**IN THE FIRST-TIER TRIBUNAL (HEALTH, EDUCATION AND SOCIAL CARE) (MENTAL HEALTH)**

**AND**

**IN THE MATTER OF AN APPLICATION BY**

**IAN STUART BRADY**

# THE REASONS FOR THE TRIBUNAL'S DECISION

## Introduction

1. Ian Stuart Brady, to whom we shall refer as "Mr Brady" throughout these Reasons for the Tribunal's Decision, says he wishes to return to prison. His views are important because he will spend the rest of his life either in a hospital or in prison. There is no possibility of him being discharged into the community. However, the determination of that issue depends substantially upon his mental condition about which there is an array of opinions amongst the medical practitioners who gave evidence to the Tribunal.

## A preliminary issue.

2. One issue which the Tribunal addressed prior to the hearing but which was relevant to the evidence which could be adduced was the findings of fact made on the application for permission for the hearing to be in public.

3. In ordering that this hearing should be heard in public the Tribunal had to decide some facts which are the same as were relevant to the issues in this case. Most notable of these was whether Mr Brady continues to suffer from schizophrenia. At that hearing the Tribunal concluded that on the evidence that had been adduced, it was not so satisfied.
4. The Tribunal has considered whether they should regard a finding of fact made at the earlier hearing to be conclusive of any fact which arose in any issue in the present hearing. It decided that it should not. It accepted that either party should be able to adduce any evidence relevant to the issues to be determined in this hearing. In respect of the finding relating to schizophrenia the Tribunal were of the opinion that while the specific fact was the same, the issues to which it was relevant were different. In the earlier hearing it was relevant to the issue of capacity. In this hearing it is relevant to the existence of a mental disorder of a nature or degree which would make Mr Brady's continued detention in hospital for treatment appropriate. Secondly, to place such a restriction would lead to the exclusion of evidence of matters which had arisen since the earlier hearing which could produce a determination which in reality was false.
5. In coming to their conclusion the Tribunal acknowledge that it could lead to the opposite decision on an issue of fact from that made in

the earlier hearing. This is not a unique situation. It occurs, for example, where a re-trial is ordered. The resolution of the apparent conflict lies in the principle that each case must be determined upon the evidence which is presented to the tribunal at that hearing.

**The issues by reference to the statutory criteria**

6. It is convenient to set out the issues which will be addressed by the Tribunal by reference to the statutory criteria.

   They may be stated in the following questions:

7. Does Mr Brady continue to suffer from a mental disorder which is restricted to a personality disorder or does it include a mental illness, namely schizophrenia?
8. Is that disorder of either a nature or degree or both which makes his continued detention in hospital for medical treatment appropriate?
9. If so, is appropriate treatment available?
10. If so, is it necessary that he continues to be detained in hospital for such treatment or could such treatment be provided in a prison?
11. There is considerable overlap of the evidence which is relevant to these questions. To repeat in detail the aspects which are relevant to each issue every time would be burdensome and, the Tribunal believes, should be unnecessary for a proper understanding of the case. In giving these Reasons for the decision, the Tribunal will not

seek to summarise, let alone rehearse all the evidence which has been adduced nor examine in detail all the arguments. Nevertheless, the Tribunal are mindful of the need to look at the overall picture presented by all the evidence in order to determine the fundamental issues posed.

**Summary of the principal issues**

12. Mr Brady disputes that he has or has ever had a mental disorder and claims that he feigned symptoms of schizophrenia in order to obtain a transfer from prison to hospital. None of the medical witnesses accepts that claim.

13. All the medical practitioners who gave evidence agree that Mr Brady has a personality disorder which includes antisocial and narcissistic disorders. The view of those who gave evidence on behalf of Ashworth Hospital is that he also suffers from paranoid schizophrenia. They contend that his mental disorder is of a nature and degree which makes it appropriate for him to be detained in hospital for medical treatment. They further contend that such treatment is available in Ashworth Hospital and it is necessary in the interests of his own health and safety and for the protection of other persons that he should receive such treatment in hospital rather than in prison.

14. The contrary view, expressed by those instructed by solicitors acting on behalf of Mr Brady, whilst accepting that the diagnosis made in 1985 of a mental illness which most agree was schizophrenia, argue that if it persists, it is neither of a nature nor degree which makes it appropriate to continue his detention in hospital for treatment. They accept that he suffers from paranoia but attribute that to his personality disorder and regard any mental illness as being of minor importance. Their view is that the appropriate placement for a person with such mental disorders as Mr Brady exhibits is in prison. Those called on behalf of the hospital take the view that it relates to his mental illness. Dr Logan explained how it resonates between both conditions. They argue that the appropriate placement is in Ashworth Hospital.

15. There is also an issue about the nature of treatment. The hospital contends for a wide interpretation of the word "treatment" They assert that he is receiving appropriate treatment in hospital and it is necessary for him to remain there for that purpose. The contrary view is that the "treatment" being offered by the hospital is not appropriate treatment and that such treatment as is necessary could be provided in prison.

**Some general comments**

16. Before considering the detail of the evidence of mental illness and personality disorder, there are a number of points which may usefully be set out. They were made by a number of witnesses. The Tribunal accepts them.

17. First, it was stressed that it was important to look at the overall picture presented by the evidence. It was variously described as looking at the picture "in the round", "taking a longitudinal view" of events and "using historical records in the interpretation of what we see now". This was stressed by Dr Collins, Dr Swinton and Dr Logan but there was no dissent amongst the other medical witnesses. The Tribunal accept that this is important when considering the inferences to be drawn as to the appropriate diagnosis and treatment required.

18. Secondly, Mr Brady has been willing to be interviewed on a number of occasions by Dr Grounds, Mr Glasgow and Professor Gournay. Dr Grounds had had ten meetings with a cumulative time of about 18 hours and had spent a similar time reading the records. Mr Glasgow and Professor Gournay have spent similar amounts of time in reading records and conducting interviews with Mr Brady.

    Details of those interviews and their comments about them have, of course, been made available to the Ashworth team.

19. On the other hand, Mr Brady has refused to discuss his case with the medical team at Ashworth for many years. He enjoys a good relationship with his primary nurse. Their frequent discussions are on a social level rather than a patient – nurse basis. That relationship is welcomed by Mr Brady and is beneficial. It is one matter that he identified that he would miss if he moved to a prison. It is accepted that this refusal and a general lack of openness does cause difficulties for the medical team in defining his diagnosis, its nature and degree and in determining the appropriate treatment and its effectiveness. Dr Collins demonstrated in his evidence both the advantage of interviews and its danger. It is difficult to make a diagnosis if the patient is uncooperative in interview. A patient may appear to be distracted but unless he or she explains the reason for their apparent distraction you do not know. On the other hand where a patient is anti-authoritarian or duplicitous and manipulative, little weight can be placed on the interview without it being confirmed by an independent source such as the patient's history. Furthermore, his lack of accuracy, whether deliberate or not, also complicates the issues.

20. Dr Collins summarised the position in these words: "you could not make a diagnosis of first rank symptoms of schizophrenia (G1) in a patient who is uncooperative at interview.

21. In her evidence Dr Logan considered this situation in detail. She explained the steps which she had taken to ensure that she had as much information as possible on which to form her opinions. She considered that it would have been desirable to have been able to interview Mr Brady. In cross-examination she said that she considered an interview to be "a definite asset". She pointed out that in evaluating an interview, one must be aware of the interviewee's self-perception and that one should avoid relying exclusively on such self-report. This is particularly in point for Mr Brady as he has been found to be inaccurate on a number of occasions. She submitted that "some form of distortion must be assumed to exist in all forensic interviews until it is disproven because the client may restrict or control the information they provide or manipulate the practitioner in order to gain some form of advantage." She continued, "As a consequence, evaluations must be substantially informed by collateral sources of information and multiple methods of assessment".
22. She also warned of the dangers which can arise from interviews if not carefully assessed. In cross-examination, she accepted that, to a substantial extent this had been done.
23. She had reviewed a large volume and range of paperwork available which provided her with a range of observations and opinions over a lengthy period of time. She interviewed those who currently work

with him in his care team. She consulted the results of risk assessments which have been conducted without his cooperation.

24. Thus whilst acknowledging the disadvantages which flowed from his refusal to be interviewed, she demonstrated how its effect can be reduced. It would have been a definite asset. She expressed the opinion, however, that she did not consider it as useful as the observations, reports and opinions of the nursing staff who are in regular contact rather than for a few hours albeit scattered through a number of years.

25. The Tribunal considered this an appropriate comment as it now had the evidence of Mr Sheppard. He is a nurse who has worked on the ward for over 2 years and has come to know Mr Brady very well. The Tribunal were highly impressed by the integrity and objectivity of the evidence which he gave. He provided a significant insight into the daily life of Mr Brady which was of considerable assistance when considering the issues of whether he continues to suffer from schizophrenia and its effects but also in relation to the issues relating to treatment. He reports his observations and opinions to the clinical team and they, together with the views of others working on the ward, provide a significant resource upon which clinical assessment and decisions can be made. The Tribunal considered that this went a substantial way to redressing the deficit arising from the lack of the

hospital's experts having been able to interview Mr Brady. It concluded that, although having been able to interview Mr Brady on a number of occasions over a number of years was an asset, the abundance of other sources of information rendered it no longer as significant as it had thought to be at the hearing in 2012. This is not to suggest that there would not be substantial benefit to Mr Brady if he would begin to cooperate with those responsible for his care, whether at Ashworth Hospital or in a prison. The Tribunal is not optimistic that he would take this step.

26. One aspect which is of importance when assessing the evidence is the fact that Mr Brady has demonstrated an ability to hide or mask his symptoms. This does create a further difficulty in determining a diagnosis.

**The witnesses**

The Tribunal were impressed by the care which each of the medical witnesses presented their evidence and their responses to cross-examination and questions from the Tribunal. Each was clearly seeking to give objective evidence, fairly and in a desire to assist the Tribunal. Their integrity was of the highest calibre. Their differences were due to honestly held beliefs based upon careful personal assessments of the information available to them whether that is medical records, interviews or observations both direct and reported.

27. The Tribunal consider it convenient to set out the qualifications and experience of the medical witnesses at this stage.

Dr Adrian Grounds is a Consultant Forensic Psychiatrist, an Honorary Research Fellow with a distinguished academic career. His previous contact with Ashworth Hospital was in 1997 and 2000 when he was a convenor of external clinical teams examining the Personality Disorder Unit at Ashworth.

His experience of the High Secure Hospital was for a period of four years prior to 1987 but he has not worked as a consultant clinician managing the care of in-patients in either a high or medium secure unit. He acknowledges that his experience of managing in-patients on a day-to-day basis is limited. He does have experience of supervising patients who have been granted conditional discharges of whom many have personality disorders. He has no experience of the type of prison to which Mr Brady would be transferred as his experience of working in prison was in Category C prisons.

28. He has interviewed Mr Brady on 10 occasions since 2003 for a total time of 18 hours and about 18 to 20 hours reading the papers.

29. The Tribunal agree that Dr Grounds was a very careful witness. He acknowledged the difficulties on interpretation which the evidence presented. He obviously found it very difficult to be definitive in his

opinion and certainly was not dogmatic. He sought to be balanced and pointed out features which may indicate one conclusion rather than another whilst seeking to explain his reason for preferring one conclusion rather than the other. He was of great assistance to the Tribunal.

30. Dr James Collins has been a Consultant Forensic Psychiatrist at Ashworth Hospital since 1993. He has extensive experience of both mental illness and personality disorders and of caring for patients with a dual diagnosis. He has been Mr Brady's Responsible Clinician since 1999.

    He has an encyclopaedic knowledge of the case and the Tribunal is indebted to him for the chronologies which he prepared which assisted in the understanding of the case.

31. Dr Caroline Logan is a Consultant Forensic Clinical Psychologist. She is a member of the Professional Advisory Panel High Security Directorate for the Prison Service. She has extensive practical experience having worked at Ashworth Hospital most recently from January 2005 to July 2009 as a consultant clinical psychologist in risk assessment and management and also on the admissions ward. She then moved to the Edenfield Unit Medium Secure Unit where she is

now the professional and clinical head for psychology in the adult forensic service.

32. As already mentioned, Dr Logan's contact with Mr Brady has been limited as regrettably he refused numerous requests to meet her. In her final submissions, Miss Lieven Q.C. acknowledged that Dr Logan was a fair and balanced witness. That was a wise concession.

33. The Tribunal found her to be a most impressive witness. Miss Lieven Q.C. went on to submit that because Dr Logan had not been able to interview Mr Brady since 1998 she was "in a poor position to judge whether there is evidence of psychosis or not". The Tribunal did not agree with that submission .Dr Logan had demonstrated quite the contrary during the course of her evidence. She had sought to equip herself with as much information from as many sources as possible and had clearly spent a considerable amount of time thinking about the case and formulating her opinions. Clearly she would have very much liked to have interviewed him but not having done so did not put her into the position suggested.

34. Mr David Glasgow is a qualified Consultant Psychologist. He modestly deferred his academic career to that of other witnesses but he has had extensive practical experience having worked in the High

Security Hospital, Park Lane which was incorporated into Ashworth Hospital, and in medium secure services.

Mr Glasgow explained his contact with Mr Brady. He had first interviewed him in 2003 since when he has spent some 20 hours doing so. He explained that those interviews have been spread irregularly over the years and have usually been shortly before a hearing was expected. He has also spent time looking at the records. In his reports and in his evidence he criticised the method of record keeping and regarded it as a particular problem in this case. This was not a criticism made by the other medical witnesses but accepting as we do that it was a problem for him, the Tribunal considered that it may have affected his consideration of the case though it is not possible to determine to what extent.

35. Dr Mark Swinton is a Consultant Forensic Psychiatrist at Edenfield Medium Secure Unit. He had formerly worked at Ashworth Hospital. He has 20 years experience as a responsible clinician.

His case load has been with long stay patients typically with a diagnosis of schizophrenia in the age range of 40 to 70 and detained because of a serious offence. That enabled him to furnish the Tribunal with specific evidence of relevance to this case.

36. His experience with personality disorder has been firstly at Ashworth and more recently he heads the Personality Disorder Assessment Team at the Edenfield Unit.

37. He explained that he considered that it made him very familiar with the arguments as to whether a patient has a personality disorder alone or both personality disorder and mental illness.

38. The sources of Dr Swinton's information were restricted. He had not been able to interview Mr Brady. He had not read the running clinical notes but had relied upon Dr Collins' chronology and summary. He had read all the reports prepared by the other medical witnesses.

39. His lack of having read the notes and reliance on Dr Collins' chronology was not surprisingly a source of criticism by Miss Lieven Q.C. especially as, to a limited extent, she had commented, not inappropriately, but adversely upon some aspects of Dr Collins chronology.

40. Miss Grey Q.C. invited Dr Swinton to explain how he thought he could assist in the absence of reading the clinical notes. His answer was that he sought to assist the Tribunal with his knowledge about the issues raised in the arguments central to the case; specifically the

presence of a single or dual diagnosis. To these points, the Tribunal will refer later. They were of considerable value.

41. Professor Kevin Gournay is a registered nurse and a Fellow of the Royal College of Nursing. He is a registered and chartered psychologist and a chartered scientist. He holds a PhD in psychological treatment and holds an Honorary Fellowship of the Royal College of Psychiatrists amongst many other distinguished qualifications.

    He has conducted six interviews with Mr Brady since March 2007. He expressed his views upon the nature of treatment and in particular that being offered to Mr Brady by Ashworth Hospital

    He was able to provide the Tribunal with the present approach to treatment in prisons.

42. Mr Mark Sheppard is a Charge Nurse on Forster Ward and has known Mr Brady for 26 months.

43. The Tribunal will indicate any further assessment of evidence given by witnesses as it becomes appropriate to do so in reviewing the evidence and arguments which relate to the questions posed.

44. It is also convenient to express here the Tribunal's general view of the evidence which Mr Brady gave. In her closing submissions Miss Lieven Q.C. made the point that it is stressful for any patient to give

evidence. She added, however, that for Mr Brady it came at the end of a long and exhausting hearing and suggested that he was plainly exhausted. The Tribunal well recognise the stress for patients of such occasions. However, the Tribunal did not perceive Mr Brady experiencing undue tiredness when answering questions and breaks in his testimony were made which were intended to assist. It is a factor which the Tribunal have kept in mind when assessing his evidence.

45. Questions were kept to a minimum by both counsel and were directed to the important issues of the case. Unfortunately Mr Brady found difficulty in answering those questions directly and rather diverted to refer to matters which were not directly to the point. This occurred repeatedly which left the Tribunal without a clear understanding of his point of view on some matters. The Tribunal will refer to this in greater detail especially when dealing with the issue of the suitability of prison.

**Question 1**

46. **Does Mr Brady continue to suffer from a mental disorder which is restricted to a personality disorder or does it include a mental illness, namely schizophrenia?**

47. There are two matters upon which there is substantial agreement: that he was suffering from a mental illness at the time of his admission to Hospital in 1985 and secondly that he continues to suffer from a personality disorder. The Tribunal considered that it was appropriate to examine Mr Brady's condition at the time of his admission to Ashworth but concluded that it ought to be seen in the context of its development. Accordingly, it proposes to set out in detail Mr Brady's history from his imprisonment until his admission to hospital in 1985. It is taken from the Chronology which Dr Collins prepared. There did not appear to be any disagreement as to its accuracy.

**The relevant history**

48. Ian Brady was convicted of three counts of murder on 5th May 1966 and sentenced to imprisonment for life. He was then 28 years old. The main source of evidence of his life prior to his convictions comes from the report of Dr Scott dated 31st May 1971. He had a number of previous convictions which had led him to be sent to Borstal Training. These are of relevance when considering the ICD 10/DSMIV criteria for personality disorder. After release from Borstal Training he had not been enlisted for National Service and maintained a job for a period. It appears that his antisocial and narcissistic personality disorders can be traced back to his adolescence and early adulthood. There is no evidence, one way or

the other, as to the existence of paranoia during the period up to his imprisonment.

49. Prior to sentence he had been subject to mental health examination. An entry in the Chronology dated 28th March 1966 by Dr Lindsay Neustatter, Senior Physician in Psychological Medicine commented "It is possible that it [difficulty in expressing himself] was an evasiveness that accounted for his rather oddly worded answers." He also commented that a diagnostic label was difficult; "a ruthless individual, cold and unemotional, without conscience or remorse;.. .he showed a pathological admiration of power and unscrupulousness".

50. He concluded the factors, "could add up to regarding him as a psychopath, and to this extent, having an abnormality of mind due to inherent causes." It is worthy of note that he remarked that "There have been no suicide attempts depressive episodes, psychotic episodes of the kind which one sometimes finds in the history of unstable people which could have a bearing on impaired responsibility".

51. Following his conviction he was transferred to Durham Prison. A year later Dr Westbury wrote, "…differentiates himself from the norm and considers himself to be unique…Some of the superficial manifestations of his personality, particularly his apparent lack of

affection and vagueness about his planning, carry the suggestion of a possibility of schizophrenia at first sight, but I found no evidence of the existence of any psychotic or neurotic illness and am firmly of the opinion that at the moment there is no mental illness.

52. In October 1967, one finds the first references to Mr Brady complaining of noises and there is a letter from an Assistant Governor which includes the statement, "I am concerned about Brady's state of mind as his mental ability appears to be beginning to deteriorate". There was a change of cell to an area where there should have been no noise. Yet he continued to make the complaint. The entry for 20th November 1967 by Dr Westbury included the following passage: "Brady was attaching at the best undue significance to them [noises] and at the worst they could have been hallucinations. I formed the opinion that at times his speech showed disconnection of thought and that his answers to questions were vague and circumstantial. The impression that I have is that these have become more pronounced since I last examined him on 11th May 1967. In addition the apparent flattening of affect and unreality about some of his thinking, that as I said in my report of 11th May 1967 were suggestive of schizophrenia, are still present.

53. In my opinion, this man has changed for the worse during the six month interval May to November. It is not possible without

observing more objective signs of mental illness to make a firm decision whether this is a schizophrenic process or the result of his isolation."

54. Shortly thereafter it was noted that he was refusing to take exercise because he was scared of violence and abuse from other prisoners. In mid to late 1968 one reads of his suspicions about the way he is being treated by the Prison Authority and The Home Office and an increase in his hostility towards other prisoners and staff.

55. On 28th January 1970 a Medical Officer wrote, "My view of Brady remains as it has done since I first knew him before his trial. He is physically fit, of reasonably good intelligence and free from mental illness. He is, however a schizoid psychopath of utter untruthfulness who has the rather unusual ability in this type of personality of dissociating himself from the crimes of which he has been convicted….increasingly I feel that it is a symptom of the terrifying intensity of his psychopathy, and that he is not defending against recalling his offences but that, as far as he is concerned, they fail to rise above his mental horizon." The Officer went on to advise that the appropriate place for Mr Brady, "for a period anyway" is a "Special hospital" on the grounds of psychopathic disorder. He concluded, "he is a psychopathic personality to an extreme and pathological degree."

56. The following month he was interviewed by Dr P. McGrath, Senior Consultant Psychiatrist, Broadmoor Hospital who provided a report on 23rd February 1970. He referred to Mr Brady's apparent enjoyment of the interview, his manifest regard for himself as intellectually superior to other prisoners. Mr Brady spoke of the noises which he had heard from other prisoners and Dr McGrath commented, "He did not give me the impression that these experiences had been hallucinatory and the prison staff said that the events could in fact have happened."

57. The Tribunal noted that the reported view of the prison staff appears to be in conflict with the contemporaneous report. And, secondly, there seems to have been some minimisation by Mr Brady of the effect which the noise had upon him.

58. Dr McGrath concluded that he recommended the transfer to hospital as being necessary, "if there is any hope of salvaging what is worth retaining in [his] personality and perhaps modifying it."

59. Dr Collins pointed out in the chronology that Dr McGrath made no mention of mental illness.

60. The recommendation made by Dr McGrath and supported by Dr Whittaker was, to quote Dr Whittaker , "of course rejected without comment by the Secretary of State".

61. On 8th February 1971 Dr Duggan-Keen wrote Mr Brady had become more suspicious and paranoid in his outlook and more and more withdrawn. He expressed the opinion, "in view of the depressive state and the development of what I believe to be an early paranoid schizophrenic illness, it is my view that this man is in need of full psychiatric investigation and active psychiatric treatment as it is my view that there is evidence that this psychiatric illness is developing and that there is a deterioration in his mental state."

62. In May 1971, Dr Scott interviewed Mr Brady on three occasions. In his report he said, "He has no thought disorder. I found no evidence of schizophrenia. He is not paranoid (i.e. he has no unreasonable or grandiose suspicions). He is not depressed to a psychotic degree." He continued, "the only positive findings, therefore relate to his personality but these are extremely severe." Dr Scott's comments upon the issue of paranoia were these. "He often speaks about being scape-goated by the Home Office by which he means that because of the nature of his crime he is being denied privileges that are rightfully his. This is not in any way paranoid.." He continued, "It has been stated in the past that he has shown paranoid features but these seem more akin to the usual suspiciousness towards authority experienced by any frustrated person e.g. soldiers or seamen on foreign service." Dr Scott's conclusions were that Mr Brady could be cared for either

in the Prison Service (if special arrangements were made ) or in Broadmoor. In my opinion as things stand at present, it would be better to transfer him under Section 72 (the then relevant provision of the Mental Heath Act 1959) to Broadmoor.

63. Following his transfer to HMP Albany on 28th August 1971 he was interviewed whilst on a period of refusing food. It is noted that there was no evidence of psychosis.

64. Mr Brady was transferred to HMP Wormwood Scrubs on 11th June 1974 where he remained until 31st March1982. In a report dated 29th October 1974, a Medical Officer reviewing his time at Parkhurst said, "We never detected any evidence of mental illness in him apart from… probable mild depression.

65. A note dated 13th December 1974 from Dr Hines, the Medical Officer states "He does not suffer from any mental illness." On 2nd September 1975 a note is recorded that his mental state was entirely unchanged. A report by Dr Lotinga written about the same time contains the opinion that there was no evidence whatever that he was suffering from any form of mental illness at that time and that his refusal of food was purely a manipulative measure. It continued that there were no medical indications for removing him from his present category.

66. A report noted at 30th April 1976 by Dr Hines contains the following entry: "there are no signs whatever of any mental illness and he is quite frank in discussing how in the past he tried to get into Broadmoor as a patient and later decided that he would avoid this at all costs." Mr Brady was keen to have the benefit of an opinion from Dr Scott and following an interview, Dr Scott wrote, "In summary, he remains as I found him in 1971, not mentally ill, but with no great change in his personality disorder. If anything, he is less trusting and more hardened in his defences than formerly." In September 1976 a Medical Officer again stated, "There is no evidence whatever, and never has been, of any form of mental illness."
67. In 1978 he was seen by Dr McGrath who acknowledged that Mr Brady still had severe personality problems but recorded "saw Broadmoor solely as a way of leading a more liberal incarcerated life with no prospect of a successful outcome of treatment in the way of change of personality or orientation and certainly not eventual discharge…Even less than I could eight years ago can I now see Brady as a "treatment "proposition.
68. On 17th November 1978 Professor Gunn wrote, "…I can find no evidence that he has ever required or received formal psychiatric treatment for a mental illness." He continued , "On examination I find him willing and eager to talk about his predicament. There was

no evidence of affective disturbance or psychosis." Further he commented, "The diagnosis in this case is not in doubt. Ian Brady suffers from a severe personality disorder." He went on to express agreement with the views of Dr Scott and Dr McGrath that he would be better located in a Special Hospital but recognised the difficulty in effecting this and the view of Mr Brady against a transfer to Broadmoor with the prospect of return to prison.

69. He underwent a period of regular consultations with Dr Marjot a Consultant Psychiatrist and in a report noted on 14th October 1981 he expressed the strong suspicion of a well organised and systematized delusional ideation and feeling underlying his past and present behaviour. It had not been confirmed by subsequent interviews with him but that there was an account of an apparently profound affective change at about the age of 16 to 18 reminiscent of that seen in psychoses such as schizophrenia. Therefore whilst Mr Brady was not formally psychotic he considered him to be seriously mentally disordered and that if the category of disorder was psychopathic, he did not consider him incurable in the sense that very considerable change could occur under the influence of the process called maturing , aided and abetted by an appropriate environment and suitable therapy. He concluded a Special Hospital would seem to be an appropriate place.

70. An entry dated 19th October 1981 notes that Mr Brady had made it "abundantly clear that he [had] no intention of returning to Rule 43 conditions in any prison and that he will do everything and anything in his power to get into Broadmoor- not for treatment but because the regime would be more agreeable there." He was transferred to HMP Parkhurst on 31st March 1982. It was noted by a Probation Officer that he was desperate to move from HMP Parkhurst and showing signs of paranoia and grandiosity.
71. In February 1983 the notes remark that Mr Brady "is going downhill. He eats meals regularly but sparingly taking prodigious amounts of salt therewith." He became more withdrawn.
72. Following his transfer to HMP Gartree on 22nd April 1983, it was noted that he appeared very retarded and expressed answers only after long pauses and stares into a corner of the room .
73. On 27th May 1983 Mr Brady is recorded as having admitted difficulty in concentration, not always being able to control his thoughts and that he had a feeling that they were being controlled by someone else. He said that the Home Office were using this. He admitted that at times he could hear thoughts repeated in his head. The conclusion was that his condition appeared to be paranoid schizophrenia.
74. On the 6th June 1983 Dr Smith who had known Mr Brady some time before confirmed that his mental and physical conditions had

deteriorated markedly and that he was now extremely paranoid. A deterioration during the short time he had been in HMP Gartree was noted by Dr McKay. He continued, "There can be little doubt that this man's personality is basically schizoid that is to say pathologically detached, cold and unfeeling. In addition to his psychopathic personality, there can be little doubt that he now has a slowly developing paranoid schizophrenic illness with feelings of thought control, hallucinations of hearing and paranoid delusions, all accompanied by considerable tensions and resultant weight loss.

75. Dr Reid on 10th June 1983 expressed the view, "I think Mr Brady must be regarded as a schizoid personality, cold distant, unemotional and with an air of perverted arrogance, very probably enmeshed in a basis of paranoid thinking.

76. On 21st June 1983, Dr Smith remarked that Mr Brady's mental and physical condition continues to deteriorate. In the following months on occasions he was heard muttering to himself which contained abusive remarks. Ideas about power and the role of the Home Office pervaded his thoughts and views. In October 1983 he sustained fractures of his finger which he said were caused when he smashed it against the wall in sheer frustration.

77. On 2nd November 1983 Dr Reid a visiting Consultant Psychiatrist noted a change in that he had been able to express himself in a

coherent and rational way. His ideas concerning the Home Office continued and led Dr Reid to comment that Mr Brady had a strongly developed paranoid relationship with the Home Office. A prison Medical Officer described a more relaxed person but added that he still persists in his nocturnal ruminations when he verbalises his paranoid fears and at time strikes out at the wall and may often bang his head against it.

78. In March 1984 it was noted that nocturnal outbursts both verbal and physical were almost a nightly occurrence and this scenario persisted thereafter being both physical and verbal in nature.

79. The use of excessive salt on food was noted during the autumn and into 1985. Comments were recorded concerning Mr Brady being manipulative during this period to enable him to achieve a transfer into the prison hospital.

80. In March 1985 Dr MacCulloch and Dr Hunter began to interview him. Dr MacCulloch reports Mr Brady describing voices which he heard, their origins and the nature of the matters which they say. He explained how he felt when he heard them. He explained the reasons for not having disclosed them to all medical practitioners who had been responsible for him.

81. Dr MacCulloch concluded that given the relatively short time he had spent with Mr Brady his opinion could only be regarded as tentative.

It was, however, that he suffered from personality disorder which could be characterised as psychopathic disorder within the Mental Health Act 1983 His personality development and abnormality go a long way back to his birth and early rearing. He said it would appear that he had for many years suffered from what appeared to be hallucinations the content of which but not the form was like conscience. He said that he suffered from a psychotic illness which did not have the features of process schizophrenia, but was relatively covert and, if one believes what Mr Brady said, has been present for some time and been concealed. Mr Brady had reported the presence of symptoms dating back to when he was detained in Durham following his sentence. Dr MacCulloch said that there was evidence from the prison reports of behaviour not inconsistent with a psychological response to these phenomena. He recommended Mr Brady's transfer to a Special Hospital. Both Dr Hunter and Dr MacCulloch completed Section 47 transfer forms dated 17th July 1985 and 9th August 1985 respectively.

82. Dr Hunter wrote, "Mr Brady has developed during the course of his long imprisonment, a psychotic mental illness of a schizophreniform nature, characterised by persistent auditory hallucinations, olfactory and somatic hallucinations, passivity feelings and a complex paranoid delusional system. His mental illness is severe and chronic in nature.

His paranoid delusional system which is at the core of his illness concerns The Home Office and prison authorities and entirely militates against any hope of improvement in his present environment."

83. Dr. MacCulloch wrote that he suffered from "a personality disorder of the psychopathic type characterised by emotional coldness, obsessionality, sadistic fantasy and practice. He has now developed a mental illness of a psychotic nature, characterised by persistent auditory hallucinations, olfactory and somatic hallucinations and a paranoid delusional system. His paranoid delusional system prevents him from accepting the advice of the prison authorities and militates against improvement in his present environment."

84. An indication of his attitude to the Home Office comes from his refusal to answer any questions from Dr Hamilton from Broadmoor who he identified as being aligned with the Home Office.

85. On 29th November 1985 he was admitted to Ashworth Hospital.

86. The position at the time of his admission may be summarised as follows.

87. Mr Brady has both an anti-social and narcissistic personality disorder. There is no evidence to support or refute any paranoia as a child or adolescent. There were no indications at the time of his conviction that he was suffering from schizophrenia. Shortly thereafter there

were some factors which led to the suspicion that he might be suffering from such. By February 1971 they appeared to have developed so that Dr Duggan-Keen concluded that he was in the early stages of paranoid schizophrenia though Dr Scott disagreed with that diagnosis. During the 1970's views similar to those of Dr Scott were expressed. They were alive to the possibility of Mr Brady trying to manipulate and achieve a transfer from prison to hospital . Any transfer seems to have been contemplated on the basis of personality disorder rather than paranoid schizophrenia. This may have affected the opinions of some who examined him both before and after this period.

88. Then, in the early 1980's opinions started to change in favour of there being a mental illness. His behaviour included muttering to himself and paranoid ideation especially in relation to the Home Office. His condition appeared to deteriorate with auditory hallucinations and paranoid thoughts being noted. This led to his admission to Hospital under Dr MacCulloch and Dr Hunter.

89. The Tribunal were referred to the detailed medical reports prepared by Dr MacCulloch and Dr Hunter.

90. Dr Collins explained his approach to diagnosing schizophrenia and to consideration of Mr Brady's condition on admission.

91. He explained that he approaches it in three stages. At Stage 1, he submitted one has to establish that the patient meets the diagnostic criteria for schizophrenia at the time of the present diagnosis or at some time in the past.

92. At Stage 2, one considers the pattern or the course of the illness. Stage 3 is to consider the kind of schizophrenia from which the patient suffers. From that point one can consider the activity of the illness at present. Accordingly Dr Collins began by considering the symptoms reported at the time of Mr Brady's admission to Ashworth hospital in 1985 by reference to ICD 10 under F20 to F20.3. By reference to the history he identified abnormalities of the possession of thought, delusions of control, influence or passivity, hallucinatory voices and persistent delusions.

93. He then moved to consider the pattern or course. He submitted that it was continuous. He looked in detail at the records relating to Mr Brady's excessive use of salt from February 1983; there are at least six occasions recorded and he included Mr Brady's explanations for its use such as, that he "liked salt". He quoted in detail an entry for 13th December 1984 when it was noted that whilst taking salt "he curses and swears at himself. Most of these events take place between 11pm and 1.00 am when the vomiting stops. There are periods of mutterings and talking to a person or persons in various corners of

his cell. This also includes swearing and punching the wall....On being asked what the voice was saying when he had been punching the wall, he just acts as if he does not know what it is you are talking about." Dr Collins suggests that he was suffering from and responding to auditory hallucinations at this time but was not disclosing the reason for his behaviour which, Dr Collins describes as "grossly abnormal". As referred to earlier, Mr Brady's refusal to make disclosures creates significant difficulties for those seeking to assist him.

94. Dr Collins then pointed out that during Mr Brady's interviews with Dr MacCulloch he had made references to auditory hallucinations, paranoia about the Home Office, olfactory hallucinations and thought insertion which could be traced back to the time he was in Durham prison. Although reports of experiences and explanations given may be false or exaggerated, Dr Collins favoured the view that at the time Mr Brady was revealing a true position. Dr Collins summarised the position as being that Mr Brady had a chronic illness which may be as long as 20 years before his admission to hospital and continued for at least ten years after his admission. He commented that in his experience, "30 year chronic illnesses don't just fade away and die". The tentative assessment of Dr Hunter and Dr MacCulloch had included a contention that it was a chronic illness, This Dr Collins submitted has prognostic implications.

95. Dr Grounds agreed that on admission to Ashworth, Mr Brady was suffering from a serious mental illness. He said that during his initial years in hospital the reports indicated that Mr Brady was thought to be showing continued features of psychotic illness, characterised by hallucinations, paranoid delusional beliefs and passivity experiences. Within ten years the reports of psychotic symptoms were considerably less. He drew the inference that Mr Brady's condition was improving.

96. Dr Grounds said that it was difficult to determine for how long that condition had been present. He commented that "you can look back and see pointers to psychotic illness but it is not clear cut."

97. The reports at the time of trial were, he said, that he had a severe disorder of personality but he was not recommended for admission to hospital.

98. During the 19 years before his transfer there were times when there was some suspicion that he might have symptoms of a psychotic mental illness but that was not such as to lead to a transfer to hospital. There were divided opinions. There was a more significant deterioration from 1983 when he was described as becoming depressed and withdrawn and having difficulty in concentrating. He began to put gross amounts of salt on to his food and lost weight. He was said to be ranting abusively at night particularly about the Home

Office, hitting the wall with his fists and hands so that there were concerns about his behaviour. This led to his assessment by Dr MacCulloch and Dr Hunter.

99. Dr Grounds said that the picture is complex because it appeared that he had been concealing psychotic symptoms from observers for a period of time. Dr MacCulloch had referred to his illness being relatively covert. In a report to Dr Marjot it was suggested that the illness had been present for some time prior to 1983 and that there had been symptoms which had not been picked up. Dr Grounds seems to have accepted that he was actively refusing to discuss them or concealing them.

100. Dr Grounds said he thought it was genuinely difficult to assess as it was not consistent. He agreed that there was consensus that the symptoms had been present for some length of time, albeit concealed, even if there was no consensus that they had been in evidence since 1967 or at a time when he had been in Durham. Dr Grounds was asked to explain the reason for its onset and he said that his truthful answer was that he did not know.

101. The Tribunal then considered the period from his admission to hospital until 2000 when he began his refusal of food. Dr Grounds said that during the initial years it was thought that he continued to

show features of a psychotic illness, characterised by hallucinations, paranoid delusional beliefs and passivity experiences i.e. an experience of one's thoughts being interfered with. He had had a period of the antipsychotic medication thioridazine between 1986 and 1987. His symptoms had reduced and his condition had improved. It was pointed out that medication had not been substantial and Dr Grounds was unable to offer any explanation for such improvement.

101.On 30th September 1999 he was transferred from Jade Ward. There was an issue whether the transfer and the regrettable circumstances in which it was carried out had had a harmful effect upon Mr Brady. Dr Grounds said although the circumstances of the transfer were extremely stressful, he saw nothing to indicate a relapse in the psychotic symptoms as a consequence of those circumstances. There had then been a short trial of anti-psychotic medication in September 2000. In cross-examination it was put to Dr. Grounds that if one looks at 2001, the period leading up to the attempt to administer medication and the reasons for it, it was the paranoid interpretation of what might have been hallucinatory phenomenon that supported the argument to give him a trial of treatment. Dr Grounds rejected the suggestion that this was a sign of relapse. He submitted that the way in which it was reported was more nuanced

and that it expressed uncertainty about whether these really were delusions and hallucinations.

102.Dr Collins view was that there had been a relapse but that it was not to the level which it had been at the time of his admission. The Tribunal considered that the further trial of medication following his transfer may be attributable to a relapse and, indeed the history of the pattern of his illness may support Dr Collins suggestion. The evidence is not clear. If there was, Mr Brady improved without more than minimal use of medication. None has been prescribed since then. He then began to refuse food due to the manner in which he had been transferred.

This brings the narrative to the year 2000.

102. Dr Grounds' overall view of the period was summed up in this way: "a period of clear illness between 1983 and 1985; a period of continuing evidence of illness over the next ten years and then very much less after that."

103. In her Closing submissions, Miss Lieven Q.C. submits that "the evidence quite clearly suggests that Mr Brady had a period of severe psychotic illness in the 1980s which by about 1995 (and probably a couple years earlier) had effectively resolved itself without medication." This is based upon Dr Grounds' evidence

104. The Tribunal accepted that the evidence did establish that Mr Brady had been suffering from schizophrenia at the time of his admission to hospital. Furthermore, the Tribunal accepted that it had been present for a substantial period but had fluctuated in its severity. At times the symptoms had abated but particularly, at times of stress and upset, they had become more pronounced. Clearly his condition had deteriorated after his transfer from HMP Wormwood Scrubs but with his transfer to hospital the symptoms had reduced. It was a serious illness which had been present for years with varying degrees of severity. The Tribunal accepted that it was severe and chronic. Its nature and degree were such as to make his detention in hospital for treatment appropriate. The Tribunal regarded Dr Grounds' assessment of its duration, in the form submitted by Miss Lieven Q.C. as being the minimum period and that in fact, the history established that the condition continued over a longer period.

105. The Tribunal accepted Dr Grounds' evidence that there had been a significant improvement in Mr Brady's condition. It acknowledged that medication had only been prescribed for a comparatively short period. There had been little in the form of psychological treatment. Thereafter any treatment had been provided through a care programme approach. The Tribunal considered this

compelling evidence that such care must have had a beneficial effect in alleviating or preventing a deterioration in his symptoms.

106. It is convenient here to consider Mr Brady's contention that his symptoms which led to his admission to hospital were feigned.

**Mr Brady's position.**

107. Mr Brady disputes that he has any mental disorder and in particular disputes that he is or ever has been suffering from schizophrenia. He asserts that his behaviour in about 1985 was a charade. He claims that the symptoms he was exhibiting were feigned to obtain his transfer to hospital.

108. The Tribunal considered that assertion is relevant to a number of issues. It may affect the weight which should be attached to his evidence generally. It may also affect the Tribunal's approach of the interviews which have been carried out since 2003 by Dr Grounds, Mr Glasgow and Professor Gournay.

109. The evidence comes from Mr Brady. None of the medical witnesses supports that contention.

110. He was questioned about the issue by Miss Grey Q.C. and she put to him "Hallucinations, delusions, you being distressed, banging your fists against the side of the cell, do you accept you were ill at that

time?" He replied, " Have you ever heard of Stanislavski?" It was later confirmed that he was referring to "method acting" His reason for acting was to obtain a transfer. When questioned by Dr Boyd on this issue he said that the situation in Gartree was intolerable but he understood that Ashworth was a progressive regime. He expressed it in these words: "it wasn't a political dustbin. It wasn't a place where they forced anti-psychotic medication on you to embalm you into a zombie." He continued that it offered him educational opportunities. He went on to say that Dr MacCulloch and Dr Hunter had grasped that he was feigning illness as he had spoken freely and, he implied that others including the Directors, social workers, psychologists, and psychiatrists also knew.

111. When questioned by Dr Boyd about the length of time he had managed to act an illness, he replied, "well you have to live the part and that's the hard part... it has to be sustained. This was sustained over a period of approximately 18 months".

112. He was asked by Miss Chadderton how he had faked the symptoms. He said that he had seen the symptoms whilst working at Wormwood Scrubs. He had asked other prisoners about medication and symptoms.

113. The Tribunal also considered the relevant entries in the history.

**The argument**

114. In support of his assertion it could be contended that he had some experience of observing the symptoms of mental disorder from his time on the prison wings especially at HMP Wormwood Scrubs and may therefore be in a position to know what he should feign.

115. Secondly, it is clear from the history prior to his transfer that whilst on some occasions prior to his admission he was diagnosed as being psychotic other clinicians did not find evidence to support such a conclusion. It may be significant that he spoke of his time at HMP Wormwood Scrubs as being a good time and was at least to an extent a period of stability.

116. Thirdly, it is clear that at the time that he was transferred he had a reason to try to achieve his transfer and therefore a reason to affect a mental disorder.

117. On the other side of the argument is the fact that some clinicians did find that he was psychotic. Secondly, he would have had to feign symptoms over a considerable period in order to convince not only the clinicians but also the nursing staff of his continuing need for treatment in hospital. Furthermore, by this very account he demonstrates how unreliable his evidence is. It is worthy of note that this suggestion only emerged recently. Dr Grounds reported during his evidence that when he asked Mr Brady in 2006 about the

symptoms he had been experiencing before his admission to Ashworth he had recalled that in prison he was troubled by noise and abuse but could not clearly recall his state of mind at the time. He did not believe he had suffered from mental illness but was acknowledging that he had been troubled by some unpleasant experiences. In short he did not appear to be suggesting that he was feigning mental illness. However Dr Grounds went onto explain that from 2010 his position has changed. He reported that Mr Brady said he had never had any psychotic symptoms at all and that he had feigned having symptoms of mental illness.

118. The Tribunal considered the detail of his history, the circumstances of his transfer and his subsequent treatment. They have already indicated that the evidence does lead to the conclusion that he was suffering from schizophrenia at the time of his admission to hospital in 1985 and been doing so for a considerable period prior to that. They reject the contention that he was able to feign such illness for such a long period of time. It would have required a plan to do so being formed at a very early stage of his sentence; that too would have been before he saw the symptoms suffered by genuinely ill prisoners. They reject the suggestion that he could have tricked Dr MacCulloch, Dr Hunter and the nursing staff. There is no evidence to support the insinuation that Dr MacCulloch and Dr Hunter and

others were acquiescent in such a charade. To have done so would have been a grossly improper action on their part. The late and differing accounts given to Dr Grounds also militates against his assertion being true. The Tribunal reject his assertion that he was not suffering from schizophrenia in 1985. The symptoms were, in the judgment of the Tribunal too severe to have been feigned and for such affectation to be maintained over a protracted period.

119. This does not mean that the Tribunal reject the possibility that at times he may have falsely said that he had symptoms or that he may have exaggerated them. The Tribunal accept the evidence that he has masked his symptoms and it may be that he has professed them when he may not have been experiencing them. As has been commented by all medical witnesses, without the cooperation of the patient diagnosis is difficult.

120. The Tribunal's conclusion does seriously call into question not only the reliability of his other evidence but also of the accounts which he gave to his own medical advisors over the periods of their interviews.

**2000 onwards.**

121. The Tribunal then considered the history from 2000. Dr Grounds gave an overview of the times he has seen Mr Brady since

2003. He said that he would describe him as settled on the ward and without major change in his mental state or behaviour. In the period March 2003 to October 2004 the monthly patient care team meeting records generally described him as settled without significant change. There are notes that there is no evidence of symptoms but it is also noted that such symptoms can be difficult to recognise in a patient that does not want to make them evident. The reports remained essentially the same thereafter. Dr.Grounds noted however, that in the period November 2010 to April 2012 there was no material change but there were 11 incidents which could be regarded as hallucinations. It was Dr Collins' opinion that these are clear evidence of continuing psychosis.

122. This led the Tribunal to consider the more recent years and the current situation in relation to the issue of schizophrenia. There are two aspects: whether he continues to experience hallucinations and whether his paranoia is attributable solely to his personality disorder.

**The factual evidence from 2008 onwards.**

123. In his evidence in chief Dr Collins referred to his First Opinion in which he had set out the record of 25 entries of Mr Brady appearing to have been talking to himself from June 2008 to January 2012. He acknowledged that people, particularly elderly people talk to

themselves. He had omitted reports in which it appeared he may have been responding to the television or radio.

124. He looked at an entry for 24th September 2012. It is relevant to the question whether there is evidence of continuing hallucinations and in particular of Mr Brady talking to himself and of paranoia. Both Dr Collins and Mr Sheppard spoke in detail of an incident of that day. The Tribunal takes the following account from the evidence of Mr Sheppard of the 24th September 2012.

125. It began with an incident in the morning in which Mr Brady was aggressive towards another patient and to members of the nursing team. It continued with an incident in the evening in which he seemed to exhibit behaviour which is said to be at least consistent with a psychotic episode or hallucinations.

126. The background was that he was physically unwell since his illness in July 2012 and was receiving a reducing dose of morphine. This probably made him increasingly irritable.

127. For some time prior to this morning Mr Brady had been making comments about one member of staff. That nurse was with Mr Sheppard when Mr Brady came for his morning medication. On seeing her, he left the dispensary and went to sit down away from it. He said in abusive terms that he would not have his medication "when that filth is on the ward". When spoken to by Mr Sheppard he said, "You have deliberately given that scum the med keys to try to

wind me up." He was then repeatedly abusive and was very angry. Mr Sheppard considered that was a clearly paranoid statement and decided to leave him. Mr Brady immediately went to his room and slammed the door. After a short time he came and asked to use the telephone. Before using the telephone he returned to Mr Sheppard and, again appeared very angry. Mr Sheppard described it in these terms. "He leaned over, pointing his pen approximately 5 or 6 inches away from my face, stating "you can stop trying to soft soap me, you daft cunt. You and her (referring to the nurse he had abused) should keep out of my way." Mr Sheppard lent back in his chair and Mr Brady thrust his pen towards him so that if he had not done so it would have made contact with him.

128. Mr Brady then went to make his phone call from the telephone booth. The staff know that if he is allowed to do that it is likely to have a calming effect.

129. Out of sight there was another patient who was reading a magazine. Dr Collins made the point that the lay-out of the ward is such that Mr Brady could not have seen the other patient from the telephone booth. After Mr Brady had finished his call he went to the other patient and said, "You're a fat fucking slug, you fat bastard, sat there." The patient asked what Mr Brady was talking about who responded by putting his pen between his knuckles making a fist

around it and said, "Do you want to do something about it?" It was done in a threatening manner. At that stage members of staff intervened and Mr Brady was asked to go to his room. As he was ushered through the ward he stopped to be abusive. The staff tried to calm him. He claimed that a patient had been throwing cereal around and smearing honey on chairs to annoy him. He exhibited serious aggression towards Mr Sheppard which was noted as "baring his teeth and spitting". He again pointed at Mr Sheppard with his pen who had to take defensive action. He appeared to accuse Mr Sheppard of provoking him into committing an assault.

130. Later Mr Brady spoke to Dr B (name recorded in the Case Notes but not to be published.) and said that the patient had been standing rather than sitting, was deliberately slamming the door shut and was making "pig noises" which were specifically directed at him. Accordingly he had gone to the patient and told him to stop. He had been annoyed that the staff had been slow to intervene. That was not the true position.

131. Mr Brady was asked about this day by Dr Boyd. He was asked about the noises and that it was suggested he had been threatening. He denied that he had been threatening. He was dismissive of the other patient and called him an "attention seeker". He said, "it doesn't matter whether it's a patient or a member of staff attention

seeking. As I'm the sole high profile patient they've got, they only have to mention my name and that's it. Everybody jumps on the wagon train. And Collins especially eagerly grasps any negative information he can use against me by collusive patients or staff'. Dr Boyd repeatedly asked whether he had heard noises of banging and grunting noises from the other patient. Mr Brady repeatedly sought to evade the question. Eventually he said that the other patient did bang the locker doors and that he had seen him and called him a "fat slug". He then went on to assert that he had been set up by the "negative staff" . When asked if he had been threatening towards anybody he said, "of course not". He said that he had had a pen in his hand because he had been taking notes whilst speaking to his solicitor. He said that the allegation concerning his pen was a "classic set up".

132. The Tribunal accepted the version given by Mr Sheppard. It is a clear account by a witness whom the Tribunal found impressive and conscientious. The account given by Mr Brady lacked these features.

133. Dr Collins analysed this and commented upon Mr Brady's aggressive behaviour towards the other patient and Mr Sheppard. The holding of a pen between the knuckles had been regarded as a form of self protection but the actions involving it being thrust at Mr Sheppard led to the conclusion that it was being held for aggressive purposes. The decision was taken to prohibit him from walking

around the ward with it in his hand. Dr Collins concluded the event demonstrated the presence of auditory hallucinations, the minimising of his own behaviour and a false belief that noises had been made and directed at him.

134. The Tribunal considered that the account given by Mr Brady was dismissive. He did not or could not give an explanation of what had happened. Insofar as he had replied, he had sought to minimise his behaviour and attribute any unpleasant behaviour to others rather than himself. The Tribunal noted that he admitted that he was abusive towards the other patient but seemed to consider it almost justifiable. The Tribunal accepted that his response could lead to the conclusion that he was in fact responding to auditory hallucinations.

135. That evening he was overheard to be in a lengthy conversation. There was no-one else in the room and he was talking to a corner. It was directed at the television. There are then entries relating to the same evening which record that he was overheard talking in his room in what appeared to be a prolonged conversation. There was no-one else present and he was looking back to a fixed point. Dr Collins concluded that this was Mr Brady responding to an auditory hallucination.

136. There was a further note of Mr Brady being overheard. Mr Sheppard thought this was indicative of hallucinations. An entry in

the Case Notes records that on 4th December 2012 when he was standing at a mirror in his bathroom he appeared to be mumbling and then grimacing.

137. The Tribunal accepted the point that an incident may be misinterpreted and one must be careful to bear in mind that there may be a simple "innocent" explanation. The incident recorded for the 4th December 2012 may be one such occasion.

138. It is convenient to set out here Mr Sheppard's account of a day in Mr Brady's life as it is relevant to the effect which the disorder has upon Mr Brady. It is also relevant to the issue of treatment which is dealt with later.

139. Mr Brady's typical day involves rising about 6.30am and after attending to his personal needs and whilst feeding, he listens to the radio and writes. He does not attend any workshops or therapies. He spends much of his day in his designated side room only leaving to take medication or for refreshment. He retires to bed between 12am and 2 am.

140. Mr Sheppard explained that following the events of 24th September 2012, a change of routine had been noted. He continued to spend much of his day in his room but asleep. He would not leave it until either night time or if it was a Thursday afternoon. Mr Sheppard pointed out that these are periods when most of the other

patients are off the ward or out of common areas. Furthermore, he began to rely upon the nursing staff to take him refreshments and medication rather than leaving his room to collect them for himself. On the other hand he spends more time with staff talking about a wide range of topics and this is not restricted to his Care Coordinator/primary nurse.

141. Dr Collins referred to the 11 occasions already mentioned on which it is recorded that Mr Brady was talking to himself. Dr Collins contrasted this with the records for 1986 in which there was only one similar record. He submitted that the difference was due to the fact that at that time, he had been reporting the hallucinations but now he did not. He pointed out that in his experience one of the characteristics of patients with personality disorders is that they do not engage openly. Further patients who have been psychotic for a while are readily able to disguise their responses to hallucinations and it is very difficult to identify that that is what is happening. It is difficult with 24 hour observation but obviously more difficult in comparatively short interviews. This means that one has to interpret behaviour and make a judgement on the basis of it and in the light of all the records

142. Dr Collins then gave evidence about incidents which, in his opinion demonstrated continuing paranoia. He traced back to 1986 and his paranoia and delusions about the Home Office and how he believed that he was being kept in a state of "psychological subjection". He cited an entry for 30th July 1998 in which it is recorded that he believed the Home Office had a special interest in interfering in his case and thwarting his attempts at litigation. These continued with the transfer to Ashworth Hospital and others became incorporated into the delusion. The Prison Officers Association was an organisation but it also related to people. Dr Collins was repeatedly said to be involved as were his predecessors.

143. This paranoia was observed by the Tribunal during the hearing of the application for a hearing in public when he asserted that the Tribunal was politically motivated and not impartial. This was given as one of his reasons for applying for a hearing in public.

144. Dr Collins set out 12 references to Mr Brady's concerns especially about legal matters since 2010. He spoke about Mr Brady's concerns about undue monitoring of his movements and bugging of his conversations.

145. He cited examples of Mr Brady's attitudes towards other professionals. One such was when in October 2012 he had indicated to Dr B that he would not take prescribed medication and she

stopped it. When he developed a chest infection and Dr B attended upon him, he was abusive towards her and about the staff calling her "a glove puppet for Dr Collins". Dr Collins submitted that there was a degree of anger which is completely disproportionate to anything Dr B may have said and done. He submits that it is because he is psychotic and angry and feels "got at".

146. Dr Collins pointed to other examples which the Tribunal has considered. These included his attitude towards medical professionals such as an optician who was in no way connected to Ashworth Hospital.

147. One incident concerned a visit by workmen. Miss Lieven Q.C. pointed out features which may make it unfair to include this in the picture and the Tribunal deliberately ignored it save as a reminder that there can be dangers in drawing a conclusion where the evidence is not fully represented or disclosed.

**Dr Ground's assessment**

147 . Dr Grounds expressed his assessment of the present situation as regards a persisting mental illness. He said that in his view over the last decade evidence of abnormal experiences is very much less, more occasional. The clinical picture has changed, he said, and not in a way that one would expect if this was a chronic paranoid

schizophrenic illness. If anything one would expect the condition to continue and to be associated with the development of negative symptoms. He said that if one takes a longitudinal view of the records and the difference between his condition in the 1980s and that recorded over the last 10 to fifteen years, there is a quite a marked difference. The records do not show evidence of chronic active psychosis consistently through the years.

148 . He said that typically a chronic schizophrenic illness is associated with deterioration in personality and by the prominence of negative symptoms. There is no evidence of such deterioration in his mental condition over a period of time.

149 He accepted that there are possible indications of psychotic symptoms in the form of occasional episodes of behaviour suggesting he might be hallucinating. They are not clear and not associated with other features of schizophrenia. He pointed out that essentially they only occur in a specific context, in his room and there are no indications of such behaviour when interacting with others on the ward. This is not something that is frequent or prominent or interfering with his daily life and demeanour and interactions. It is very equivocal and does not reach a threshold of seriousness or severity which warrants treatment.

150 He expressed the opinion that Mr Brady is very similar to the way he was in the 1960s' and if he were now being considered for admission to hospital he would not be sectioned. The description does not fit the way Mr Brady is. The diagnostic guidelines for schizophrenia do not currently apply in his case. He concluded, "You simply cannot make a diagnosis of schizophrenia with any significant degree of confidence."

151 In reply to questions from Dr Boyd he said that in his view the evidence of mental illness is "pretty minimal". He does not exhibit significant psychotic symptoms. He has not been involved in any significant violence to others or self harm. "Given that he has a severe personality disorder I square this because the illness component has changed significantly in my view".

152 Dr Grounds said that the point he was making is that these incidents where he may have been hallucinating were only very occasional in an otherwise in a long period. They were none the less striking.

153 He then addressed the issue of paranoid beliefs. He said that they are prominent and expressed vehemently but I do not think they amount to delusions. He concluded that he did not think it could be asserted with confidence that Mr Brady was still suffering from a mental illness. The objective evidence is not sufficient.

154 He gave the following reasons. Firstly, they are understandable in terms of his very severe personality disorder and can be accounted for on the basis of that. Secondly, his beliefs arise in an understandable context. They do not have a kind of bizarre, impossible quality that you normally get in psychosis and which he had on admission to hospital. They have a link with real history. One should be very cautious where the beliefs which the person expresses have an understandable context before concluding that they amount to delusions.

155 He made two more specific clinical points about delusions. He said that they normally arise from a sense of subjective threat of something happening that is frightening and threatening. Secondly, as is clear from ICD 10 typically they are attempts to explain the disturbing abnormal experiences you get. Persecutory voices maybe an explanation of the awful experiences one is getting. That does not apply to Mr Brady's expressed beliefs about the hospital.

156 He concluded that the residual symptoms of mental illness do not make it appropriate to detain him in hospital.

157. He said that in the period from April 2012 to May 2013, there was no evidence of cognitive changes due to the epileptic incident in July 2012.

158. Dr Grounds spoke of the  interviews. He said that Mr Brady's presentation has not changed essentially. Sometimes he is more calm others more angry, impatient or irritable. His speech has been coherent and fluent. There has been no impairment of concentration and attention which is focused and he does not become distracted. Dr Grounds' conclusion was there was nothing to indicate he is being disturbed by abnormal experiences at the time of the interview.

158. His affect is congruent in that it is appropriate to what he is talking about. He did not believe there was a mood abnormality as can sometimes happen in schizophrenia. He felt that his impatience and irritability are features of his personality and not psychosis.

159. His approach to and view of the hospital is unremittingly critical hostile and contemptuous. He will not talk to Dr Collins but does speak with his primary nurse. He is paranoid in terms of feeling that there are conspiracies and efforts being made to undermine and oppose him.

160. Of the use of headphones whilst taking feed, he says it is to block out ward noise. Dr Grounds said that "at face value, it has a certain plausibility.

161. He said that Mr Brady's view of specific incidents  where it is suspected that he is hearing voices is one of wholesale rejection of

such a possibility. He speaks in terms of talking to himself to express his views, responding to what is on the television or exercising his vocal chords.

162. He said that in interview March 2013, Mr Brady had been more relaxed than he had been at any time previously. His speech was coherent and attention sharp but dismissive of questions about topics which he did not wish to discuss. Mr Glasgow had a similar experience.

163. Dr Collins explained his reasons for concluding that it was paranoid schizophrenia by reference to F20.0 and DCR-10. He addressed the point made by Dr Grounds that, in a case of untreated chronic paranoid schizophrenia one would expect to find significant negative symptoms. He accepted that such symptoms are "not massively in evidence". There was some self neglect and some constriction rather than blunting of emotions. His view was that their absence is not an exclusion criterion and does not provide a reason not to diagnose paranoid schizophrenia if the criteria specified for its diagnosis are present.

164. Dr Grounds' position was that the evidence of psychotic symptoms is very equivocal and he did not think there is evidence of mental illness that reaches any kind of threshold of seriousness or severity or something that warrants treatment.

165. Dr Collins then addressed the general diagnostic criteria for a personality disorder. He pointed out that there was no evidence of Mr Brady exhibiting paranoia before he was sent to prison. He contrasted this with the indications in childhood of narcissism and antisocial personality disorder. Furthermore, his ability to maintain a relationship with Myra Hindley and to maintain work and the relationships which that would have required did not accord with such a diagnosis.

166. He accepted that there can be a paranoid edge to people who have antisocial or narcissistic personality disorders but not of the chronic type seen in Mr Brady. He compared Mr Brady's behaviour to that of patients known to have narcissistic or antisocial personality disorders and said that Mr Brady does not present as a typical person with personality disorders. He contrasted Mr Brady with them and concluded that there was something which overrides his narcissism and that is schizophrenia. In a lot of his behaviours, one sees the combination of the two: his contempt for other patients, his anger and his paranoia.

167. In cross-examination, he said that he attributed the paranoia and much of his mistrust consequent upon that to his mental illness. The primary elements of his personality are his narcissism and

antisocial characteristics. He agreed that Mr Brady is at the extreme end of severe personality disorder but he said that his presentation is quite unlike other men with severe personality disorders. Although one sees aggression in people with an antisocial personality disorder, with age it tends to reduce but Mr. Brady's continued hostility to a whole range of people repeatedly is very unusual.

168. On the subject of conflict and extreme difficulty getting on with people, he said it is a feature of antisocial personality disorder and it manifests itself in the way in which they interact with one another; they fall out. Mr Brady is different in that he also stops interacting with other people. He withdraws which is a feature found where there is depression or a phobia but he thinks that in relation to Mr Brady it is a reflection of paranoia.

169. His interpretation of Mr Brady's lack of socialising is because he is paranoid. It is on a different scale. Narcissism does not mean that a person with that disorder will isolate himself to the extent which Mr Brady does.

170. He agreed that elements of his presentation do cross over between narcissistic personality disorder, dissocial personality disorder and paranoid personality disorder. He rejected the suggestion that his desire to stay in his room and not to mix would be perfectly

consistent with a diagnosis of antisocial personality disorder because such a person does not isolate himself to this extent.

171. He summarised the position about his condition in this way. My estimate of the activity of the illness is that it lies somewhere between Dr Grounds' estimate of its activity and the level of 1985. I think it has been affecting his behaviour significantly throughout the period. It is not at the 1985 level. You can see ebbs and flows in it. It continues in the same way.

172. He submitted that the depth of paranoia was inconsistent with antisocial and narcissistic personality disorder. It is the chronic nature (he called it "the chronicity") and continuing presence of low level, simmering irritation, irascibility which is the continuing paranoia. He was asked about delusions which may not appear to be bizarre. He accepted that some of the explanations did not necessarily appear to be bizarre. He confirmed that delusions need not be bizarre. If they are it is easier to identify them. But he made the point that it is the continuity and strength of his antipathy. Mr Brady rationalises it in some circumstances but in others it is not so rational. Dr Collins concludes that there is no logic or order or proportion or balance in Mr Brady's comments. He submitted that it demonstrates that he was still paranoid and disproportionately so

to an extent which is incompatible with being only antisocial personality disorder.

173. He was asked to comment on a passage from Professor Gournay's report in which he had commented that the records were overly inclusive and incidents such as jam smearing were events which are common on many ordinary psychiatric wards. He rejected that as being consistent with his general experience and his experience within Ashworth Hospital. He rejected the suggestion that this demonstrates that the records were overly inclusive.

**174.** He was asked about the importance to be attached from a diagnostic point of view of behaviour which is targeted at other or specific patients. He said that it was evidence of continuing paranoia and needs to be interpreted in the light of earlier behaviour. He said that he thought it was very serious and reflected a high level of paranoia. The patients targeted have done nothing to merit his behaviour towards them. In Dr Collins view it is paranoid and is based either on a false perception or delusional belief.

175. Dr Logan expressed her opinion on the issue of diagnosis. She pointed out that since the commencement of his desire to be returned to prison, he has had good reason to conceal the symptoms of mental illness which would ensure the continuation of his detention in hospital. It is suggested that such concealment

from his experts would be very difficult. But against that it is said that they become apparent to others when viewed over a longer period of time.

176. Dr Logan considered that he has a mental disorder co-existing with a severe disorder of personality for the following reasons.

177. He undoubtedly had a mental illness in the 1980s. The present signs and symptoms are recorded and remain consistent with the presence of a psychotic disorder. His refusal to cooperate is confirmation for her of this.

178. Thirdly she does not regard his presentation to be accountable solely by personality pathology. She based this on her expertise in this area. She has studied patients who have what she terms "pure personality disorder", that is those who have a mental illness uncomplicated by personality pathology and those who have a mixture of the two. On the basis of this experience she considered Mr Brady and concluded that his presentation was not typical or representative of somebody who only has a personality disorder. Next she said that he is motivated to try to conceal the presence of psychotic symptoms which makes their assessment a challenge. Finally she pointed out that his disorder has barely been treated with medication (recommended interventions) which makes relapse more likely and remission less so.

179. She then explained in detail the tests which she had carried out in relation to his personality disorder and the key features of his personality disorder as established by the results. She then turned to consider his paranoia and its relevance to both personality disorder and mental illness. She expressed the view that it lies neither wholly with personality disorder nor mental illness but is a feature of both conditions and most pronounced when he is acutely mentally ill. She explained that in the case of people with such co-morbid presentations, one resonates with the other. It then becomes difficult to separate them as if they were independent because they are not; they have a dependency on each other and that affects risk.

180. When cross-examined she explained that the three categories of Personality Disorder identified are not clear line categories, they are "fuzzy" and not pure diagnostic distinctions so that some evidence may fall into one or more categories.

181. There is a spectrum of matters which fall into the category "paranoia." It is a dimension and people will range up and down it.

182. She addressed the issue of Mr Brady's alleged belief that there was bugging of his conversations. She accepted that the more a suspicion has a rational basis the more it may be thought to be on the suspicious rather than the paranoid end of the spectrum. There may be types of paranoia which look more like mental illness or

personality disorder. Mr Brady's claim that the Home Office were manipulating him through voices is a kind of delusional paranoia bordering on the bizarre and strongly indicative of mental illness. Sometimes it is necessary to see a matter in context. Then it is useful to be able to discuss it with the person.

183. The absence of explanation for Mr Brady creates an ambiguous situation which invited multiple explanations. She agreed that paranoia can be a feature of both conditions.

184. On the question of a person's vulnerability to relapses she said that it is relevant to have regard to the patient's history.

185. In 1999 he stopped talking to the care team and that made it very much harder to know what was going on. By then he said, "I want to go back to prison". He was therefore motivated not to have anyone think he was mentally ill. So if he had control then it is possible to think he was exerting it because he did not wish to leave himself open to scrutiny.

186. Dr Glasgow gave evidence. He said that in the last ten years he has seen a modest change in moods but little evidence, if any, that he has suffered from significant psychotic symptoms. He said that he had seen nothing which could not parsimoniously be described by

paranoid, narcissistic and compulsive traits as explained by Dr Grounds.

187. Mr Glasgow commented on Dr Logan's evidence. He said that he did not see the qualitative difference in paranoia that is concluded by the hospital. Despite confronting him, there has not been anything which is without any understandable context. In this, he echoes Dr Grounds.

188. On the issue of the recurrence of psychotic episodes and Mr Brady disguising symptoms of his psychosis, he said that he thought that was a possibility and he certainly would not rule it out; but he did not think it is likely. He concluded that he would not be as confident of the absence of psychotic phenomenon as Dr Collins is of its presence. "I don't think the degree of confidence that has been expressed is warranted."

189. He considered the pre-occupation with the presence or absence of psychosis was self defeating. He said that he felt it was much more relevant to focus on the much more salient personality issues of day-to-day relationships. He said that he did not think the focus on the presence or absence of psychosis is helping Mr Brady at all but leads him to be suspicious of staff.

190. He said that Mr Brady thinks the staff are listening to him to find evidence of psychosis. His own opinion is that there have been

instances recorded in the case notes of psychosis which were not in fact a correct interpretation. He explained that Mr Brady's view is that it is the intention to misrepresent his mental state, which then pushes him towards the paranoid state.

191. In cross-examination he accepted it is right that staff should continue to observe and to documentary possible changes in presentation relevant to the existence of a mental illness. That has direct relevance to the formulation of clinical issues and appropriate treatment.

192. Whilst acknowledging the criticism of Dr Swinton's evidence, the Tribunal considered his contribution on the general matters of the nature of the mental disorders was useful.

193. He spoke of points which may usefully be borne in mind when evaluating the arguments about symptoms being referable to mental illness or personality disorder.

194. He suggested four matters. Firstly, the basic principle is that very specific criteria for diagnosing mental illness, which are often tighter than the published criteria but then softer rules are used for the diagnosis of Personality Disorder. The effect is that diagnosis of patients will tend to shift from being mentally ill to being personality disordered.

195. Secondly, it is inappropriate to look at symptoms one at a time rather than in the round. Information may indicate psychosis but it might be ambiguous and does not amount to an unequivocal case for psychosis which could lead to an opinion that the patient is not psychotic. There may be an approach of treating each new behaviour and each new symptom as though it were a new illness and start from an assumption of sanity at each point. This leads to the third point that it is important to use the historical record in the interpretation of present observations. He accepted in cross-examination that Dr Grounds had taken a longitudinal study of the evidence of Mr Brady's presentation in order to assess whether he meets the statutory test. The fourth point is a danger to over emphasise interview but one must assess its contents. The Tribunal considered it useful to have these comments in mind.

196. Dr Swinton referred to the two diagnostic systems: DSM IV and ICD 10 and pointed out they are based on symptoms and time courses. It led to a discussion about the meaning of schizophreniform with which the Tribunal does not feel compelled to review save in one regard. Dr Grounds favoured its use and thought that Dr Hunter had used it in the same way as he had namely meaning a condition like schizophrenia. The Tribunal doubt that he is correct. Its use by Dr Hunter would fit with it being used within the diagnostic criteria and

he did move on to describe the condition as schizophrenia. The Tribunal has already indicated that it accepted that is the correct diagnosis for Mr Brady's condition in 1985.

197. Dr Swinton went on to discuss the two broad groups of symptoms which it is said are absent namely bizarre delusions and deterioration leading to negative symptoms.

198. He defined bizarre delusions as delusions that could not possibly happen. They are to be contrasted with non-bizarre delusions which are false beliefs that could happen. He gave the examples of a person saying he could walk through walls as against conspiracy between the doctor and Home Office to keep someone in hospital. Dr Swinton said that it is not necessary for patients to have bizarre delusions or deterioration though many patients do have one or the other or both. He pointed out that when bizarre delusions are present the diagnosis of schizophrenia is straightforward and uncomplicated. Dr Grounds, on the other hand, regarded them as being the most typical manifestation in the course of schizophrenia.

199. He then moved to the diagnosis of Personality Disorder. There was again an issue between them concerning the diagnostic criteria. Dr Swinton asserted that the diagnostic criteria required that the feature must be present from adolescence. Dr Grounds said in his experience as long as the clinical features of the disorder were present, the time

course was not necessary. The Tribunal has already commented on the dearth of evidence on this point so far as paranoia is concerned.

200. Dr Swinton's point is that Dr Grounds is applying strict criteria for the diagnosis of schizophrenia but looser criteria for the diagnosis of personality disorder. The inevitable consequence is that he will tend to shift patients from mental illness to personality disorder.

Dr Swinton then observed that when someone has had schizophrenia for five or ten years "it doesn't go away". It may ameliorate but not go away. This was a point raised by Dr Boyd with Mr Glasgow who did not disagree. He believed that the intensity of psychotic symptoms does tend to diminish that it can happen even without drugs but confessed that he did not have sufficient experience to be categorical.

He said that drawing off experience of working with long stay patients, he has found that the florid dramatic psychosis seen in patients in their 20s and 30s is no longer apparent. Their typical pattern is that they are irritable, abusive, they may sit and mutter and have a routine in which they do not do very much.

He said that his experience was that positive symptoms probably lessen with age. So the fact that if Mr Brady's positive symptoms may have improved would not be unusual. He said that negative symptoms do not necessarily get worse over time but can stabilise.

Dr Grounds clarified that by the expression "deterioration in schizophrenia" he did not mean a worsening of negative symptoms but that in chronic schizophrenia negative symptoms develop.

**The Tribunal's conclusions.**

The Tribunal had to decide whether, generally, they accepted the evidence of the witnesses called on behalf of Ashworth Hospital or those called on behalf of Mr Brady. The Tribunal has already set out the qualifications, experience and expressed its acceptance of the integrity of each of them. It is impossible to accept all that each has said as there are so many conflicting views. The Tribunal has tried to indicate the evidence relating to those issues and to an extent has already set out some of the aspects which it has accepted or rejected. Generally speaking, the Tribunal concluded that the general experience of those who had given evidence on behalf of the hospital was more closely relevant than that of those called on behalf of Mr Brady. Furthermore, they had more direct experience of dealing with the problems which Mr Brady's mental disorder posed.

As has already been said the Tribunal agreed that Mr Brady is suffering from personality disorders namely antisocial and narcissistic. He was correctly diagnosed in 1985 with paranoid schizophrenia of a nature and degree to which reference has already been made.

The differences in eminent medical opinion demonstrate that his present mental condition is complex. The present diagnosis is made more difficult because of the lack of information from him. That may be due to a deliberate choice of his or due to his mental condition. But it means that there is no direct evidence to assist.

In making this comment the Tribunal does have in mind that Mr Brady did speak with those medical experts called on his behalf in the interviews. However, his presentation during his evidence and his claim to have feigned mental illness led the Tribunal to look with very great care at the material which those experts were able to report from their interviews. That in no way seeks to criticise either the way in which they approached those interviews or their evidence or their integrity. They have sought to present as fair a picture of the case as they could. The Tribunal acknowledge that during the interviews none of them observed behaviour which struck them as being unequivocally indicative of mental illness.

This presents a danger in that it may lead to an incorrect conclusion. This can be seen in relation to the lack of evidence that he experiences bizarre delusions. Dr Grounds rightly says that he could find no evidence of the sort of bizarre experience which he disclosed in 1985. That does not mean, however, that he does not continue to do so. The sole source of evidence for the existence of such experiences would be Mr Brady and, to quote Dr Collins, "he's not for telling". Thus while one cannot conclude that he is

suffering from such bizarre experiences, it does not follow that one can say he is not.

The Tribunal accept that the lack of positive evidence of the continuation of such experiences does not preclude the presence of schizophrenia.

The consequence of the lack of disclosure from Mr Brady is that the medical witnesses and the Tribunal must look at the other evidence and consider what proper inferences which can be drawn from it. Before coming to a conclusion the Tribunal must consider whether there is any other proper conclusion. A suitable example is the conclusion drawn by Dr Collins that the comment said to have been made by Mr Brady whilst walking along a corridor was evidence of the existence of an olfactory hallucination. It is a possibility but the fact that it is the only occasion which gives rise to such a conclusion and the fact that he does express unpleasant comments about members of staff leads to the rejection that it is established as an olfactory hallucination.

The Tribunal accept that it is fundamental to an understanding of Mr Brady's case that one takes a longitudinal view of the evidence. That was the view of all witnesses.

The Tribunal accepted the point made in particular by Dr Swinton that it should be careful not to look at individual aspects of the case. It was entirely proper for the witnesses to present their evidence in such a way. Dr Grounds and Dr Collins looked at the evidence of personality disorders, of

paranoia and the continuation of hallucinations. But, as Dr Logan commented the lines are "fuzzy" and the various matters interrelate. She made the point in relation to paranoia which sometimes seemed to emanate from mental illness and at others from his personality disorders. The Tribunal sought to keep an overall view of the medical condition and recognised that particular parts of the evidence may point to one conclusion rather than another.

The Tribunal started by looking at the position in 1985 as has already been said. It considered that the seriousness of his schizophrenia and its duration were important. It accepted the comment, that such a condition does not "just go away" especially given the nature as described in the reports of Dr Hunter and Dr MacCulloch and its degree at that time.

It noted the improvement in his mental condition even though the administration of drug based treatment was comparatively short. As will be seen from the view formed by the Tribunal on the issue of treatment, it considered the care which has been provided to Mr Brady has ameliorated and prevented a deterioration in his condition. The Tribunal considered that Dr Grounds underestimated its value when considering the continuation of a mental illness.

Miss Lieven Q.C. submitted that the evidence that Mr Brady continued to suffer from hallucinations is highly equivocal. She pointed out that the recorded incidents amounted to 2 or 3 a year and that others were equivocal.

She reminded the Tribunal of Dr Grounds' comment that essentially they appear to occur only when Mr Brady is in his room. She finally submitted that even if the Tribunal concluded that they did continue, they were not such as to disable him in any sense.

Miss Gray Q.C. submitted that those incidents were clearly abnormal and they are suggestive of hallucinations.

The question is whether those occasions identified as possible instances of hallucinations are in fact hallucinations. The Tribunal looked at matters "in the round" and in the light of the known history. Dr Grounds recognised that the group of 11 incidents is suggestive of hallucinations and certainly did not dismiss them. Dr Collins was assertive. Miss Grey Q.C. invites the Tribunal to accept that they also colour less obvious occasions. She points out in her submissions that Professor Gournay agreed that there was a spectrum and that although he was at the end favoured by Dr Grounds he would be very suspicious. Mr Glasgow also accepted that some of the episodes were evidence of psychotic symptoms.

The Tribunal considered that the evidence of those instances was strongly indicative of the continuing existence of the symptoms. One feature which troubled Dr Grounds was the fact that they were all observed whilst Mr Brady was in his room. The question whether that may be part of his attempts to hide his illness was not explored. Miss Lieven Q.C. pointed out that he is an elderly, socially isolated man who could be expected to talk to

the television or one might reasonably add, to himself. This is a possible explanation which the Tribunal considered.

The Tribunal considered that the instances had to be viewed in the context of a long and serious mental illness in which the symptoms had been severe and had borne similarities to the eleven instances. This led the Tribunal to conclude that he was still suffering from hallucinations on occasions. They are indicative of the nature and degree of the illness. Dr Grounds suggested that they were at most residual occasions of an illness that has largely ameliorated. In relation to this submission the Tribunal considered that the beneficial effect of the environment must be taken into consideration. It acknowledged that it is difficult to assess the extent to which the condition is ameliorated but having regard to the present stability set against the seriousness of the illness prior to and at the time of his admission, it must be a significant factor. The Tribunal concluded that the hallucinations did continue. Their precise frequency is not capable of being ascertained because of the lack of information from Mr Brady. But the Tribunal did not accept that they were simply residual. Miss Lieven Q.C. submitted that if he is suffering from hallucinations they do not disable him in any sense. She continued that , "they are clearly not controlling his actions and are not considered to need medical treatment."

The Tribunal is of the view that this is to isolate one aspect of the case. Mr Sheppard gave a detailed account of a day in the life of Mr Brady. The

Tribunal considered that it demonstrated that his mental condition was clearly leading him to an isolated lifestyle. This was noticeably worse since his illness in July 2012. It is not possible to isolate one aspect and assert that it does not disable. It does; it contributes to his withdrawal from activities with other people. The Tribunal accepted Dr Collins evidence about the relative roles of his antisocial and narcissistic personality disorder and how his overall mental condition was different to those suffering from those disorders; there is something more and that is his schizophrenia.

There is no dispute that Mr Brady exhibits paranoia. The issue has been whether that it is part of his mental illness or personality disorder. Miss Lieven Q.C. submitted that the beliefs do not have a bizarre quality. The Tribunal has already commented upon that. She acknowledged that Dr Grounds agreed that it is not necessary for his beliefs to have a bizarre quality. When he was disclosing matters in 1985 he spoke of the circumstances which were clearly bizarre. She submits that now they are primarily "attributions of malevolence". She further submits that his paranoid views now arise from his life in the hospital. They are all focused around his existing environment and are rooted in real events which has some explicable basis. The Tribunal accept that to a large extent they do relate to his life in Ashworth and those with whom he is in contact. This can be traced back to when he was in prison. Then it was directed to those who represented the Home Office. At a time when he was still clearly ill, it was

directed to a series of Responsible Medical Officers leading eventually to Dr Collins. But it goes much further because it also involves those not connected with the hospital. There is no factual and explicable basis for his attitude towards the optician or to the Tribunal. Miss Lieven Q.C. accepts that it is disproportionate and extreme in terms of its duration. This is Dr Collins' point which he says is indicative of it being paranoia greater than would be consistent with personality disorder. The Tribunal acknowledged that it is a very difficult to isolate those aspects which relate to one or other condition. It considered the evidence of Dr Logan particularly important in this regard when she spoke of the symptoms resonating off each other. They considered the features which indicated mental illness as an origin rather than his personality disorder. The Tribunal accepted the evidence of Dr Collins on this aspect. It acknowledged that Dr Grounds can point to a factual origin but the extent of his paranoia, its duration and the transferability of it seem to demonstrate that it is due to his mental illness.

The Tribunal accepted the comment of Dr Collins that it is a difficult exercise even for those who are monitoring him on a 24 hour basis.

The Tribunal therefore did not accept that Mr Brady's present mental condition was simply due to his personality disorders. The Tribunal accepted that its nature is of a chronic psychotic illness namely

schizophrenia. The restricted lifestyle explained by Mr Sheppard is indicative of the profound effect which it has upon him and which makes it appropriate that he should receive treatment.

The Tribunal accepted that it does vary in its intensity. Dr Collins described it as ebbing and flowing. At times of stress it has been seen to become more apparent. This has been noted throughout the time since he was in prison and at Ashworth Hospital. It can be seen in his behaviour in the autumn of 2012. The Tribunal considered that it is certainly of a nature to make his continued detention in hospital appropriate and probably also of a degree.

**Is appropriate treatment available?**

201. The Tribunal then considered the two issues relating to treatment: is appropriate treatment available at Ashworth Hospital and is it necessary for Mr Brady to continue to be detained there for such treatment or should it be provided in a prison?

202. The factual premise for their consideration of the first issue was that the Tribunal had determined that Mr Brady continues to suffer from a mental disorder which is both a personality disorder and paranoid schizophrenia and is both of a nature and degree that it is appropriate for him to receive treatment.

203. It is clear that drug treatment is not envisaged by Dr Collins. A different view may be taken by the new Responsible Clinician who will be appointed but the Tribunal considered it speculative to

address that situation. It is also clear that Mr Brady is very unlikely to take part in any psychological treatment. Although both may be possible forms of treatment, and if chosen would be available, the Tribunal were of the opinion that it was not appropriate to base a decision upon that premise.

204. The Tribunal therefore concentrated upon the wider definition of "appropriate treatment" as outlined in Section 145 Mental Health Act 1983 and in particular the Care Programme Approach. In so doing the Tribunal examined the specialised care and treatment which is both available and provided to Mr Brady in what is generally termed the "therapeutic milieu". Whether equivalent suitable treatment could be provided in prison is more properly relevant to the second issue: is his detention in hospital necessary or should he be detained in prison? There was considerable disagreement amongst the medical witnesses.

205. All agreed that treatment is widely defined in law. The core issue was whether the way that Mr Brady is being looked after, or, it is proposed that he should be looked after. amounts to treatment and in particular was "appropriate treatment"

206. The Tribunal first considered the meaning in law of "treatment".

207. Section 145(1) Mental Health Act 1983 provides "medical treatment" includes nursing, psychological intervention and

specialist mental health habilitation, rehabilitation and care. The Tribunal observed that this sub-section does not seek to provide a comprehensive definition. It sets out various actions which may be taken when seeking to assist a patient. There may be a degree of overlap of the nature of that assistance encompassed by the items mentioned but they must also connote some different action. Thus, in the opinion of the Tribunal whilst "specialist care" may include nursing" it must also encompass other actions. Conversely, "nursing" does not necessarily encompass "specialist care". This indicates the width of meaning of the term "treatment"

208. Section 145(4) provides that "… medical treatment, in relation to mental disorder, shall be construed as a reference to medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations".

**209.** In **MD v Nottinghamshire Health Care NHS Trust [2010] AACR 34** it was pointed out that "purpose" is not the same as "likelihood". Medical treatment may be for the purpose of alleviating or preventing a worsening of a mental disorder even though it cannot be shown in advance that any particular effect is likely to be achieved.

210. Moreover, even if particular mental disorders are likely to persist or get worse despite treatment, there may well be a range of interventions which would represent appropriate medical treatment. It should never be assumed that any disorders, or any patients, are inherently or inevitably untreatable. Nor should it be assumed that likely difficulties in achieving long-term and sustainable change in a person's underlying disorder make medical treatment to help manage their condition and the behaviour arising from it either inappropriate or unnecessary.

211. The Tribunal then referred to the Code of Practice Mental Health Act 1983. For convenience the relevant parts are set out in full.

212. Paragraph 6.15 : For some patients with persistent mental disorders…management of the undesirable effects of their disorder may be all that can realistically be hoped for.

213. Paragraph 15: "Safe and therapeutic responses to disturbed behaviour"

214. Paragraph 15.1: The guidance covers a range of interventions which may be considered for the safe and therapeutic management of hospital patients, whose behaviour may present a particular risk to themselves or to others, including those charged with their care."

215. Paragraph 15.16 "Individual care plans are fundamental to the appropriate management of disturbed behaviour. In addition, problems may be minimised by promoting the therapeutic culture of the ward or other environment and by identifying and managing problem areas. Among such measures are:

216. Developing a therapeutic relationship between each patient and a key worker or nurse

217. Ensuring an appropriate mix of patients

218. Ensuring an appropriate mix of staff to meet patient's needs

219. Identifying those patients most at risk and implementing appropriate risk management plans.

220. The Code then addresses what may be regarded as "Appropriate medical treatment" for those with a Personality Disorder.

221. Section 35.8: What constitutes appropriate medical treatment for a particular patient with a personality disorder will depend very much on their individual circumstances. First and foremost, that calls for a clinical judgement by the clinicians responsible for their assessment or treatment.

222. Section 35.9 A proposed care plan will not, of course, meet the Act's definition of appropriate medical treatment unless it is for the purpose of alleviating or preventing a worsening of the patient's mental disorder, its symptoms or manifestations

223. Section 35.10 Generally, treatment approaches for personality disorders need to be relatively intense and long term, structured and coherent. Sustainable long-term change is more likely to be achieved with the voluntary engagement of the patient.

224. Section 35.11 People with personality disorders may take time to engage and develop motivation for such long-term treatment. But even patients who are not engaged in that kind of treatment may need other forms of treatment, including nurse and specialist care, to manage the continuing risks posed by their disorders, and this may constitute appropriate medical treatment.

**225.** The need for the treatment to be tailored to the circumstances of the particular patient was emphasised in the judgment in **South West London and St George's Mental Health Trust v W [2002] EWHC 1770 (Admin)**

226. Para 36 "It is to be noted… that a conclusion that certain treatment amounts to medical treatment does not necessarily mean that such treatment will be likely to alleviate or prevent deterioration of the patient's condition. That is a separate matter."

227. Beginning at Paragraph 53 it is recorded that Professor Eastman in giving evidence had divided the treatment of patients with mental health problems into three different forms, which had been

referred to during the case as limbs one, two and three. They were regarded as a helpful basis for consideration of treatment by the judge. This Tribunal agrees.

228. Limb one is treatment of the patient's core disorder; limb two is seeking to give the patient the skills necessary to cope with situations that they had previously found difficult or stressful but without attempting to change the core disorder; limb three is management focused on managing the patient's environment so that conflict in situations is minimised. This includes management in the hospital when the patient is on leave from the hospital and when the patient is in the community; "this neither alters the core disorder nor gives skills to the patient."

229. At Paragraph 81 it was pointed out that if a time were to come when neither limb two nor limb three was in fact in prospect, then, even though he might be said to continue to receive some treatment, a serious question would arise whether such treatment was likely to alleviate or prevent the deterioration of the patient's condition. Those matters will need to be kept under very careful review."

230. The Tribunal then reviewed the evidence adduced and considered the application of these principles to the facts.

231. It was common ground that apart from medication prescribed and taken in the period after his admission to hospital, there had been no treatment by the use of antipsychotic medication. As has already been noted Dr Collins did not exclude the possibility of its use in the future. It would be a matter for the Responsible Clinician who was to take over from him if Mr Brady remains at Ashworth. Mr Glasgow appeared to support at least a trial of medication. Similarly, there had been no direct psychological treatment. Mr Brady has not seen a psychologist on a regular basis since Dr Logan had meetings with him in 1996. She pointed out that these were not formal treatment sessions. Mr Brady made it clear that he did not consider he required either form of treatment.

232. The Tribunal therefore considered the ways in which Mr Brady is currently being looked after in Ashworth Hospital. It was the hospital's case that it amounted to treatment. It was the case for Mr Brady that it amounted to no more than containment which could equally, indeed should be provided in prison.

233. The Tribunal first considered the approach which was being taken and then its practical application. The essential sources of evidence for these issues were Dr Collins and Mr Sheppard.

234. Dr Collins explained how the Care Plans are formulated . The care plans are informed by the Patient Care Team which meets

weekly. The PCT review the patient's presentation during each week. These then form the basis of the nursing reports which include the observations and interventions that took place during the month. These are then discussed at the multi-disciplinary team meeting when the team formulate appropriate interventions in relation to Mr Brady's care and management.

235. The Care Plan is then co-ordinated by the clinical and nursing team under the leadership of Dr. Collins.

236. In Mr Brady's case he has contact with a wide range of people who work in the hospital. He has issues with many of them as the result of his disorders.

237. Guidelines have been set which try to create therapeutic atmospheres within the ward and within the boundaries necessarily imposed by a high secure hospital to provide as relaxed an atmosphere as possible. This has included firstly the selection of the ward on which he is a patient. A decision was made to accommodate him on a low dependency ward to reduce any hostile response from other patients. This involved consideration of the patients who are actually resident on the ward. In reply to Dr Boyd's questions Dr Collins said. "were we not concerned about his risk of assault there is absolutely no way Mr Brady would be

considered suitable for a low dependency ward. He is there as part of the care plan to reduce the likelihood of him being assaulted"

238. In Dr Collins' opinion they are delivering a skilled form of care.

239. So far as therapeutic relationships are concerned Dr Collins pointed out that Mr Brady was a very difficult man to nurse and with whom to develop and maintain a therapeutic relationship. He explained that with any paranoid patient it is always very difficult as built into the disorder is a likelihood of misinterpretation. He pointed out that there have always been nursing staff at Ashworth who have been able to build a relationship. It is agreed that he does enjoy a very good relationship with his primary nurse but that is conducted on a more social basis.

240. His change of habits within the last year has demonstrated this difficulty though he is more trusting of the staff than the other patients. The relationship enables them to work with him. In that sense there is a therapeutic relationship but the Tribunal accept it is not of the nature which is envisaged by the NICE Guidelines.

241. The nursing staff are aware of his psychopathology as is manifested by his abuse of staff and other patients. They are tolerant of him and work with other patients to ensure that they do not become overly anxious about it. He can be subversive and sometimes tries to split off groups of staff which can lead to difficulties though it is

managed by providing supervisory processes for the staff. The staff ensure that he receives any required medication for physical problems and, if he refuses, they seek ways of dealing with that.

242. Since he was taken ill in July 2012 and his substantial withdrawal from the common parts of the ward, they even provide him with medication and hot drinks in his room.

243. This factual account was not challenged. The Tribunal accepted that it was the approach which had been taken by the hospital.

244. The Tribunal then considered the evidence relied upon as the implementation of this approach. It was essentially given by Mr Mark Sheppard who is the Charge Nurse on Forster Ward. For some 28 months he has spent a considerable amount of time with Mr Brady. Until the incident of the 24th September 2012 Mr Sheppard says that he would have said he enjoyed a good relationship with Mr Brady. That relationship was adversely affected by the events of that day. Mr Brady then refused to speak or even acknowledge him for a time but more recently there has been some improvement in the relationship. The Tribunal considered that Mr Sheppard was able to provide a good overview of the care which is being provided for Mr Brady. The Tribunal was impressed by the care with which Mr Sheppard presented his evidence. Professor Gournay acknowledged that he was not as well

placed as Mr Sheppard to describe Mr Brady's presentation on the ward. Mr Sheppard did that from his own observations and from the observations which colleagues gave to him. He confirmed Dr Collins' evidence as to the way in which care plans were drawn up

245. There are discussions amongst the nursing staff and nursing reports are prepared at monthly Care Team meetings which result in a Care Team Report.

246. In his first report dated 10th May 2012 Mr Sheppard described Mr Brady's typical day (para 2.9) It has already been set out and the Tribunal reminded itself of the details when considering this issue and in particular the role of the Care Co-ordinator/Primary Nurse

247. He was asked about the staff's approach to caring for him. It is based upon their assessment of his needs and the use of their nursing skills to producing a settled response from him. He expressed the view that "an important element of nursing care and management is to be aware of Mr Brady's strengths and protective factors which help to promote mental well-being." An example is that the staff acknowledge that he finds symptoms of his disorder embarrassing so they do not focus on that matter.

248. In summary, Mr Sheppard said, "By utilising the "nursing process" approach of assessment, planning, delivery and evaluation, Ian's daily management is individually tailored and constantly adapted to

meet his specific and changing needs. Nursing staff are encouraged to evaluate the care given to improve clinical decision-making, quality and outcomes, using a range of methods amending the plan of care where necessary and communicating change to others. This positively influences the quality of Mr Brady's care."

249. Dr Logan, in discussing his treatment needs in relation to the core disorders, said that they can be identified but any willingness on the part of Mr Brady to acknowledge and address these needs appears to be absent. She expressed the view that, nevertheless, it is possible for those with personality disorder in general and narcissistic personality disorder in particular to respond positively to a managed care environment by the delivery of a structured case management directed at the core disorder as the principal means of controlling the effects of that disorder. She said that in her opinion that is the form of intervention that has been most evidence in Mr Brady's care in the last decade at least and the most successful.

250. In her opinion, he is managed in a non-confrontational way that has helped to keep him reasonably cooperative and it has allowed him to feel he is in some way in control. This helps to keep him generally calm, cooperative and relatively content.

251. She agreed that it is important to look at treatment from Mr Brady's perspective as he views it as being intrusive of which he is entirely intolerant.

252. Dr Grounds specifically deferred to Professor Gournay on the issue of treatment. He made the point that Mr Brady's personality disorder is not amenable to treatment in hospital. The Tribunal assume that he was referring to the core disorder which is called Stage 1 by Professor Eastman.

253. He said that the general principles that apply are that treatment should be based on a therapeutic alliance with the patient. Mr Brady is not amenable to, interested in or willing to cooperate with any of those. His contempt towards any such engagement is very strong and consistent. In short, the starting point for a psychotherapeutic engagement is not there.

254. He added that he did not think that the ward environment amounts to specific treatment in Mr Brady's case.

255. In cross-examination, he was asked whether he was saying that he was not receiving treatment at all within the Mental Health Act or that the treatment is not appropriate or it is not necessary as it could be replicated in prison.

256. His answer was that he does not think he is receiving treatment within the Act. When pressed, he said he was not receiving any

specific treatment but he would go a bit further than that. He is being looked after by staff who are nurses. In that sense he is in receipt of the attention of nurses. His understanding is, he said that treatment referred to things being administered to the patient. They are not actually or essentially to do with the broader environment; they imply some personal relationship, some personal interaction. "I don't think he is receiving treatment which is addressing his mental disorder. I'm being a little vague here but I can't see there are forms of clinical intervention that are being administered to him as a patient".

257. He agreed that because of Mr Brady's approach to treatment directed at his core disorder, it is necessary to seek to work around him. He agreed that treatment under the Mental Health Act can be aimed at preventing a deterioration in the patient's condition but he was unwilling to accept that the relative stability indicated more than the fact that the hospital had been able to manage some of the manifestation rather than preventing a deterioration in his condition. He said he found it difficult to find evidence beyond the general statement that in the environment the management has been tolerant.

258. Professor Gournay acknowledged that whether the care being provided by the hospital amounted to "appropriate treatment" was for him a very difficult topic. He repeated the comments which he had made in his reports that he considered that Mr Brady is in an environment where there is plentiful available treatment but that it is not appropriate to him and that Mr Brady is simply being detained.

259. In his examination in chief, he was asked for his reason for concluding that he did not view the regime described by Mr Sheppard as being "appropriate treatment". He explained that care can be provided to manage behaviour in different settings and that there has been a considerable rapid evolution in psychiatric nursing not only in hospitals but also in other settings which include but is not exclusively in the prisons. This led him to express his opinion in these terms: "I am unable to see how the management interventions are really impacting on the disorder itself. They provide a framework of management, but I can't see how they constitute appropriate treatment." It appears to the Tribunal that it is the fact that the care does not impact on the disorders which caused Professor Gournay to reject the suggestion that it was "appropriate treatment".

260. He then looked briefly at each of the possible disorders in turn and concluded that he did not think one could treat the level of narcissism that Mr Brady exhibited. He considered that so far as antisocial personality disorder was concerned the regime was such as he managed those who manage him. As for a paranoid personality disorder he concluded the same applied.

261. When asked about mental illness he expressed the view that "the hospital's case comes down to the care provided by the staff allows Mr Brady to control or manage his own mental illness." He went on to add, "If he was remitted to prison, then he would be likely to relapse very quickly." But he then expressed this view: " I don't think his mental illness is being managed by Ashworth. I think there are occasions when he may be experiencing hallucinations but I don't think they are being managed in any way which you could call "appropriate treatment".

262. These views were discussed further by Miss Grey Q.C. in her cross-examination of Professor Gournay.

263. He accepted that Mr Brady had shown improvement since his move from Lawrence Ward in February 2001 but he rejected the suggestion that it was indicative of him being responsive to his environment. He attributed it to a variation in his condition and

said that personality disorders tend to improve on their own as one ages.

264. He agreed that Professor Eastman's propositions of three limbs were a useful basis for consideration of treatment.

265. He agreed that the hospital is providing "care" that is consistent with limb 3: management focused on managing the patient's environment so that conflict in situations is minimised.

266. He also agreed that the hospital were attempting to deliver care in the terms of limb 2 namely finding strategies for Mr Brady to cope with situations that are causing conflict and managing them in such a way as to minimise conflict both for himself and for others

267. Professor Gournay said, however, that he considered these were aspirational and had not been successful and that led him to conclude that whilst they were available they were not appropriate treatment.

268. He seemed to be saying that because it was not successful it was not appropriate treatment.

269. In discussing the Code of Practice, Professor Gournay accepted that Paragraph 15.16 provided an uncontroversial description of a therapeutic milieu to manage disorder. He accepted that in applying some of the strategies the hospital were managing his behaviour

but rejected the suggestion that they were managing the disorder because, he said it continues unremittingly.

270. When Paragraph 35 was put to Prof Gournay and it was suggested that the conduct of the hospital was precisely that envisaged by the Paragraphs, he rejected that it was treatment for Mr Brady. He said that he accepted that you should approach the most difficult patients and you should remain positive that they are going to engage. He continued "But I think when you come to a position where years and years and years have not led to any form of therapeutic engagement you can't… you have to give up". He asserted that as, in his view, it had not impacted on the disorder, it was not appropriate treatment for the disorder. Miss Grey Q.C. suggested that that would in effect recreate a treatability test which was removed from the legislation by the Mental Health Act 2007

271. He said that the current position in terms of mental health policy is that offenders with severe personality disorders would be expected normally to be treated in prison rather than hospital. For a person with a Personality Disorder to be considered for transfer to a hospital, there needs to be something additional, some mental illness.

272. Mr Glasgow said that he did not think that one could readily describe or measure the intangible therapeutic factors or milieu but

he did think that the plan needed at some stage to be systematic and evaluated and measured. It is not enough for it to be simply intangible. It needs to have a target that is declared regarding which there is an understanding about the nature of the problem, the degree of the problem and the frequency of the problem. A clear definition of what is going to happen and be done in relation to it and then an evaluation. It is not enough for the treatment plan to be simply to treat somebody well and respectfully. He considered the plan of 2011/12 to be more positive. There are elements in the following year's plan which are the same as the preceding one and there does not appear to have been any evaluation of that element from that preceding year. The difficulty is that it is not taken forward from care plan to care plan.

273. He accepted that it was reasonable to take into consideration that Mr Brady would not engage when formulating a care plan other than with management and therefore one cannot expect the care plan to produce anything. It is pointless to include matters which are purely aspirational. He suggested that what one should do is to concentrate on those things which are obstructing engagement in therapy.

274. He repeated that, in his opinion there were not sufficient goals and that opportunities were not strategically exploited. He understood

the dangers of doing so as one faced rejection. You risk him becoming angry, disengaging from a contact that has previously been supportive of him and potentially worsening of the position that prevails on the ward. Whether to engage in such risks is a matter for clinical judgment. He thought the risk had to be taken and something had to change. He said he would adopt the approach of Dr Logan that even if one does not seek to address the core disorder but there should be proper therapeutic goals.

275. The Tribunal accepted, as indeed did Dr Collins that the way in which Mr Brady is being looked after at Ashworth Hospital does not amount to treatment which is addressing the core condition. Nevertheless, the Tribunal accepted that the treatment being provided by Ashworth Hospital does constitute "appropriate treatment".

276. It has been formulated following the Guide.

277. The Tribunal considered that Dr Collins as the Responsible Clinician is the person best fitted to devise the Treatment Plans. That is specifically acknowledged in Section 35.8 of the Code. He has considered whether it is appropriate to prescribe medication. It is a judgment with which no-one but Mr Glasgow disagrees and even he is not unequivocally advocating it. The Tribunal

acknowledge that other clinicians may take a different view to Dr Collins but reject that it should be done just because something different should be tried.

278. The Tribunal accepted the evidence of Mr Sheppard and concluded that the regime was one which was having a beneficial effect. It acknowledged, as did at least Mr Glasgow, that it is difficult to quantify the benefit. The fact that Mr Brady has not presented with symptoms approaching those which led to his admission to hospital is, in the Tribunal's judgment plain evidence that there is a beneficial effect. Moreover that must be to a significant extent. There is, therefore significant evidence that the symptoms or manifestations of the disorder are being alleviated or at least being prevented from worsening and that the the treatment is to that extent successful.

279. The Tribunal did not accept that the stability was simply attributable to the ageing process. Its duration militates against that contention. It may have a role but it is not the sole or main factor. That is due to the treatment being provided.

280. It follows that the Tribunal reject the contention that the way in which Ashworth Hospital is providing for Mr Brady amounts to no more than containment. The Care Team has tailored a carefully considered environment in which it seeks to maintain the level of

stability in Mr Brady's mental disorder which enables him to cope with its symptoms. Professor Gournay was not prepared to follow Miss Grey's logical questioning which should have led him to agree that at least Stage 3 of the Eastman test was established.

281. The Tribunal agree with the submission of Miss Grey Q.C. that to follow Professor Gournay's approach would be in danger, even if not in fact re-creating the "treatability test" which had been put to rest by the Mental Health Act 2007.

282. The Tribunal were of the opinion that both Professor Gournay and Dr Grounds underestimated the nature and degree of Mr Brady's mental disorder which has led to an underestimation of the value of the therapeutic environment and care regime being provided.

283. The Tribunal were satisfied that appropriate treatment is not only available but is being provided by the hospital.

**Is it necessary for Mr Brady to continue to be detained in hospital or could such treatment be provided in prison?**

284. The Tribunal then considered whether it is necessary for Mr Brady to continue to be detained in hospital for such treatment or could such treatment be provided in a prison?

285. In approaching this question it must be remembered that the Tribunal has concluded that Mr Brady does continue to suffer from

a mental disorder of a nature and degree which make it appropriate for him to receive treatment and that appropriate treatment is available in Ashworth Hospital.

286. Mr Glasgow specifically declined to express an opinion on this issue.

287. The case for transfer into prison is essentially based upon the premise that Mr Brady has a personality disorder with minor residual symptoms of schizophrenia. In such a case the appropriate placement is in prison. This contention is based upon the NICE guidelines; the National Institute for Health and Clinical Excellence January 2009, Clinical Guidance for Antisocial Personality Disorder Treatment Management and Prevention. In cross-examination, Dr Collins pointed out that they are now policy and that at Ashworth Hospital they follow them unless there is a reason not to do so. Dr Logan made a similar point that they are for guidance and not required practice and anticipate deviation when necessary. The Tribunal accepted those contentions in principle. But their importance has to be judged in the light of the Tribunal's finding on the previous issues.

288. The Tribunal were of the opinion that it remained appropriate to consider whether the benefits which could flow from such a

transfer outweighed the possible dangers and were mindful of Mr Brady's apparent wish to be transferred.

289. The Tribunal will set out parts of his evidence as the questioning evolved rather than by topics because it gives an insight into the way in which Mr Brady approached the topics in, what the Tribunal considered, was a dismissive manner.

290. Miss Lieven Q.C questioned Mr Brady about three topics: his reasons for wanting to leave Ashworth Hospital, his reasons for wishing to go to prison and what he knew about current facilities in prison. His answers were not clear. Dealing with the first, he said that when he was transferred into Ashworth Hospital it was a progressive hospital under the Home Office. When it became a Trust, it became a prison where security was the priority. That was not official policy he said, but was covert and the Prison Officers Association took over and turned it into a penal warehouse. Miss Lieven Q.C. refined her question and asked what it was about the regime on the ward which he finds so difficult but again his response really did not attempt to answer the question. She changed to ask the second question; his reasons for wishing to go to prison. He referred to the circumstances in which he had been transferred from Jade Ward on 30th September 1999 before she put the question again. This time he responded that he was under no

illusions: "I'll never see the conditions that I experienced at Durham special security wing with such characters the Krays and the train robbers and such. I will never see those excellent conditions again. I won't even see again the good conditions I experienced personally at Wormwood Scrubs." She tried again by drawing his attention to Professor Gournay about improvements and deteriorations within prisons and asked if he did not think conditions would be as good as they had been in Durham in the 1960s, why did he want to go? He replied, "I don't know. There may be pockets that I don't know about." No clearer answer was given. Miss Lieven Q.C. tried a different tack by inviting his attention to specific aspects of prison life. Firstly, she asked him about being in a cell for many hours and the possibility of segregation. He said he had previously dealt with it and had to keep his vocal chords in order by reciting. He then wandered from the topic before being brought back again and he responded by saying that one adapts to the reality. He was asked about leaving some of the staff with whom he got on. He accepted that it was a possibility that a consequent feeling of distress could affect his mental condition but he would have to plan ahead. It was pointed out that prison staff may be less tolerant to his abusive and difficult behaviour and what is likely to be a more rigid disciplined system in

prison. He said he had always dealt with it. If he encountered someone who tried to provoke him, he would deal with them "by writing immediately to the right people".

291. In cross-examination Miss Grey Q.C. asked about the same topics albeit from a slightly different angle. "What problems can you foresee should you return to prison?" she asked. His reply, "I'm not omnipotent. I'm in tune with the regressive changes that have been taking place throughout the whole penal system". They spoke about the problem of overcrowded prisons and he dismissed it with the comment that there has always been overcrowding. She asked whether he could foresee any other difficulties for him personally should he return to prison. His response: "No. it would be quite the opposite. I don't glorify myself. I say I am simply a parcel. I will be sent to prison." He went on to say that he did not envisage the conditions he had experienced in Durham or Wormwood Scrubs. He concluded that in his opinion the whole penal system is now "zoological".

292. The Tribunal concluded that Mr Brady either did not wish to recognise the difficulties and restrictions which a transfer into prison would have or was incapable of doing so. In either situation the Tribunal did not accept that he exhibited a balanced and rational appreciation of the consequences of such a transfer.

293. The most obvious possible benefit is the effect which it could have on his refusal to take food what has been called, his hunger strike". It might remove the reason for this action which would probably be, at least to the benefit of his health.

294. Dr Collins' chronology sets out the occasions and circumstances on which Mr Brady has indulged in such action. There have been a variety of reasons e.g. when his application to meet with Myra Hindley was refused. They may be characterised as occasions on which he has not been able to get his own way. The present action had a different type of origin. It followed the inappropriate manner in which his transfer from Jade ward was conducted. It was a protest at that. But it changed to a wish to be able to decide his own future and whether and when he would die.

295. Miss Lieven Q.C. put to him whether, if transferred would he try to commit suicide. He replied he had answered the question many times. He said, "I've answered hypothetically from all angles. He likened his position to that of a monkey in a cage and posed the question, "how can you pretend to be omnipotent at that time? You can't make plans when you have no freedom of control, movement or anything… you can't talk sensibly or predictively about anything such as a question like that."

296. Dr Boyd sought to ask him about this topic. He put to him that he has said that one of the reasons that he wanted to go back to prison was that he could continue a hunger strike and not be force fed. He said he could clarify but then proceeded to give a history of the development of the policy concerning hunger strikes which had evolved from the cases of the Northern Irish hunger strikers. Dr Boyd tried to bring him to the point and asked, "…in the last ten years you have said that you want to be able to go back to prison so that you can stop eating and kill yourself. Is that the situation?" he immediately digressed. When Dr Boyd sought to bring him back to the question again, he said that it was an irrelevant question. His final answer was, "If they force feed me I then have another plan in mind".

297. It is worthy of note that according to Mr Sheppard, Mr Brady does break his hunger strike and take food. The staff do not highlight it but it is happening. In his evidence he maintained that he continued his action despite Miss Lieven Q.C specifically clarifying the position as she was instructed. Miss Grey Q.C. put to him in cross-examination that he was eating and his response was "Am I? According to whom?"

298. Mr Glasgow also gave evidence on this topic. He said that Mr Brady's account has varied over the years. At one time he said it

was his intention to return to prison, to continue to refuse food and then die. At other times he said it was a protest at the way in which he was transferred from Jade Ward and he will follow it until in some way the conflict with the hospital is resolved. Put in that way, it becomes much more a protest element. It also gives him a sense of control.

299. On the issue whether he breaks his strike he said that Mr Brady sometimes deprives himself but at other times, he relaxes and then he will try to disguise the fact that he has enjoyed something. It may be he does this because of a concern that it would be a potential control point to be used contingently to influence his behaviour. He thought that Mr Brady would not speak about as it is a matter of "keeping his powder dry". It is one of the few things over which he has control and he cherishes that.

300. The Tribunal concluded that it was not possible to determine whether he would or would not continue his action. One could conclude that even if he did, a situation could easily arise in which for one reason or another he might decide to begin it again. In the Tribunal's view the apparent benefit is not such that one could be reasonably optimistic that it would have such a benefit.

301. The Tribunal considered the approaches of Ashworth Hospital and of a prison, their respective facilities and the changes which being in prison would bring.

302. There would be a difference of approach. Dr Swinton pointed out that the nursing staff treat Mr Brady on the basis that he is mentally ill. Everything they do and everything they think is premised on the basis that they think this patient is mentally ill. That would not be the premise in prison. They manage individuals on the basis that those individuals are acting rationally and can make choices. In Ashworth Hospital he is treated for a mental disorder.

303. Dr Logan added to the discussion. She paid due respect to the work of the Prison Service. In a prison he would not be treated for a mental disorder even though the Prison Service is now trained to deal with prisoners who are suffering from a personality disorder. The Tribunal accepted the generality of this point. It acknowledged that in practice it may depend upon the specific prison to which Mr Brady was transferred.

304. It was pointed out that the patient composition of the ward is carefully managed. There are specialist nurses on the ward. They are regularly on duty and have acquired considerable knowledge of his medical history. They do not use "Bank Nurses" so there is

continuity of staff. In a prison staff ratios may not be as high, and continuity of staff may not be as consistent. The Tribunal agreed that as Mr Brady's mental disorder is extremely complex these are very important considerations which would probably not be replicated in prison.

305. The Tribunal then considered the changes which the different regime would mean to him and the likely effect which they may have. There would be a substantial restriction upon his freedom. In Ashworth, the nursing staff seek to anticipate and defuse a situation before it develops. One way in which that is done is by allowing him to contact his solicitors whenever he wishes. That would not be readily available to him in prison and this would cause him irritation. A useful tool to diffuse a situation would be lost and the likely consequence would be that his behaviour towards the Prison Officers would be confrontational. At present, abuse and bad language is tolerated. Dr Logan expressed the view that that could not be allowed in prison as it may lead to a loss of discipline by other prisoners. This could lead to him being placed in segregation. Presently he enjoys a freedom to stay in his room or leave even late at night whenever he wishes. Such freedom would not be available in a prison. The Tribunal accepted these points were valid.

306. Miss Lieven Q.C. in her submissions suggested that being in segregation would be no hardship for him. The Tribunal disagreed. It considered it was at best doubtful that he would take readily to enforced as opposed to voluntary separation from other people. In the Tribunal's view it is clearly arguable that he would rapidly become angry and demonstrate it in his attitudes towards others.

307. Dr Logan commented upon the risk of him harming others. She said that this continues to require active management even though the sporadic acts of aggression seem to have diminished in more recent times they should not be minimised by reason of his age. He has a history of the most extreme violence and his refusal to engage with the medical staff impedes an understanding of his condition. She pointed out that he remains an untreated violent and sexual offender. This means that the management of the risk he poses has to be more rather than less restrictive. In cross-examination she said that in psychopathic people one does not see a change of presentation with age as one does with Antisocial Personality Disorder. One does not see that sort of age related drop off of risk of harm to others. She did agree, however, that that risk could be managed in prison.

308. The question which then arises is whether he would be likely to suffer a relapse and, if so, whether that would be likely to occur

rapidly. Miss Lieven Q.C. submitted that the suggestion that it would occur rapidly was speculative. Miss Grey Q.C. rejected that suggestion and said it was for the Tribunal to make a judgment. Dr Grounds regarded it as no more than a possibility or not very likely and thought it more likely that he would stay well. Mr Glasgow spoke in terms of a possible mental disorder in the longer term.

309. On the other hand both Dr Collins and Dr Logan were of the view that transfer to prison was not appropriate and a deterioration would be within a short time.

310. Dr Swinton said that he would predict that if Mr Brady does return to prison there would soon be considerable concern about his mental health and pressure for him to return to hospital. It would be in the near future. Miss Lieven Q.C. suggested that there is simply no evidential basis upon which to find that Mr Brady is at material risk of relapse to a condition anything comparable to that in 1985. With respect to that argument, it does not need to be "anything comparable to his condition in 1985". The history of episodes prior to 1985, his response in 2000 and 2012 indicate his continued vulnerability and do provide an evidential basis upon which to make an assessment. The Tribunal preferred the evidence of those who advocate the continuing nature and degree of his mental disorder and the likelihood of relapse to those who

minimise it. The Tribunal considered that they were therefore assessing the factors in the light of their view of his present mental condition whereas Dr Grounds and Professor Gournay were more likely to assess it upon a basis rejected by the Tribunal.

311. The Tribunal were not presented with any clear plan of the accommodation which would be provided in prison and had to work from a general statement of likely facilities. Miss Lieven Q.C. raised the possibility of the Tribunal adjourning for more specific evidence. The Tribunal are strongly of the view that if a transfer to prison were ordered Mr Brady's mental condition would deteriorate within a short time and would lead to his transfer back to hospital.

312. The Tribunal recognise that there are mechanisms for transfer between the Estates but, in fact, he was detained in prison for 19 years before his transfer to hospital. That may have been due to non-medical factors as is hinted at in a report and we understand would be urged by Mr Brady. With the benefit of hindsight, that was clearly far too long. Doubtless there would be no such delay if that situation arose.

313. One must also remember that he is now a 75 year old man. When he was in prison he was much younger. He is now physically much weaker. But, his notoriety has not diminished. The inmates of a prison would not be selected as the other patients on the ward are.

That would create a significant risk to his safety even though the prison officers are acknowledged to have the skills to deal with such issues.

314. The Tribunal concluded that it has been demonstrated by this evidence that it is necessary in the interests of his own health and safety that he be detained in hospital for treatment and that appropriate treatment is available.

315. The Tribunal considered that it would be inappropriate to make any recommendation because, in its judgment it is not appropriate to recommend his discharge. It acknowledges that the position for those subject to a "whole life tariff" raises difficult and interesting issues but in view of the judgment now given they do not arise.

His Honour Judge Robert K. Atherton

Dr. Cameron Boyd

Miss Patricia Chadderton

11th December 2013