits been better understood, they could have been incorporated into a clinical formulation. This would have provided a clinically legitimate framework for staff to record and

raise matters which, in the absence of such a framework, were regarded as subjective impressions. We cannot say to what extent such an approach would have led to changes in Mr Hardy's management. But one matter we think is relevant is that had his personality been better understood, less importance would have been attached to his compliance with care plans.

14.10.6 We consider that where a patient is causing particular concern to staff, and where that concern arises from a perception that the patient's personality is abnormal, the team should be able to refer the patient to a specialist personality disorder service for assessment.

14.10.7 While we think it possible that a clinical formulation of Mr Hardy's personality would have changed his management as an in-patient, we do not believe this would have modified his personality or his behaviour. We accept, however, that a clearer formulation of the relationship between his personality traits and the management of the risks associated with his mental illness could have led to a more cautious approach to his discharge.

11 Chapter 11 Risk Assessment and Risk Management

14.11.1 Several risk assessments were carried out and documented during Mr Hardy's 2002 admission. The information and analysis included in these conveyed what was known and believed by the treating team and reflected views expressed in previous psychiatric assessments. The forms referred to the relevant factual matters in Mr Hardy's history and highlighted the uncertainty about the death of his first victim. The forms clearly identified the risk of violence to others. Regarding management of risk, the forms refer to the main risk factors and how they are to be monitored and managed. The discharge care plan dated 18th December 2002 provided further reinforcement.

14.11.2 The formal risk assessments did not fully convey either the seriousness of the risk or its nature, as including a significant element which was not attributable to mental illness and/or alcohol.

14.11.3 People were very troubled by what they knew and believed, but they did not find a way of feeding their concerns into the risk assessment process. Trust policies recognise that clinical supervision sessions are capable of facilitating this. In essence, staff clearly had concerns about Mr Hardy's past and current

behaviour, but their reasons for being concerned remained only vaguely formulated, and to a large extent implicit in their expressed feelings, rather than explicitly described and monitored. The translation of implicit to explicit knowledge is essential in developing adequate care plans in general, and in risk management in particular.

14.11.4 A number of witnesses to the Inquiry spoke about the difficulty of incorporating the circumstances of the first victim's death into the risk assessment. The difficulty arose because while the circumstances were suspicious, there was no evidence on which mental health professionals felt able to rely to prove that Mr Hardy had been responsible for the death. Moreover, because there was a post-mortem finding that she died of heart failure and a Coroner's verdict that her death was due to natural causes, mental health professionals felt constrained not to blame Mr Hardy. The way in which they dealt with this difficulty was to inform themselves about and record the facts surrounding the death, but not expressly to rely on those facts in the formulation of risk.

14.11.5 Our analysis is as follows. The circumstances of the death were suspicious. Given that the victim was known to have worked as a prostitute, it was reasonable to infer that her presence in Mr Hardy's flat was for the purpose of sexual activity. Mr Hardy failed to offer any explanation to allay the suspicions to which the circumstances gave rise. In fact he lied in claiming that he did not know the victim was in his flat and he thus fuelled the suspicion that he had something to hide. His history showed he was capable of sexual violence against women - in the past against his former wife and the woman who alleged he indecently assaulted her in 1998. It was therefore reasonable to take into account the circumstances surrounding the first victim's death as a risk factor predictive of violence associated with sexual activity.

14.11.6 We emphasise that by factoring in the first victim's death we have not demonstrated that it was possible to predict that Mr Hardy would commit homicide. On the contrary, our conclusion is that the risk of future homicide was not predictable in this case. In Appendix 4, we explain why the prediction of future homicide is so difficult. Even with the most careful assessment, for every future homicide correctly predicted, there would be at least 40, and probably

nearer 200, individuals incorrectly predicted to commit homicide in the future.

14.11.7 What should have happened during the 2002 admission was the formulation of after-care plans to manage risks following discharge. It appears to us that, prior to receiving the forensic assessment in November 2002, the assumption was that the arrangements would be much the same as those that had been in place prior to January 2002, with the addition of attendance at alcohol services. However, this was not formulated in a care plan prior to the managers' decision to discharge the section 37 hospital order.

14.11.8 We acknowledge that had Mr Hardy not returned to his flat, but instead been discharged to supported accommodation, there would not have been the same opportunity to take women home. However, we think it likely that women would have been at risk even if Mr Hardy did not have his own flat to which he could take potential victims. We base this first, on the fact that he had in early December assaulted a woman in circumstances which we believe to have been very similar to those in which he killed his three victims. Secondly, we agree with the view expressed by Professor Maden, the Inquiry's expert witness, that to the extent that Mr Hardy's psychopathology can be understood by psychiatrists, there is no reason to believe that psychiatric intervention would have made any difference. While Mr Hardy was getting effective treatment for his bipolar affective disorder, the risks he presented arose predominantly if not entirely from his abnormal personality, which was unlikely to respond to treatment, and certainly not amenable to treatment within the setting of general adult inpatient unit or treatment in the community by a community mental health team. The only intervention which would have significantly reduced that risk was detention in conditions which would have denied him access to potential victims.

14.11.9 The view that the role of Mental Health Services is to treat and manage those forms of mental disorder that are amenable to mental health interventions is, in our opinion, compatible with a pragmatic approach to risk management. Such an approach makes use of the available resources, without the need to distinguish risks which are attributable to a treatable mental disorder from those which are not. But there is still a need to be clear in a case such as this that there are uncertainties and risks which are not amenable to psychiatric interventions.

12 Chapter 12 The death of Mr Hardy's first victim

14.12.1 We believe that the first victim died in the course of a sexual encounter with Mr Hardy, but we are not able to say whether he intended to kill her or whether her death was an accident. Whatever his state of mind at the time of her death, when the police came to his flat on 20th January 2002, he was sober and we are in no doubt that he was fully aware that she had died and that her body was in the bedroom. Indeed, a short time before the police arrived he had been in the bedroom with a bucket of warm water. It is not clear what he was intending to do when he was interrupted but it seems possible that, as he later did with the two later victims, he was going to pose his victim's naked body and take photographs.

14.12.2 We accept that mental health professionals were not in a position to know how the first victim died and that they were most unlikely to get any further information or explanation from Mr Hardy himself. But the circumstances were undoubtedly suspicious and disturbing.

14.12.3 We agree with the mental health professionals that, in the absence of new evidence, they would not have been justified in concluding that Mr Hardy had killed his first victim. If new evidence had emerged it would have been their responsibility to pass it on to the police. It is not the job of mental health professionals to investigate criminal allegations. However, in our view it would have been legitimate, in planning and managing Mr Hardy's care, to take into account the circumstances of this death. For this purpose it was not necessary for those involved to reach a conclusion about his culpability.

14.12.4 The explicit inclusion of the first victim's death in the risk assessment would in itself have had an impact on Mr Hardy's management. It would have provided a clinically legitimate basis for speaking to him about the concerns arising from her death and for explaining that the account he had given was not accepted as true.

14.12.5 We believe that the reluctance of the mental health team to discharge Mr Hardy from hospital came from their concerns about risk, which arose from the uncertainties surrounding his first victim's death. Their problem was articulating and formulating those concerns.

14.12.6 The circumstances surrounding this death provided important and relevant information about Mr Hardy's personality, for example his emotional detachment and untrustworthiness. It was not necessary to speculate on how the victim had died in order to derive this information from the circumstances. Had a formulation been made which took account of his personality, it would not only have been more comprehensive than the care plans which were prepared, but it would also have reflected more accurately what people were feeling and discussing among themselves.

14.12.7 In conclusion, if the question asked about the first victim's death was what was known about Mr Hardy's involvement, little if any useful information would have been forthcoming during his admission in 2002. If instead the question was what could be learned of relevance to Mr Hardy's management from the circumstances surrounding the death, a considerable amount information would.

13 Appendix 6 The Coroner's Inquest into the first victim's death

14.13.1 We conclude that there was not a sufficient inquiry by the Coroner into the death of the first victim. The Coroner was not told of the suspicious circumstances surrounding the death. It is beyond the remit of this Inquiry to consider what might have happened had the Coroner had more information available to him when he was considering his verdict.

14 Conclusions

14.14.1 We have investigated in detail the care and treatment of Mr Hardy by Mental Health Services, particularly during 2002. We have identified some aspects of Mr Hardy's care that could have been improved and we have, within our remit, made recommendations based on our findings. However, it is important to stress that the aspects of care we have identified where there was room for improvement do not, either singly or together, amount to negligence or anything equivalent. It is unfortunate that the care and treatment of individual patients is seldom investigated in such detail except where a serious adverse outcome has occurred, like the tragic deaths of the three women in this case. If we had chosen at random another case to investigate in the same detail, even of a patient who had a very favourable outcome, it is likely that there too we would have identified aspects of care that could have been better, not least through

the benefit of hindsight. It does not follow, therefore, that any inadequacy of management or care in Mr Hardy's case should automatically be assumed to have contributed to the tragic outcomes in this case. In fact, for every criticism we have made, we have examined the likelihood that, had the care and treatment been optimal, Mr Hardy would have been prevented from committing further murders.

14.14.2 Our conclusion, even with the benefit of hindsight, is that Mr Hardy alone was responsible for his actions. We acknowledge that this conclusion provides a very limited answer to the questions in people's minds. It also fails to offer reassurance. However, in this instance, the fact that the person who killed three people happened to have a mental illness was coincidental, and made no contribution to the murders. Statistics indicate that on average in England and Wales, one to two murders are committed every day. The murders committed by Mr Hardy should be considered alongside these, rather than being seen as seen as a failure of Health and Social Services to support someone with a history of mental illness.

Appendix 1.

Key to People Referred to in the Report

- Dr A - Consultant Forensic Psychiatrist with the North London Forensic Service whose first contact with Mr Hardy was in early 2002 when Mr Hardy was on remand in Pentonville prison. In 2003 he assessed Mr Hardy and wrote a report.
- Dr B - Specialist Registrar with the North London Forensic Service who, under Dr C's supervision, carried out a forensic assessment of Mr Hardy in 2002 and wrote a report which was sent to Dr E on 29th October 2002.
- Dr C - Consultant Forensic Psychiatrist with the North London Forensic Service who supervised Dr B's forensic assessment and who himself examined Mr Hardy in August 2002.
- Dr D - Consultant Psychiatrist on the Mornington Unit who was Mr Hardy's responsible medical officer from 8th - 28th April 2002.
- Dr E - Consultant Psychiatrist on Cardigan Ward who was Mr Hardy's responsible medical officer from 29th April - 4th November and who thereafter continued to treat him both in hospital and as an out-patient. As a member of the Kentish Town Community Mental Health Team, Dr E had known Mr Hardy since October 2000.
- Dr F - Consultant Forensic Psychiatrist with the North London Forensic Service who assessed Mr Hardy in November 1995 and wrote two reports, in November and December 1995.
- Dr G - Consultant Forensic Psychiatrist from the Norvic Clinic who assessed Mr Hardy at Norwich prison in 1987 and 1989 at the request of Mr Hardy's solicitors.
- Dr H - Consultant Forensic Psychiatrist at Broadmoor Hospital who became Mr Hardy's responsible medical officer following his transfer there in November 2004.
- Dr I - Consultant Forensic Psychiatrist who assessed Mr Hardy in 2003 in connection with the criminal proceedings.
- Ms J - Clinical and Forensic Psychologist who assessed Mr Hardy in 2003 in connection with the criminal proceedings.
- Dr K - Consultant Forensic Psychiatrist who assessed Mr Hardy in 2003 in connection with the criminal proceedings.
- Dr L - Consultant Forensic Psychiatrist who assessed Mr Hardy in 2003 in connection with the criminal proceedings.
- Ms M - Nurse, ward manager of Cardigan Ward during Mr Hardy's stay there in 2002.

- Ms N - Director of Nursing, Camden and Islington Mental Health and Social Care Trust.
- Dr O - Consultant Forensic Psychiatrist who treated Mr Hardy at Wakefield Prison in 2004 and referred him to Broadmoor Hospital.
- Mr P - Detective Chief Inspector, Metropolitan Police.
- Ms Q - A woman with whom Mr Hardy formed a relationship in 2002 while they were both patients at St Luke's Hospital.
- Mr R - Community Psychiatric Nurse, member of the Kentish Town Community Mental Health Team, who took over as Mr Hardy's care co-ordinator in October 2001 and continued in that role until Mr Hardy's arrest in January 2003.
- Mr S - Nurse on Cardigan Ward who in November 2002, during a period when Mr R was absent because of sickness, temporarily became Mr Hardy's care co-ordinator.
- Ms T - Manager of the Kentish Town Community Mental Health Team.
- Ms U - Community Psychiatric Nurse, Mr Hardy's care co-ordinator in 2001 before Mr R took over.
- Mr V - Social Worker employed as an alcohol worker with the Alcohol Advisory Service who saw Mr Hardy on a number of occasions in 2002.
- Ms W - Occupational Therapist for Cardigan Ward.
- Mr X - Director, Camden Mental Health Services, Camden and Islington Mental Health and Social Care Trust.
- Dr Y - Consultant Forensic Pathologist who carried out the post-mortem on Sally White and attended the Coroner's Inquest into her death.
- Ms Z - Assistant Director of Housing, Camden Council.

Appendix 2. Glossary

Alcohol Advisory Service (AAS): part of Camden and Islington Mental Health and Social Care Trust. It is an integrated service providing a range of therapies for people with alcohol problems.

Alcohol Recovery Project: a drop-in service in King's Cross run by the voluntary sector.

Argyle Walk Registered Care Hostel: a hostel in Camden for people with mental health problems.

Camden and Islington Mental Health and Social Care Trust (the Trust): the organisation which provides specialist psychiatric care and social care to residents of Camden and Islington with mental health problems. The NHS Plan, published in July 2000, first proposed the creation of Mental Health and Social Care Trusts "to ensure that mental health and social care provision can be properly integrated locally".

Camden Borough Inter-Agency Risk Management Panel: a body which brings together a number of statutory agencies and which, through monthly meetings, shares information about offenders and co-ordinates the assessment and management of risk.

Cardigan Ward: an adult acute mental illness ward at St Luke's Hospital.

Care co-ordinator: under the Care Programme Approach, the person with responsibility for co-ordinating the services provided to an individual in accordance with the care plan.

Care Programme Approach (CPA): the framework for care co-ordination and resource allocation in adult mental health care. Its four main elements are: systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services; the formation of a care plan which identifies the health and social care required from a variety of providers; the appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate care; and regular review and, where necessary, agreed changes to the care plan.

Columbus project: now known as Tottenham Mews Resource Centre - see below.

Community Mental Health Team (CMHT): an integrated team of people from a variety of professional backgrounds, aiming to provide one point of access to mental health services to people assessed as suffering from a severe mental health problem.

Complementary Housing Management Service (CHMS): part of the London Borough of Camden's Housing Department which advises and assists District Housing Offices on issues affecting vulnerable tenants.

Diorama: a registered charity which runs a wide variety of arts projects and classes to benefit local people in Camden. Within Diorama, Studio Upstairs is a therapeutic art studio.

Focus Homeless Outreach Team (Focus): a team which works with homeless single adults with mental health problems. It is part of Camden and Islington Mental Health and Social Care Trust.

Highgate Centre: a day service for mental health service users which is part of Camden and Islington Mental Health and Social Care Trust.

Hospital managers: a committee of at least three people, one or more of whom may be non-executive directors of an NHS Trust, which has power under section 23 of the Mental Health Act 1983 to discharge patients from detention.

Huntley Centre: an in-patient psychiatric unit, comprising a number of wards, within St Pancras Hospital. It is part of Camden and Islington Mental Health and Social Care Trust.

JIGSAW team: the public protection unit, comprising four police officers and two probation officers, based at Holborn police station.

Kentish Town Community Mental Health Team - see community mental health team above.

King's Terrace project: a housing project providing supported accommodation for people with mental health problems.

Mind dual-diagnosis group: a group run by a dual diagnosis (mental illness/substance abuse) worker, employed by Mind, to help people think about their substance use within the context of their mental illness.

Mornington Unit: an intensive care ward within the Huntley Centre - see above.

Multi Agency Public Protection Arrangements (MAPPA): a framework for inter-agency co-operation in assessing and managing violent offenders in England and Wales.

Multi-Agency Public Protection Panel (MAPP): within MAPPA - see above - the panel which provides assessment and management of the 'critical few' - those who pose the highest risk or whose management is so problematic that multi-agency co-operation at a senior level is required.

North London Forensic Service: provides forensic mental health services to the boroughs of Barnet, Enfield, Haringey, Camden, Islington, Redbridge and Waltham Forest. It is part of Barnet, Enfield and Haringey Mental Health NHS Trust.

Psychiatric Diversion Team at Highbury Corner Magistrates' Court: a multidisciplinary team which carries out psychiatric assessments of defendants at Highbury Corner Magistrates' Court, primarily for the purpose of ensuring that, where appropriate, people with severe psychiatric problems are diverted from a custodial remand to a mental health facility for further assessment and treatment.

Rugby House: a residential detoxification from alcohol facility.

Responsible medical officer (RMO): as defined by section 34 of the Mental Health Act 1983, in relation to a person detained under the Act, "the medical practitioner in charge of the treatment of the patient".

St Luke's Hospital: a psychiatric hospital which is part of Camden and Islington Mental Health and Social Care Trust.

Section 17 leave: under section 17 of the Mental Health Act 1983 the responsible medical officer may grant a patient leave of absence from hospital "either indefinitely or on specified occasions or for any specified period".

Section 37: a hospital order under section 37 of the Mental Health Act 1983 is an order made by a criminal court, usually following conviction, which authorises the detention of a person in a psychiatric hospital. *"Once the offender is admitted to hospital pursuant to a hospital order... his position is almost exactly the same as if he were a civil patient. In effect he passes out of the penal system and into the hospital regime. Neither the court nor the Secretary of State has any say in his disposal. Thus, like any other mental patient, he may be detained only for a period of six months, unless the authority to detain is renewed ... Furthermore, he may be discharged at any time by the hospital managers or the responsible medical officer ..."* R v Birch (1989) 11 Cr.App.R.(S.) 202.

Studio Upstairs: see Diorama above.

Trust - Camden and Islington Mental Health and Social Care Trust - see above.

Tottenham Mews Resource Centre: a walk-in service which provides practical, social and emotional support to mental health service users. It is part of Camden and Islington Mental Health and Social Care Trust.

Appendix 3. Forensic History

Extract from Dr B's Confidential Forensic Psychiatric Report on Mr Anthony Hardy.

5th April 1982: Attempted murder of wife (charges not pursued)

His wife's account of this incident is given in one of her reports in the divorce proceedings. She reports that this incident occurred shortly before they left Australia. She recalls that on the 5th April 1982 at 6.30 am she was asleep in bed. Her husband took a frozen water bottle from the freezer and struck her on the side of the head whilst she was asleep. She reports being stunned, semiconscious and in considerable pain. Mr Hardy then carried her to the bathroom, where he had filled the bath with water. He pushed her over the bath and thrust her head under the water in an attempt to drown her. She reports that she tried to pull the plug out but it was jammed in. The attack stopped when her eldest child came into the bathroom and began screaming. She was taken to hospital by ambulance and was found to have mild bruising to her head and legs. At the time Mr Hardy admitted that he intended to kill her. She states the incident occurred without warning. He described himself at the time as having a Dr Jekyll and My Hyde personality. His wife stated that if she didn't behave as he liked, then the bad side of his character would come out.

At interview today My Hardy's account of this incident broadly mirrored that of his wife. He states that he had been preoccupied with the thought of killing his wife for at least two weeks prior to the offence. He stated that their relationship had deteriorated over a long period of time prior to this and that his wife treated him like her worst enemy. He stated that their sex life was non-existent and he felt extremely resentful about this. His opinion of his mood at this time was that he was neither elated nor depressed. He reports that the frozen water bottle was in the freezer as they used it as a cooler in a picnic box. At this stage in the interview he stated that he had not put the bottle in the freezer with the intention of using it as a weapon. However he later stated that some time prior to the incident he had read a novel where a man made a dagger out of ice in order to commit a murder where no weapon would be found. He confirmed his ex-wife's account of the attack. He stated that he had intended to kill her and that the attack was not preceded by any argument. He also stated that he had not been drinking alcohol and was not under the influence of any illicit drugs. He reported that his feelings for his ex-wife were so strong that he couldn't tolerate the idea of losing her.

No charges were brought regarding this event.

1982: Kidnap of wife

Mr Hardy took his wife to a hotel and then locked the door refusing to allow her to leave. It is reported that he threatened to kill his wife, but relented when she spoke of their children. Following the kidnap of his wife, she applied for a divorce, requested that he leave the matrimonial home and have no contact with their four children. I have read through many pages of evidence that she gave explaining his behaviour and have summarised it here.

On the 14th May 1982 she filed for a divorce petition on the grounds that her husband had behaved in such a way that she could not reasonably be expected to live with him. She made this shortly after they returned from Australia. They subsequently attempted a reconciliation, which broke down by February 1984.

1985-1987 - Harassment of wife

On the photocopies in the notes, Mr Hardy has written that his wife requested that he obtain work away from home and she subsequently started another relationship. She restarted divorce proceedings, but then by September 1984 became reconciled again. This lasted until February 1985 when again proceedings were started. Her husband wanted to reconcile and refused to leave the house. He stated to her that if she slept with him and withdrew from the divorce she could have Dr Jekyll but if she did not that she would definitely have Mr Hyde. She continued to stay at the matrimonial home and he refused to leave. When she gained a Decree Nisi there were substantial difficulties in serving the petition to Mr Hardy who she alleges took every step possible to avoid such service. She feels even when served he did not accept that the marriage had irretrievably broken down.

It appears that he made life very difficult for her.

On the 22nd August 1985 he saturated the bed with water and as a result she had to sleep on the floor. He then stopped her working the following night by taking the fuse out of her typewriter. He then took all the money out of her bag. He went to a calendar and put a big red circle around the date 13th October and wrote beside it "K.L.". That night when she went to bed he had left a Halloween mask under the covers. During that month he continued to take the children away for weekends with a girlfriend and his wife felt too afraid to refuse. It was his wife's opinion that he was irresponsible in looking after them, forcing them to stay up to 3.30 am at a barbecue.

On Sunday the 9th September 1985 he took a ladder from a neighbour's garden and tried to climb through her bedroom window.

He subsequently took the children plus his girlfriend and three other children to see his parents in Burton-on-Trent. He had not spoken to them for a year and he gave no notice of the visit. They refused to see him. Three days before she left the matrimonial home he refused to let her sleep by turning up the volume of the radio. He threatened to make her feel as miserable as he was feeling. He told her that even if he left the house, she was not to think that she would sleep easy in her bed, as he would ensure that she did not.

A restriction order was completed in November 1986 requiring that Mr Hardy restrain from molesting, assaulting, or in any other way interfering and communicating with his ex-partner and the four children or to enter or go within 250 metres of their previous matrimonial home. He broke these terms and was sentenced to two months' imprisonment.

On the 8th December he made repeated phone calls to his ex-wife. On the 11th December 1986 whilst Suffolk constabulary were installing alarm mats at the matrimonial home they found microphones in various central heating vents.

On the 13th December 1986 a number of clothes and a woman's blonde wig worn by Mr Hardy when previously following Mrs Hardy were found in the garage of the matrimonial home and this was reported to the police.

On the 14th December 1986 he made a further two telephone calls to his ex-wife. On the 30th December 1986 he was spotted parking his car outside the home and when two neighbours drove to the local police station to report this he followed them in this car. On the 2nd January he again followed his ex-wife's car from London. On the 3rd January 1987 a pane of glass had been removed from the front door in exactly the same manner as he had previously done on the 1st December 1986. On the 5th and 11th January 1987 he made repeated telephone calls to her whilst she was away from the house. A neighbour reported that the phone frequently rang all night.

On the 12th January 1987 her phone number was changed and made ex-directory. Within five hours, despite only telling close friends, Mr Hardy obtained it and made calls.

On the 27th January 1987 a male friend who was staying at her house to provide emotional support found that four tyres of his car had been slashed. He found a threatening message left on his answer phone from the respondent.

On the 28th January 1987 he made a phone call to her which was answered by her male friend. Mr Hardy stated that "if she persists in refusing to talk to me she will be sorry". On the 19th January 1987 she received a card through the post. It contained the words "Is there a chink in your armour, I wonder? Tony. PS So near and yet so far away."

In March and May he telephoned the family home ten times. On the 8th June 1987 a brick was thrown through his ex-wife's window and four tyres on her car were slashed. On the 9th July 1987 she smelt cigarette smoke drifting upstairs late at night that her husband smoked. She telephoned police who came instantly. They found her car had one tyre slashed. On the 13th July 1987 a brick was again thrown through her window. A card written by Mr Hardy was found attached stating "This brick was chosen with care, I hope you like it. T.". The same day a total of five cars in the local area were found with all four tyres slashed. These people were all friends of Mrs Hardy's. On the same date she received a card which stated "To the stars or to hell? The choice is yours."

He reports that earlier in the year he hired a car in order to drive to see a girlfriend in Norfolk. He then decided to keep the car (i.e. stole it) and use it to work as a minicab driver. He changed the number plates to a car he had seen of a similar description and continued to use it for most of the summer. He then drove to Bury St Edmunds to harass his ex-wife.

On the 21st July 1987 Mr Hardy again entered her house, boarded up the garage with wood and jammed the front door lock with a metal object. A car belonging to her male friend was stolen and Mr Hardy was subsequently found guilty of stealing it.

At Bury St Edmunds County Court he was sentenced to twelve months imprisonment on the 16th September 1987, for contempt of court. He was also in custody with respect to a number of criminal charges relating to the above. He pleaded guilty to these charges. He came before the magistrate's court in January 1988. They took the view that their powers for sentencing were insufficient and they committed Mr Hardy to Crown Court for sentencing.

2nd January 1989: Theft of a car, and of ex-wife's boyfriend's car

He test-drove a car, which he was planning to buy. He copied the keys and later stole it, using it as a minicab in London. He reports that he had fallen into the company of a group of prostitutes and heroin users and had decided to organise a New Years party for them. He decided to drive to Norwich to fetch friends to attend the party. On impulse on the 2nd January 1989 he diverted to Bury St Edmunds. He reports that he had been consuming large quantities of alcohol prior to this. He then threw a large stone through the window of her house. Her cohabitee identified him and police were notified. A roadblock was set up in Thetford and a police chase ensued down the motorway at great speed. He eventually lost control of the car and crashed. He was in a drunken state on arrest but refused to provide specimens. His behaviour was difficult during his period of detention and he damaged the police cell.

He was charged with;

Reckless driving whilst disqualified, driving without insurance, failing to provide specimens, criminal damage to ex-wife's house and to the police cell and theft of a motor vehicle.

1991: Theft: Served 6 months of a one year sentence

1992: During his time at Arlington House, where he was a resident he was accused of beating up residents and hitting hostel staff and making sexually inappropriate comments to hostel staff and tenants (suggesting making pornographic videos). He was obliged to leave following court proceedings. At interview today he denied this behaviour.

1998: Indecent assault and sexual assault (charges dropped)

Mr Hardy stated at interview today that he had offered to share his flat with a prostitute from the Kings Cross area of London. She was eighteen years of age. He states that on the evening of the incident, they had both been drinking heavily and were also under the influence of cannabis. He reports that he removed her jeans and top and she did not object. He states that he then inserted two fingers into her vagina and she objected. He states that she did not object prior to this and in his opinion she was not so intoxicated that she would not have been unable to refuse consent. I understand that she reported to police that he raped her but she later refused to press charges and the case was dropped.

2002 - Index offence

Social History

He reports that he has been prone to heavy drinking binges since the 1980's. In the latter part of 2001 he was drinking heavily. His longest period of abstinence was around two days. He reports an increased tolerance to the effects of alcohol, strong cravings and memory blackouts. His account of withdrawal symptoms does not fit the normal pattern and it appears as if he was not suffering from these.

He reports using cannabis though denies the use of other street drugs.

Index offence

This relates to events that occurred on the 20th and 21st January 2002.

Mr Hardy's account of events were as follows. He reports that over the previous year the tenant in the flat above his (the victim of index offence) had a bathtub which leaked water into his flat every time she emptied it. He states that when this first occurred he did nothing about it as he was feeling depressed at the time and could not motivate himself to report it. He also stated that he was afraid of what her reaction would be. He states that he later reported this to her and the housing association but she didn't attend to the problem immediately and at one stage turned away workmen who had arrived to fix the problem. He states that at a later date she did attend to the problem. He reports that in the weeks leading up to the 20th January he had become increasingly preoccupied and angry about how she had behaved.

He denies having committed any earlier acts of harassment on her. However, the victim reports that in November 2001 a corrosive substance was poured through her letter box and her car was frequently vandalised (tyres slashed and windscreen wipers bent). Mr Hardy denies any knowledge of this, though conceded he may have done it but cannot recall due to an alcohol induced blackout.

He was drinking large quantities of alcohol at this time. On the evening of the 20th January he poured acid from a car battery into a cup. He states that he found the car battery on the street a few days earlier and was planning to use it as a weight. He denies obtaining it for the purpose of criminal damage. He then went to the neighbours front door with the acid in the bowl, a cider bottle with the bottom cut off as a funnel and a paint brush. He painted the words "Fuck off you slut" on it with the acid and poured acid through her letter box. Clearly there was some degree of planning.

Mr Hardy states that is all he can remember about the events up until being in a police cell the next day.

Detective Sergeant Goldsmith of Camden Police disclosed the following information. His neighbour discovered the damage the next morning and called the police. When the police arrived they found a trail of battery acid leading from her front door to Mr Hardy's flat. They knocked on the door and Mr Hardy

answered. He was fully clothed and though smelling of alcohol did not appear intoxicated. Mr Hardy immediately admitted causing the criminal damage. The police then asked to search his flat, which Mr Hardy allowed. His flat consists of a kitchen, bathroom, living room and one bedroom. When the police tried to gain access to the bedroom they found the door locked with a key. Mr Hardy denied having a key for the room. When searched they found the key in the lining of the jacket he was wearing. On entering the room the police found the dead body of a woman lying naked, with her legs spread apart, on the bed. A towel was over her face. Next to the body on the floor was a bucket of soapy water, described by the attending police officers as being hot. In the corner of the room was a photographer's lamp. Her clothes were folded on the floor. The woman had a superficial graze to her head which had bled. Inside the hood of her top, blood was also found, which implied that it had been removed after the injury, either by herself or by Mr Hardy. The window to the room as locked from the inside and police feeling that it is unlikely that anyone else had been in the room when they arrived. Also in the room were various contact adverts from Loot, advertising the services of Russian and eastern European prostitutes.

When the room was later examined by forensic experts using a "LUMILIGHT" (an ultraviolet device used to show up small or hidden evidence) they discovered that under the fresh coat of paint that had been applied to the room, various names of women had been written onto the walls. These names were Sandra, Jayne and Tracy.

He was arrested on suspicion of murder and criminal damage.

The neighbour reported seeing Mr Hardy with a woman that night but could not identify her due to poor eyesight. Another neighbour reported hearing screaming at 4 am. Mr Hardy was arrested on suspicion of murder. He made no comment at the time.

A post-mortem on the dead woman revealed that she died of a myocardial infarction secondary to ischaemic heart disease.

At interview today, Mr Hardy stated that he still has no recollection of events after he damaged his neighbour's door. He has subsequently learnt that the dead woman was a woman named Sally Rose White and that she was a prostitute working the Kings Cross area of London. Mr Hardy speculates that he must have invited her back to his flat sometime later that night. He reports that he frequently uses prostitutes from the local area and police confirm that he is known to some prostitutes in the area.

Due to the lack of conclusive evidence of foul play he was not charged with murder and instead charged solely with criminal damage. He pleaded guilty and was admitted to the Morningson Unit PICU under section 37 of the Mental Health Act 1983 on the 9th April 2002.

Appendix 4 Figures and Assumptions used for the prediction of homicide figures calculation in Chapter 11

1. Annual in-patient psychiatric admissions during 2001-2 for England alone were approximately 150,000 (National Statistics - Hospital Episode Statistics, Table 7)¹³⁹. Some patients will have been admitted more than once, so for these calculations, it will be assumed that 140,000 patients had in-patient admissions for mental health in 2001-2.
2. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness¹⁴⁰ identified 1579 homicides in England and Wales during the 3-year period from April 1996.
3. Assuming no substantial change in homicide rates between this period and 2001-2, there were approximately 525 homicides in England and Wales during 2001-2.
4. The populations of England and Wales respectively are 49,138,000 and 2,903,000 (2001 Census)¹⁴¹.
5. From (3) and (4), assuming that homicide convictions were proportionately divided between England and Wales, there were approximately 500 homicides in England during 2001.
6. According to the National Confidential Inquiry, 9% of homicide perpetrators were in contact with Mental Health Services in the 12 months before the homicide. On this basis, 45 homicide perpetrators during 2001-2 would have been in contact with mental health services during the 12 months prior to their homicide offence.
7. Among those homicide perpetrators who had been in touch with Mental Health Services in the 12 months before their offence, it is not possible to predict accurately what proportion had been in-patients, although it is possible to say with confidence that this was less than 100%. It will be assumed that this figure is 70%, although this is likely to be an over estimate. Hence of the 45 homicide perpetrators who had been in contact with

¹³⁹ Hospital Episode Statistics, Table 7 (2001-2) (available at www.hesonline.nhs.uk).

¹⁴⁰ Safety First: Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Department of Health, 2001 (available at www.doh.gov.uk/mentalhealth/safetyfirst).

¹⁴¹ National Statistics: Census 2001 (available at www.statistics.gov.uk/census2001).

services, 32 will have had an in-patient admission during the year prior to the offence.

8. Thus the task of any predictive test for homicide among those admitted as in-patients to a mental health unit would be to identify the 32 people who commit homicide among a total of 140,000 patients admitted annually.

Assumptions

9. The main aim of a predictive test of homicide is clearly to identify correctly all those who will commit homicide: that is, to minimise the false negatives - individuals who will commit homicide but are classified by the test as non-perpetrators.
10. No test is 100% perfect, so it will be assumed that the false negative rate is only 1%. Most tests perform much more poorly than this, but this assumes an ideal test.
11. It is a property of all predictive tests that as they reduce the rate of false negatives, the rate of false positives rises. If a test has only 1% false negatives, the rate of false positives will be substantially larger. For the calculations below, it will be assumed that the rate of false positives is either 1% or 5%.
12. The data above, together with the assumptions listed, yield the results in the Table 1 below.

Table 1: Performance of an 'ideal' predictive test of future homicide (with 1% false negatives and two rates false positives)					
			(Future) Homicide		Total
			Yes	No	
1% False Positives	Test predicts future homicide?	Yes	32	1400	1432
		No	0	138,568	138,568
5% False Positives	Test predicts future homicide?	Yes	32	6,998	7,030
		No	0	132,970	132,970
		Total	32	139,968	140,000

13. With a test that performs almost ideally and better than most would be expected to in practice, all 32 of the individuals who will commit homicide would be identified successfully. However, because of the very low rate of homicides committed by psychiatric in-patients, the 1% of false positives would amount to a substantial number of patients overall. The test would identify no fewer than 1,432 patients predicted to commit homicide in the future. In other words, for every future homicide correctly predicted by this 'ideal' test, 44 patients would be identified as likely to commit homicide in the future who would not actually commit homicide. Put another way, for every correct prediction of homicide, there would be 44 incorrect ones (false positives).
14. The figures above are based on a 1% false positive rate. If the false positive rate were 5% (which would still amount to a very good predictive test), nearly 7,000 patients would be identified by the test as going to commit homicide who would not in fact do so. In this case, for every homicide correctly predicted, there will be 218 individuals predicted incorrectly to commit homicide.

Appendix 5 RISK ASSESSMENT PROCEDURES

1. We have criticised the risk assessment procedures used in this case as being insufficiently detailed, and for not conveying an impression of the way in which evidence was used to form a judgment. However, it is also clear that the clinical team followed Trust policy in conducting the risk assessments. The main problem therefore appears to be with limitations of the policy, rather than the way that it was followed in this individual case.
2. Each NHS Trust has developed its own procedures for risk assessment. The fact that the purpose of risk assessment is identical from one Trust to the next makes this seem an unnecessary duplication of effort. However, when formal risk assessment procedures were first introduced, there was no national procedure available, nor specific guidance on developing local policies, hence the development of policies by individual Trusts was inevitable. Some Trusts developed detailed risk assessment tools, where individual risks were quantified, and each risk assessment yielded a quantitative measure of overall risk, which was sometimes linked to particular management plans. However, this format of risk assessment has been criticised, rightly in our view, for its inflexibility. Generating a single number to represent the overall risk in an individual case, and then developing a management plan based on that number, is likely to lead to particular details being overlooked. Other Trusts have adopted the same approach as has Camden and Islington Mental Health and Social Care Trust, namely to have a risk assessment procedure which includes reminders of important considerations in the process of assessing risk, without being prescriptive. Such a process clearly allows greater flexibility, with the possibility of assigning different weighting and significance to individual elements of risk. However, it also runs the risk of becoming simply another piece of paperwork that has to be completed, usually by cataloguing a list of identified risks.
3. We have contrasted the standard risk assessment procedures with the assessment of risk in the forensic report prepared by Dr B. However, it is unrealistic to expect that routine risk assessments will be recorded in the detail demonstrated by Dr B's report, or even that the reasoning and evidence should be laid out as explicitly as in Dr B's report. Every mental health service requires a standard framework for risk assessment and

management. To be helpful, any such framework needs to be able to encourage clinicians to reflect on the risks they have identified, and how these might be managed.

4. With this in mind, we used this case as an example to try to develop a risk assessment template that improved on the template used by the Trust. Our template is shown in the accompanying table, completed for Mr Hardy based on what was known in December 2002. From what witnesses have told us, and from our observations from the clinical records, we consider that this risk assessment template might have assisted the clinical team in formulating the risks to others more than the Trust's risk assessment procedures, as they then were. We offer some observations on the development of this template, which might assist clinicians in further developing their own risk assessment procedures.
5. Completing the proposed template probably takes very little if any more time than that needed to complete the Trust's standard risk assessment procedure. However, a key feature of the proposed template is that different risks are identified individually (listed in the columns of the template) and clinicians are encouraged to think about the important elements of each type of risk by having these listed in the rows. The elements themselves come from the Royal College of Psychiatrists' Council Report on assessment and clinical management of risk of harm to other people¹⁴² - they are questions to be asked about each identified risk.
6. Two features of this template were introduced with the benefit of hindsight. First, the interventions to reduce risk are divided into mental health interventions, and others. As we have concluded, Mental Health Services cannot be responsible for managing risks that lie outside their sphere of competence. However, when such risks are identified, it is very important that whoever identifies them gives careful consideration to resources and/or agencies that may be able to help in their management.
7. The second feature dictated by hindsight is the inclusion of an estimate of the value of the stated evidence of risk in predicting future risk (see Table). Before this was added to the template, there was no way of including in the risk assessment any consideration of the death of Sally White. As we have

¹⁴² Royal College of Psychiatrists' Special Working Party on Clinical Assessment and Management of Risk: *Assessment and clinical management of risk of harm to other people*. Council Report CR53. The Royal College of Psychiatrists, London, April 1996.

stated, there was a consensus that, following the Coroner's verdict, Mental Health Services had to accept that no evidence had been found to implicate Mr Hardy in Sally White's death. Nevertheless, numerous witnesses told us that they continued to suspect that Mr Hardy was in some way responsible. Including the row 'Value of evidence in prediction' in the template allowed these concerns to be recorded, while at the same time assigning them a low weight in terms of predicting future violence. There are three main advantages of this. First, members of the clinical team could legitimately record that there are serious concerns, as part of the overall risk assessment. Second, formulating the risks in this way could help staff to focus on identifying further evidence associated with the identified risks. Such further evidence could lead to the reappraisal of the risks identified, either as more or less serious than originally considered. Third, sharing this risk assessment with Mr Hardy himself, as would be expected as part of the Care Programme Approach, might have provided further evidence of his lack of concern about how these risks were managed.

8. The need to examine each type of risk according to its features and the possible reliance to be placed on it in predicting future risk would make it less likely that the proposed template would be completed in a cursory manner, and the template could show more of the processes of judgement and decision-making than were likely to be revealed by the standard Trust risk assessment form. Furthermore, the template lends itself to use in a dynamic way, rather than completion from scratch at each risk assessment - for example: further evidence of the individual risks might accumulate between one assessment and the next, estimates of the predictive value of the evidence might change, and so on.
9. We developed the risk assessment pro forma with the considerable benefit of hindsight, to see whether it was possible to produce a form that was better able than the Trust's form to accommodate the concerns of the multi-professional team about Mr Hardy. In this specific instance, we think that our form would have been more helpful than the existing Trust form. We cannot say whether this form is likely to be more helpful generally in risk management than existing ones, but we invite clinicians to consider this, possibly by piloting the form in their own practice.

ANTHONY Mr Hardy: SUMMARY OF RISKS TO OTHERS BASED ON WHAT WAS KNOWN IN DECEMBER 2002					
RISK	Vindictive reactions to others	Violence towards others	Antisocial acts	Violence associated with sexual activity	Disinhibited behaviour secondary to manic episode
EVIDENCE	<ul style="list-style-type: none"> Battery acid through letter box and painting offensive words on neighbour A's door Abusive and threatening letter to neighbour B Barred from hostel because of harassment of others living there Slashing car tyres at ex-wife's home Harassment of wife after separation/divorce Behaviour towards family and friends when still living with wife 	<ul style="list-style-type: none"> Attempted premeditated murder of wife 	<ul style="list-style-type: none"> Stealing car Stealing minicab radios Attempting to remove CD from OT Department 	<ul style="list-style-type: none"> Accused of rape of a sex worker, but charge not proceeded with Wife reported that he forced her to have sex on occasions Death of Sally White left questions among clinical team about Mr Hardy's culpability, despite coroner's verdict 	<ul style="list-style-type: none"> Was manic when assaulted another patient in 1998 Possibly manic when accused of rape
VALUE OF EVIDENCE IN PREDICTION (3=certain, 0=none)	Very strong because of consistent and persisting pattern of behaviour(3)	Although evidence of attempted murder of wife is clear, no similar incidents since then (1)	Very strong because of consistent and persisting pattern of behaviour(3)	No reason to disbelieve wife's account (3). Regarding rape, was diverted from criminal justice system because of psychiatric history and accusation appears plausible (2). No evidence that he contributed to Sally White's death, but circumstances remained suspicious (1)	Fairly strong - evidence of at least one incident in the context of relatively few recorded episodes of mania (2)
SPECIFIC OR GENERAL?	General	?Specific to intimate relationships	General	Applies to prostitutes and to women with whom he forms intimate relationships	General

ANTHONY Mr Hardy: SUMMARY OF RISKS TO OTHERS BASED ON WHAT WAS KNOWN IN DECEMBER 2002

RISK	Vindictive reactions to others	Violence towards others	Antisocial acts	Violence associated with sexual activity	Disinhibited behaviour secondary to manic episode
PRECIPITATING FACTORS	??Perception that he has been badly treated in some way	Discord within an intimate relationship	Unknown	Unknown	Poor control of his mood disorder leading to hypomanic episode
EXACERBATING FACTORS	Disinhibition due to excessive alcohol consumption	Disinhibition due to excessive alcohol consumption	Disinhibition due to excessive alcohol consumption	Disinhibition due to excessive alcohol consumption	Disinhibition due to excessive alcohol consumption
LIKELIHOOD	Likely because of numerous incidents in the past, the most recent only a few months ago	Unlikely unless relationship he formed with a female patient developed further	Quite probable because of numerous incidents in the past, the most recent only a few months ago	Difficult to assess - current erectile dysfunction could make this either more or less likely	Unlikely as long as his mood is reasonably well controlled
PREDICTABILITY	Unpredictable - volatile - could happen at any time	Only likely to happen within an intimate relationship	Unpredictable	Unpredictable	Likely to happen only during relapse of his mental illness
MENTAL HEALTH INTERVENTIONS TO REDUCE RISK	<ul style="list-style-type: none"> • Help him limit his intake of alcohol 	<ul style="list-style-type: none"> • Help him limit his intake of alcohol 	<ul style="list-style-type: none"> • Help him limit his intake of alcohol 	<ul style="list-style-type: none"> • Help him limit his intake of alcohol 	<ul style="list-style-type: none"> • Ensure good adherence with mood stabilising medication • Regular monitoring • Help him limit his intake of alcohol
OTHER INTERVENTIONS TO REDUCE RISK	<ul style="list-style-type: none"> • Transfer to supported accommodation where closer monitoring might be possible • Disclose information to MAPPA 	<ul style="list-style-type: none"> • If he makes the team aware of an intimate relationship, insist that he tell his partner about his past • ?Disclose information to MAPPA 	<ul style="list-style-type: none"> • ?None 	<ul style="list-style-type: none"> • ?? Treat his erectile dysfunction (could either reduce or increase risk - see above) • Disclosure to MAPPA (with acknowledgement of uncertainties) 	<ul style="list-style-type: none"> • Transfer to supported accommodation where closer monitoring might be possible

Appendix 6 - The Coroner's Inquest into Sally White's Death

Introduction

1. It is not within our terms of reference to review the proceedings before the Coroner's Court concerning Sally White's death. Nonetheless, it is clear to us that those involved in assessing and managing Mr Hardy in 2002 attached importance to the Coroner's verdict. For this reason, and in the light of Mr Hardy's subsequent plea of guilty to her murder, we have considered the circumstances which led the Coroner to conclude in April 2002 that Sally White had died of natural causes.

The Nature of the Coroner's Jurisdiction

2. The inquest into a death has a limited role, as provided by the Coroners Act 1988. It has to answer four questions: who the deceased was; and how, when and where the deceased came by his or her death. In relation to Sally White's death the only one of these questions which was at all difficult to answer was as to how she died.
3. If the evidence is insufficient to found a positive verdict,¹⁴³ an open verdict can be returned. It is not part of the function of a Coroner's Inquest to apportion blame. Rule 42 of the Coroner's Rules 1984 expressly provides that: "*No verdict shall be framed in such a way as to appear to determine any question of (a) criminal liability on the part of a named person, or (b) civil liability.*"
4. Proceedings in the Coroner's Court are inquisitorial. Unlike adversarial litigation, there are no parties to an inquest. It is a fact-finding investigation by the Coroner. In order to carry out a full and effective inquiry the Coroner depends upon witnesses to provide relevant information, in the form of oral or written evidence, on which the Coroner's findings are based.

The Inquest into Sally White's Death

5. The evidence presented to the Inner North London Coroner at the inquest into Sally White's death comprised oral evidence from Dr Y, the pathologist, written

¹⁴³ Such as death by natural causes, unlawful killing, misadventure etc.

statements by Sally White's father and her housing advice worker, and a letter dated 14th February 2002 signed by a Metropolitan Police detective sergeant attached to the Serious Crime Group in Hendon.

6. We have not read the statements of Sally White's father or her housing advice worker, but we think it unlikely that they assisted the Coroner in determining how she died.
7. We have seen a transcript of the short hearing which took place on 15th April 2002 at St Pancras Coroner's Court. In his oral evidence Dr Y referred to the relevant matters in his post-mortem report and confirmed that in his opinion Sally White had died of natural causes:

"Sally White was a well nourished woman whose death is consistent with natural causes. Death was a result of coronary artery disease, which is the preponderant evidence."

8. Dr Y reviewed other possible causes of death. He found no evidence that Sally White had died from poisoning or an assault. In his opinion, such injuries as were found on her body, including a scalp wound, a bite mark and some bruising and abrasions, had not caused her death.
9. We have considered the letter provided by the detective sergeant attached to the Serious Crime Group. It says that Sally White was found naked in a locked room inside Mr Hardy's flat; that he *"gave no account of her being in his flat"*; and that when he was interviewed by police officers he made no reply. It refers to the finding of the pathologist that Sally White died of coronary artery disease. It concludes as follows:

"Police have conducted an investigation and although it is obvious that Mr Hardy is in need of psychiatric treatment there is no evidence to suggest that he was responsible for the death of Sally White. The investigation has concluded and the matter has been subsequently classified as No Crime. As the investigation is now closed Police have no need for the body of Sally White to be retained."

10. The Coroner summed up the evidence as follows:

“I’m entirely satisfied from the evidence of the pathologist that there is really no suggestion of any foul play or third party involvement or any violence bestowed on this unfortunate woman. She died as a result of coronary artery disease. I will accept this as the medical cause of her death, so there really is no other conclusion other than to conclude this inquiry by recording a verdict that she died as a result of natural causes.

Clearly from the available evidence, I’m entirely satisfied from the police enquiry and involvement that there is no suggestion of any foul play or third party involvement in this death ...”

Discussion

11. We are not in a position to comment usefully on Dr Y’s post-mortem findings, but we do have concerns about the letter provided by the police. It is what the letter omitted to say that causes us concern. There was no mention of the presence of the bucket of warm water in the room where Sally White’s body was found, which proved that Mr Hardy was lying when he denied any knowledge of her presence in his flat. The statement did not say that Mr Hardy lied when asked if he had a key to the locked room where her body was discovered, or how he reacted when the key was found in the lining of his jacket by a police officer. It did not mention the clothing that had apparently been cut from Sally White’s body when she was dead. The police had all this information but they did not convey it to the Coroner. The Coroner had no other way of knowing these things. Had these matters been communicated to the Coroner we think it likely that he would not so easily have been satisfied that there was no third party involvement or foul play.

12. We accept that this circumstantial evidence did not prove that Sally White had been unlawfully killed by Mr Hardy. But that was not the only issue. The relevance of the circumstances surrounding the discovery of Sally White’s body was that they cast doubt on the conclusion, which would otherwise have been

drawn from Dr Y's evidence, that she had died of natural causes. Had the Coroner been given this additional information he might well have wished to inquire further, in order to be able to decide whether he could be satisfied, on the balance of probabilities, that Sally White had died of natural causes. If he was not satisfied he would have had to consider possible alternative verdicts, including an open verdict.

13. The effect of the letter written by the police was to close off any further inquiry by the Coroner. It did this both by withholding information which we consider was relevant to the Coroner's inquiry and by stating that there was nothing to suggest that Mr Hardy was responsible for Sally White's death. It thus conveyed a misleading, and unduly reassuring, impression about the circumstances.
14. When we raised these matters with the police we were told that the letter had not been intended to be used as evidence at the inquest. What follows is taken from the written response we received from the Metropolitan Police:

"On or before the 14th February 2002 the Coroner at St Pancras Coroner's Court asked for documentation from the police to allow release of Sally [White]'s body for burial.

In response, a factual letter [the statement dated 14th February] was prepared by [a detective inspector] outlining the [Serious Crime Group's] brief inquiry and, making reference to Dr [Y's] recorded pathological cause of death, stating that the investigation was closed and police have no need for the body to be retained. This letter, addressed to the Coroner re the release of Sally White's body was signed by [a detective sergeant] and submitted [under cover of a message form which showed its purpose was to enable the Coroner to release Sally White's body].

[The detective sergeant] was never asked to provide a statement to the Coroner or to attend the inquest. Accordingly, he never supplied any further documentation that may have assisted the Coroner's decision-making, or for him to refer to in his decision-making.

Regrettably, for an unascertainable reason, the letter sent to the Coroner for the purposes of releasing Sally White's body was tendered in evidence and the wider concerns of the investigative team were not fully brought before the Coroner."

The reference to "*wider concerns*" is intended to convey that police officers in the Serious Crime Group continued to believe that the circumstances were suspicious, notwithstanding the post-mortem examination.

Conclusion

15. We conclude that there was not a sufficient inquiry by the Coroner into Sally White's death, and that reliance on the letter received from the police, which had been prepared for a different purpose, contributed significantly to this deficiency. We do not wish to speculate on what would have happened if the Coroner had been provided by the police with all the relevant information.
16. While we accept the explanation provided by the police, we consider that the letter dated 14th February 2002 said much more than was necessary for the limited purpose of satisfying the Coroner that the police investigation had been concluded and that no one was to be charged in connection with Sally White's death. That is all he needed to know in order to be able to release her body. Had the letter confined itself to those essential matters the Coroner would not have been justified in drawing the wider conclusion "*that there is no suggestion of any foul play or third party involvement in this death*". We consider, however, that he was entitled to reach that conclusion on the basis of the letter of the 14th February.
17. We hope that those with responsibility for Coroners Courts will review what happened in this case and consider whether steps need to be taken to avoid a repetition of what occurred. We are not in a position to say whether this would best be achieved by issuing guidance to police officers to assist them in preparing evidence for Coroners; or whether rules should be made to prevent a document submitted for the purpose of enabling a body to be released, being relied on as evidence in the Coroner's inquiry into the death.