Northumberland, Tyne and Wear NHS
Strategic Health Authority

# Report to Northumberland, Tyne and Wear Strategic Health Authority of the Independent Inquiry Panel into the Health Care and Treatment of Craig Sexton

**May 2006**

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## THE REASON FOR THE INQUIRY

On the 18th June 2004, Craig Sexton killed his former partner Lynda Lovatt, the mother of his two children. He pleaded guilty to the offence of manslaughter and on 12th February 2006 was sentenced to a hospital order with restrictions under section 37 and section 41 of the Mental Health Act, 1983.

Craig had been referred to the crisis assessment and treatment service (CATS) by his GP on the 17th June 2004 and had been seen by them on the 17th June and twice on the 18th June. The CATS was part of the Newcastle, North Tyneside and Northumberland Mental Health Trust (3Ns). At the time of the incident, Craig Sexton was living in North Tyneside. He had previously lived in South Tyneside with Lynda Lovatt and during that period he received help and treatment from primary care services in South Tyneside.

The inquiry was therefore established by the Northumberland, Tyne and Wear Strategic Health Authority (SHA) under the terms of Health Service Guidance (94)27 - guidance on the discharge of mentally disordered people and their continuing care in the community. This provides for an independent inquiry to be commissioned on behalf of the SHA whenever a crime of murder or manslaughter is committed by a person who has been receiving mental health services.

## THE INQUIRY PANEL

The inquiry panel was appointed in January 2005 and was:

| | |
|---|---|
| David Gray (chair) | Solicitor, Newcastle upon Tyne |
| Elizabeth Lines | General manager, adult mental health services |
| Dr Gerard Roney | Consultant forensic psychiatrist, Yorkshire |

## TERMS OF REFERENCE

Craig Sexton, date of birth 29.7.1973.

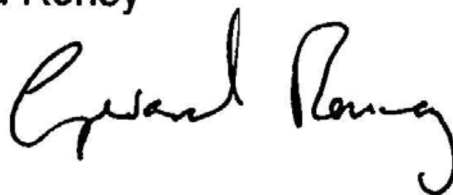
The terms of reference of the inquiry were to examine the circumstances surrounding the health care and treatment of the above patient, in particular:

- The quality and scope of his health care and treatment, in particular the assessment and management of risk.
- The standard of record keeping and communication between all interested parties.
- The extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health and good practice.
- To prepare a report for, and make recommendations to, Northumberland, Tyne and Wear Strategic Health Authority.

David Gray
Chairman

Elizabeth Lines

Dr Gerard Roney



## EXECUTIVE SUMMARY

The death of Lynda Lovatt on 18th June 2004 was a tragedy. It affected many people – particularly her own family and especially her two young children. The inquiry interviewed many people including the families of Lynda Lovatt and Craig Sexton in an attempt to understand the circumstances leading up to Lynda's death.

Craig Sexton admitted the manslaughter of Lynda Lovatt on the grounds of diminished responsibility. The criminal court, before sentencing him, directed that he be assessed by psychiatric services. He was eventually made subject to a hospital order with restrictions.

Everyone who dealt with Craig Sexton and who gave evidence to the inquiry covering the period from his first contact with GP services in South Shields in 2001 until 18th June 2004 – including both families – state categorically that they never perceived of any risk being posed to Lynda. The psychiatrists who assessed Craig Sexton for the Crown Court over a period of over a year also concluded that it would have been difficult to foresee any risk to Lynda or anyone else.

A person can only be detained in hospital against their wishes if they meet the strict criteria set out in the Mental Health Act, 1983. The inquiry concludes that those criteria were not met and therefore there were no grounds to compulsorily detain Craig Sexton in the period immediately prior to his killing Lynda on the 18th June.

Furthermore, the inquiry concludes that at the material times, though Craig Sexton's family may have preferred that he be admitted to hospital, Craig himself did not wish to stay in hospital.

The inquiry considers that with the benefit of all the information that was available at the time, and which has been made available to the inquiry, the decision to proceed with home based treatment was appropriate in the context of the risk involved. The risk was of self harm to a person who was threatening to kill

himself at an unspecified date in the future.

Given these tragic events, the criticism by the families of Craig Sexton's treatment prior to the death in not keeping him in hospital is understandable. The clamour from some sectors of the press is less so. It is to be hoped that on reflection it will be appreciated that decisions to detain people in hospital can only be taken when the evidence justifies it. In the present case, having reviewed that evidence, the inquiry is firmly of the view that it did not.

The inquiry recognises and appreciates the impact that the incident, the criminal proceedings, the internal inquiry and this independent inquiry and associated press coverage has had on the two families and all witnesses.

## A SUMMARY OF RELEVANT DATES AND EVENTS

1. Craig Sexton was born on 27th July 1973 in North Shields, where he lived with his parents and one younger sister. He attended mainstream school, leaving at age 16.

2. After leaving school, Craig Sexton had a number of jobs - mainly in supermarkets. He is reported as finding it difficult to mix with people and in the end found travelling difficult to manage. He last worked in 1996, since when he was in receipt of incapacity benefit.

3. Apart from the current incident, Craig Sexton has no record of criminal activity.

4. In February 1993, Craig Sexton met Lynda Lovatt. Lynda was born on 13th February 1975. She was Craig's first and only serious relationship and they met at her 18th birthday party. They saw each other regularly but initially both lived separately with their respective parents.

5. In 1996, when Lynda Lovatt was pregnant with their first child, Craig Sexton moved in with Lynda and they lived together in their own house in South Shields until February 2004.

6. On 17th May 1997 – a son was born.

7. On 7th June 2000 – a daughter was born.

8. On 22nd November 2001 – his GP noted that Craig Sexton 'complained of panic attacks and was nervous when going out'. Alcohol consumption of 80 units per week was recorded. The GP referred him to the personal advisors service (PAS) - a primary care mental health service - in a letter wrongly addressed to the community mental health team. This identified a

history of chronic anxiety and also referred to his alcohol intake as ‘excessive’.

9. From 28th January 2002, until he was discharged on 20th May 2002, Craig Sexton attended 12 counselling sessions for his ‘anxiety’ with the primary care counselling and cognitive therapy and personal advisors service (PAS) – part of the South Tyneside Primary Care Trust.

10. From May 2002 until September 2002, Craig Sexton visited his GP four times. The GP notes continue to identify ‘panic attacks’

11. During the period 2003 until February 2004, the evidence from Craig Sexton himself, from his family and from Lynda Lovatt’s family suggests that Craig Sexton was not taking his prescribed medication regularly and that he was drinking excessively.

12. On 19th January 2004 – Craig Sexton next visited his GP. The notes record Craig Sexton being ‘still very, very shy– doesn’t go out alone’. The GP recommended a further referral to the personal advisors service, which Craig Sexton agreed to consider.

13. By February 2004, Craig Sexton’s relationship with Lynda Lovatt had deteriorated to the extent that he had been sleeping separately for some time. Lynda Lovatt had asked him to leave and had arranged with the housing department for him to see a new flat in South Tyneside. Lynda Lovatt had moved back to her mother’s with the children.

14. 16th February 2004 – having seen a new flat earlier that day, Craig Sexton returned to the family home. Lynda Lovatt and the children were at her mother’s. Craig Sexton took an overdose of fluoxetine and paracetamol.

15. In the morning on the 17th February, Craig Sexton travelled across to his parents’ in North Shields from where his sister took him to the accident

and emergency department at North Tyneside General Hospital (NTGH). He was examined and underwent a risk assessment and was then discharged. He was advised to see his own GP for further help. A letter was also sent by the self harm co-ordinator/liaison nurse to the doctor who had seen Craig Sexton in accident and emergency (copied to the mental health liaison team at South Tyneside General Hospital and to his South Tyneside GP). This confirmed that the mental health liaison team based at South Tyneside General Hospital had been contacted and had agreed to offer a follow up appointment to Craig Sexton and would be writing to him in due course. This was not followed up by Craig Sexton as his sister contacted the liaison team to say that alternative arrangements were being made. He was seeing his GP.

16. After 17th February, Craig Sexton stayed at his parents' home, collecting his possessions from the house in South Shields over the following few weeks. After several weeks he was given his own flat which was close to his parents' home. He decorated the flat with the help of his family and bought bunk beds to accommodate the children when they visited. Evidence suggests that he stopped his drinking once he moved back to North Shields in February 2004.

17. Craig Sexton saw his GP in South Tyneside on 23rd February when it was agreed to re refer him to the community mental health team (CMHT). The GP wrote to the CMHT – in fact the personal advisors service.

18. Craig Sexton last saw his South Tyneside GP on 22nd March 2004. He reported that he was due to see the community psychiatric nurse and that he was moving to North Shields. It was noted that he was not suicidal.

19. On 14th April – Craig Sexton saw his new GP in North Shields. A new patient assessment was undertaken. It was noted that he appeared 'very nervous' and was seeing a counsellor in South Tyneside.

20. On 20th May 2004 (wrongly recorded as 2nd May) – Craig Sexton was seen by a different GP at the North Shields practice where he was noted as being 'terribly anxious'.

21. Although the South Tyneside GP had referred Craig Sexton for counselling on 23rd February 2004, the counselling service (personal advisors service) did not see him until 25th May 2004. An appointment was sent to Craig Sexton on 4th March for a session on the 25th March. This was cancelled due to 'unforeseen circumstances' – in fact long term staff sickness – by letter to Craig Sexton dated 22nd March. A further appointment for the 25th May was sent to Craig by letter dated 13th April 2004.

22. On 25th May 2004 – a counsellor from the personal advisors service (PAS) saw Craig Sexton. A risk assessment was undertaken. By then Craig had moved to North Shields permanently. He was advised 'to contact his GP in North Shields to access services in that area'. A letter was sent from PAS to the GP dated 26th May 2004 with a copy of the assessment. The letter 'urged' the GP to see Craig Sexton 'very soon'.

23. Craig Sexton saw his North Shields GP again on the 4th and 8th June 2004, when his medication was changed and it was decided to refer him to a counsellor.

24. On 10th June 2004 – the GP wrote to the community psychiatric nurse (CPN), who worked with the practice, for further advice – this was received by the CPN on 14th June.

25. On or about 11th June 2004, Craig Sexton learned from Lynda Lovatt that she had a new boyfriend. Craig Sexton had been keeping a wall chart diary in his bedroom. Craig marked the chart with 'find out truth at last'. He had continued to see the children but had found it difficult to manage them

together when they visited his flat. The wall chart referred – amongst other matters - to contact Craig made with Lynda in June 2004.

26. 12th June 2004 - Craig Sexton saw the children but returned them to Lynda Lovatt earlier than planned at 3.30pm. Craig sent Lynda an unpleasant text indicating he did not want to see her or the children again.

27. 15th June 2004 - Craig Sexton saw a locum GP again when it was noted that there was 'no suicidal ideation'.

28. 17th June 2004 - Craig Sexton's family contacted the GP expressing concern about Craig's deteriorating condition over the last week and his very agitated state. The GP agreed to visit and saw Craig with the family at Craig's flat at 5.30pm. GP contacted the crisis assessment and treatment service (CATS) whilst he was with Craig and CATS agreed to visit.

29. 17th June 2004 at 8pm – two clinicians from the CATS visited Craig Sexton at home. He was assessed and arrangements were made for Craig to stay overnight with his parents and for a further visit from the CATS the following morning, 18th June.

30. Craig Sexton stayed overnight with his parents but returned to his own flat in the morning. Craig's family were concerned about his mental state and his sister telephoned CATS requesting an urgent visit. Two different clinicians, including a nurse consultant, attended from the CATS at 10.15am on 18th June in response to the family's request. Another assessment was made and arrangements made for Craig Sexton to stay at home, be prescribed additional medication and to attend the CATS offices on 22nd June for a series of one-to-one sessions.

31. By 2pm on 18th June 2004, the family were again concerned about Craig Sexton's mental state. An ambulance was called and Craig and his father

went to North Tyneside General Hospital (NTGH) accident and emergency department, where he was seen at 2.35pm. The crisis assessment and treatment service (CATS) was later telephoned by NTGH and agreed to attend. Craig and his father waited in a separate room at NTGH. Two different clinicians from CATS attended NTGH at 7.30pm, spent one hour with Craig and his father and assessed his mental state. It was agreed that Craig Sexton would return home to stay the night at his parents', further medication was taken and arrangements made for the CATS to see Craig again at 9am on 19th June. Craig and his father left NTGH at 8.45pm and walked home to his parents' house.

32. In the evening of the 18th June 2004, Craig Sexton had a meal at his parents' and then returned to his own flat. Craig's father visited him and was told that Craig was going to visit Lynda Lovatt.

33. 18th June 2004 10.10pm – Craig Sexton telephoned Lynda Lovatt to say he was coming across to visit – he believed the children would have made Father's Day cards for him.

34. 18th June 2004 10.20pm – Craig Sexton's father walked with Craig from his home to get the 10.30pm ferry to South Shields. Craig travelled alone on the ferry arriving at South Shields at 10.36pm

35. 18th June 2004 10.45pm - Lynda Lovatt telephoned Craig Sexton's father indicating she did not want Craig to visit. Father telephoned Craig who was then on the bus from the South Shields ferry to Lynda's house.

36. 18th June 2004 11.00pm (approx) – Craig Sexton arrived at Lynda Lovatt's house.

37. 18th June 2004 11.20pm (approx) – Craig Sexton violently killed Lynda Lovatt – the children were unharmed and in bed upstairs.

38. 18th June 2004 11.25pm (approx) – Craig Sexton telephoned his father to say that he has killed Lynda Lovatt.

39. 18th June 2004 11.28pm – Craig Sexton's father telephoned police.

40. 18th June 2004 11.51pm – police attended and arrested Craig Sexton for murder.

41. On 19th June 2004 – Craig Sexton was charged with murder.

42. On 21st December 2004 – Craig Sexton pleaded guilty to a charge of manslaughter on the grounds of diminished responsibility - a plea which was accepted by the prosecution and by the court. The case was adjourned for sentence.

43. Craig Sexton was remanded in custody to Durham Prison from June 2004 until 5th May 2005, spending most of that time on the hospital wing.

44. On 5th May 2005 – Craig Sexton was transferred to a secure hospital for further assessment under section 38 of the Mental Health Act, 1983. He was assessed until 4th October 2005 and then transferred to another unit on 4th October 2005 for further assessment.

45. On 12th February 2006 – after a number of adjournments in order to complete the psychiatric assessments, Craig Sexton was sentenced at Newcastle Crown Court to a hospital order with restrictions under s.37 and s.41 of the Mental Health Act, 1983.

46. The long period of assessment was caused at least in part by the difficulty in coming to a clear conclusion as to the diagnosis and the most appropriate way of dealing with his case.

## THE INQUIRY'S METHODOLOGY AND ACTIVITIES

The inquiry panel first met on 11th February. It met a total of 15 times.

A large amount of background material has been supplied to and considered by the panel. The Newcastle, North Tyneside and Northumberland Mental Health Trust (3Ns) had conducted an internal review and the inquiry had the benefit of that report. It also requested and received background material relating to the work of the crisis assessment and treatment service as well as primary mental health services in South Tyneside. It was able to consider the police file including witness statements and all psychiatric reports prepared for the crown court proceedings as well as all medical records relating to Craig Sexton. The inquiry received the full cooperation of individuals and organisations in supplying any requested material and is grateful for their assistance. All relevant statutory guidance was considered.

The inquiry initially visited the families of both Lynda Lovatt and Craig Sexton at their homes. Craig Sexton was seen at Bede Ward at St Nicolas Hospital, Newcastle upon Tyne at a time when he was on assessment from the Crown Court prior to sentence. He was seen with the consent of his consultant who was also seen separately on the same day. All other witnesses were seen at the offices of the strategic health authority.

All witnesses were given the opportunity to discuss the inquiry and its procedures in advance with the inquiry's co-ordinator. With the exception of the interviews with Craig Sexton, his consultant, Craig Sexton's family and Lynda Lovatt's family, all interviews were recorded and transcribed. All witnesses were given a copy of the record of interview and invited to make any 'corrections' or additional statement.

The inquiry tried to see witnesses chronologically as far as the relevant events were concerned. It first saw the administrators, clinicians and GP from South Tyneside who had been involved with Craig Sexton in the period from November

2001 until 25th May 2004. The inquiry then interviewed relevant members of the crisis assessment and treatment service and the North Shields GP who had involvement with Craig after he returned to North Shields in February 2004.

The inquiry appreciated the cooperation of all witnesses in what must have been a difficult personal situation particularly for those who had been involved with Craig Sexton shortly before the incident. The inquiry assumes that all evidence received by the inquiry, whether written or oral, was based on full and frank disclosure

The inquiry met on a number of separate occasions to review and consider evidence and to formulate its conclusions.

The inquiry records its thanks and appreciation to the inquiry co-ordinator, Mrs Catherine Weightman. Her assistance to the members of the inquiry throughout was invaluable and her facilitating role with the witnesses in particular was extremely helpful.

## PROVISION AND DELIVERY OF RELEVANT MENTAL HEALTH SERVICES IN SOUTH TYNESIDE

The inquiry thought it important to give a brief overview of relevant primary care mental health services in South Tyneside. Secondary services are not described as Craig Sexton was never referred to them whilst living in South Tyneside.

Primary care mental health services are administered by the South Tyneside Primary Care Trust. Delivery is primarily through GPs and other health care professionals attached to GPs' practices.

It includes personal advisors from social work, nursing and counselling backgrounds, graduate workers and psychologists and counsellors working through the personal advisors service (PAS). The personal advisors are aligned to GP practices, although until early 2005 there were insufficient personal advisors and therefore referrals from some GPs came to a central referral pool.

The core business of the PAS team is to:

- Ensure holistic assessments of individuals presenting with mental distress
- To provide counselling or other therapeutic interventions.
- To ensure that individuals are able to access other advice, support and interventions that are outside their role, remit or experience - including if appropriate to a drug and alcohol service.
- To maintain links between primary and secondary care.
- To be a full member of the primary care service.
- To prepare and maintain mental health skills audit, skills gap analysis and training needs analysis for each GP practice.
- To facilitate education and training within the GP practice to meet identified training needs.
- To facilitate user/carer input in the development of good practice.
- To promote awareness of mental health issues with all members of the primary care teams and make links with health promotion.

- To participate with other agencies in the care of people with severe mental disorders and facilitate their engagement with primary care as necessary.
- To assist in the management of people with common mental health problems in crisis.

The accident and emergency mental health liaison team offer a direct service to anyone attending accident and emergency with mental health difficulties and a point of access for anyone experiencing a mental health crisis.

The drug and alcohol team provides a team of specialist workers dealing with some aspects of drug and alcohol problems within the South Tyneside area. They deal with aspects of the reduction of the hard drugs like heroin and help with withdrawal of alcohol when required. They also advise the community mental health teams and other service providers with their specialist knowledge. Referrals are directly to the team or by another health service professional.

## PROVISION AND DELIVERY OF RELEVANT MENTAL HEATH SERVICES IN NORTH TYNESIDE

The inquiry thought it would be helpful to describe the relevant health services in North Tyneside that Craig Sexton came into contact with or was considered for referral to.

### Primary care mental health services

Primary care services are provided by GPs and other health professionals attached to their practice. For mental health services these are likely to be community psychiatric nurses (CPN), psychologists, occupational therapists and counsellors. GPs are also able to access and refer to other statutory, private and not for profit agencies such as drug and alcohol services. For people with severe and enduring mental health problems or those presenting in a crisis, GPs can refer straight to secondary mental health services including specialist services.

**Secondary care mental health services**

North Tyneside is one of three localities within the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust (3Ns) which provides secondary mental health services including:

- **The crisis assessment and treatment service**

The crisis assessment and treatment service (CATS) for Newcastle and North Tyneside was established in 2000, with part funding through Health Action Zone money through the health improvement programme allowing for the modernisation of mental health services within Newcastle and North Tyneside.

The CATS mission statement is that people experiencing an acute psychiatric crisis receive the least restrictive and most appropriate assessment and treatment services. Such people will be presenting with significant risk of self harm or harm to others. Inpatient admission will be being considered and the person will need to be seen within the next 24 hours. The service therefore has a gate keeping role for all acute psychiatric services in the area. This is managed by a 'triage' process whereby potential patients are referred to the service and an initial assessment is made as to their suitability for home based treatment. It is important therefore that referrers are made aware of the CATS criteria. Once accepted by the CATS a patient can expect access to CATS 24 hours a day, seven days a week to cover the crisis period. CATS seek to actively involve the patient and their carers in assessment and treatment planning. CATS treatment and interventions will normally last up to six weeks

- **The deliberate self harm team**

The team offers a liaison service, assessment and follow-up for people who have self-harmed. Assessments are carried out within North Tyneside General Hospital accident and emergency department.

Following the assessment, short term intervention may be offered in specific cases or a referral back to primary care. For those requiring prolonged

intervention the person is signposted to the most appropriate service

- **Acute inpatient services**

Any hospital admission would have been to North Tyneside General Hospital, where ward 21 is the principal acute psychiatric inpatient facility. It is a mixed gender 29 bedded ward, which at the relevant time had 17 mixed plus 12 exclusively female beds. Due to the development of the crisis assessment and treatment service, admission rates to ward 21 had fallen but the level of dependency for each patient had risen.

## THE EVIDENCE REVIEWED

This section of the report describes four time periods:

- The period to November 2001.
- The period from November 2001 to early 2004.
- The period from early 2004 up until June 2004.
- The period immediately leading up to the death of Lynda Lovatt.

Each historical section will be described from three perspectives:

A. The factual evidence from contemporaneous records.
B. Evidence pertaining to each time period given at interviews held by the inquiry.
C. A commentary on each time period.

## THE PERIOD TO NOVEMBER 2001

### A Factual information for the period to November 2001

The only documentary information during this period is Craig Sexton's general practice and health service records. There is no evidence of him being involved in previous offending.

Craig Sexton was born on 29th July 1973 in North Shields. His general practice records date from the time of his birth and he first had a recorded contact on 28th September 1973. Throughout his childhood he had predictable, unremarkable contacts with his GP.

In February of 1999 he registered with a new GP in South Tyneside. An initial patient medical recorded that he was consuming four units of alcohol although the frequency of this consumption was not stated.

## B Interview evidence for the period to November 2001

The inquiry team interviewed the families of both Lynda Lovatt and Craig Sexton. These interviews provided a perspective on Craig Sexton's background and functioning.

Craig Sexton's family described him as a healthy child who had a normal childhood. He was said to be a "happy young lad, quiet but happy". He attended normal schooling. The family reported that they became aware that he became a nervous person as a teenager. The family felt that they were conscious of his nervousness but did not believe that other people would be aware of this. In particular he found dealing with people outside the family difficult. Despite his nervousness this was not considered such a problem that external help was thought to be required.

There is no history of behavioural disturbance at school or substance abuse at that time. He enjoyed playing snooker and participated in athletics at school.

His relationship with Lynda Lovatt began when he was nineteen in February 1993. They became engaged early in their relationship. In 1996 Lynda Lovatt fell pregnant and six months into the pregnancy they began living together in a house in South Shields. Their first child, a son, was born on 17th May 1997. Within a week of the baby's birth he required surgery. Craig Sexton's family reported that Craig found this very hard to deal with. He is said to have lost two stone in weight at this time. He felt unable to cope with his son's illness at a few weeks of age especially when this necessitated surgery.

Craig Sexton's family described a pattern of increasingly limited socialisation by Craig and Lynda. Lynda would rarely visit Craig's parents' home.

Historically, Lynda Lovatt's family perceived Craig Sexton as a quiet, friendly and pleasant man. Following the birth of their second child, a daughter, in June 2000

Lynda Lovatt's family were conscious that the couple did not go out much but given their financial circumstances they did not perceive this as unusual.

At interview Craig Sexton gave an account of his difficulties. He reported that he had always had problems coping with people other than those he knew. He was relaxed with his family and with Lynda and the children but knew few people outside the immediate family. He reported that he had first gone to his doctor in South Shields when he had started a training scheme and could not cope being in a room with a lot of other people. This is in contrast to the view expressed by Lynda Lovatt's family who felt that he had originally stopped working in an attempt to manipulate the welfare system by pretending to be depressed.

Craig Sexton's employment history provides some information on his functioning in relation to other parties. He originally started working in North Shields on a YTS scheme. This lasted a few months only. Craig had a minor disagreement with a more senior member of staff and he was too upset to return there. His mother completed an application form for him to work in Safeway in North Shields and he started working there on the delicatessen counter before becoming a trainee manager. On his first day his mother had visited him at work and found him to be very nervous. He was subsequently transferred to a branch in South Shields and then to Gateshead. He coped satisfactorily with these changes but when the Gateshead shop closed and he was offered a post at the branch on the outskirts of Newcastle he felt unable to cope with the journey. He refused the job, stopping working in 1996. He did not work between 1996 and 2001 when he saw his GP with anxiety symptoms. This appears to have been precipitated by his inability to cope with the training scheme.

### C Commentary on the period to November 2001

The inquiry considers that there were no significant pre-morbid indicators of problems that his family or the health service were aware of or should have been aware of in the period leading up to November 2001. He presented as an anxious man in social situations who appears to have focused his life upon his

partner and family. It appears that the level of his anxiety was such as to impair many aspects of his functioning. It had been present for a long time - certainly since his teenage years. It led to difficulties in socialising and coping with change and resulted in limited relationship formation such that he made no relationships outwith his family.

## THE PERIOD FROM NOVEMBER 2001 TO EARLY 2004

### A Factual information for the period from November 2001 to early 2004

Craig Sexton's general practice records reveal that between March 1999 and November 2001 he had no contact with his GP. On 23rd November 2001 he attended his GP (ST1) complaining of panic attacks. Craig stated he felt nervous when going out and had attended for a sick note. He said this had gone on for six months. At this assessment he gave a history of drinking eighty units of alcohol per week. He was prescribed the beta blocker Propanolol and referred for counselling. His GP then wrote to the personal advisors service (PAS1) on 23rd November 2001 referring his history of anxiety. His GP (ST1) informed the personal advisors service (PAS1) that he had advised Craig to reduce his alcohol intake which 'recently has become excessive'. The GP stated 'I wonder if you could discuss any management techniques with him and I would be most grateful for your advice'.

An initial assessment was undertaken by the personal advisors service on 28th January 2002. He was offered a twelve session course of counselling which started on 4th February and finished on 20th May 2002. PAS1 wrote to the GP (ST1) on 11th February to confirm that Craig had attended his first appointment with a student counsellor and the 'presenting issue that we have agreed to work with is anxiety'. Throughout this period of counselling he continued to attend his GP. On 12th February 2002, he reported continued panic attacks and anxiety. On 14th March 2002 he reported that he was anxious and he was prescribed a beta blocker Propanolol. On 26th April 2002 he reported that he was not going

out much and that he had continued panic attacks. It was noted that he “benefits from counselling but anxious ++”. Craig was stated to suffer from an anxiety state with panic attacks. He had his final counselling session on 20th May 2002. On 13th June 2002 he attended his GP again reporting continued panic attacks. It was recorded ‘counselling finished but no better – does nothing’. The antidepressant Fluoxetine was added. He attended his GP on three further occasions in 2002. On 11th July he reported continued panic attacks but he was ‘a little better’. He was doing more around the house. On 12th September 2002 he again reported panic attacks but stated he was ‘a little more active’. It was reported ‘encouraged to look for suitable job’. He did not attend his GP again until 19th January 2004, although his GP completed an IB113 in respect of his ongoing entitlement to incapacity benefit on 23rd September 2003.

The inquiry had access to the personal advisors service records of counselling. Craig saw a student counsellor (PAS2). It was said there had been much improvement at the end of his period of counselling. On 23rd May 2002, PAS1 wrote to Craig’s GP (ST1) confirming that Craig had completed their counselling sessions, that a client-centred approach had been used to help him cope with the depression, anxiety and grief he has been experiencing. The letter stated that there had been much improvement and that Craig had been discharged from the personal advisors service.

### B Interview evidence for the period from November 2001 to early 2004

This section is based upon interviews with Craig Sexton’s and Lynda Lovatt’s families, an interview with Craig Sexton and an interview with one of his GPs (ST2). We were unable to meet with the personal advisors service practitioner involved in providing counselling in early 2002.

Craig Sexton’s family was conscious that he had remained a nervous person and had been referred for and received counselling as well as having received a prescription for medication. At that time they knew that he was suffering from panic attacks when he would sweat and shake. In particular this was likely to

occur when dealing with other parties such as appointments with doctors or dentists or job interviews. They were aware that he would drink alcohol to calm himself down. He had told his father that he had to drink alcohol in order to leave the house and mow the lawn as he was anxious that a neighbour might speak to him. The family was conscious that he would drink in the morning and had been in this habit from 2001. He gained weight as a result. The family had joked that he may be becoming an alcoholic. The family appeared to describe the development of a physical tolerance for alcohol.

Lynda Lovatt's family reported their perception that Craig Sexton had initially attended his doctor to avoid returning to work. They were aware that he had been prescribed medication for depression and that he had seen a counsellor. They reported their belief that he did not take his medication. They reported that the tablets he had not taken were still in Lynda's house after her death. Lynda Lovatt's family described Craig Sexton in the period following 2001/2002 when he was first prescribed medication by his doctor and saw a counsellor. They said that he spent most of his time at home when he would watch television, play his Playstation or play snooker on a small snooker table. They commented that although still devoted to the children he became very possessive of Lynda and very demanding of her attention. He would call her on her mobile phone when she was out shopping. They quoted an example of his phoning Lynda Lovatt asking her to return home to make him a sandwich. He demanded that Lynda Lovatt provide him with all the bills of any shopping she had bought and he was critical of her, for example when she bought magazines or sandwiches. They felt he put her down if she made an effort to dress up when they went out as though he did not want her to look too attractive. They reported that during this time CS and LL began to have arguments and they would fall out and not speak. They were conscious that he began drinking at home and he would ask Lynda to buy alcohol for him from the supermarket. They described him drinking six to eight cans of lager "at a go". They described Craig becoming moodier when he drank.

They were aware of Lynda's increasing unhappiness in the relationship in the year leading up to Lynda's death. Lynda Lovatt's family was aware that she had

considered leaving Craig in the Autumn of 2003. At that time she had reported that they were no longer sleeping together and that Craig Sexton had had to buy a camp bed for himself.

**C Commentary on the period from November 2001 to early 2004**

During this time period Craig Sexton's anxiety symptoms became more evident and disabling. Alcohol abuse became a problem. The inquiry considers that his GP (ST1) did not act inappropriately in November 2001 in making a referral to the personal advisors service (PAS). He was aware of the PAS and set out clearly his concerns in the letter dated 23rd November 2001. He specifically referred to the excessive drinking. GP (ST1) equally however could have reasonably referred Craig Sexton to a substance misuse service.

The inquiry does, however, note that GP (ST1) made no follow up to his request for 'advice and support' from PAS, particularly when it was clear from correspondence from PAS in the letters dated 11th February 2002 and 23rd May 2002 that the problem of excessive drinking was apparently not being addressed by them. There is no evidence from general practice records that GP (ST1) made any follow up re the alcohol abuse which had so concerned him in November 2001 despite the fact that Craig Sexton - from his own evidence to the inquiry and that from his family and Lynda Lovatt's family - was clearly continuing to drink excessively. This was a lost opportunity and a significant failure by the GP (ST1) – particularly in view of the frequent contact he was having with Craig Sexton during this period of counselling from the personal advisors service.

The personal advisors service (PAS) provided client centered therapy and a course of counselling sessions over a period of four months. The letter of instruction from GP (ST1) – 23rd November 2001 - clearly identified 'excessive drinking' and sought 'advice and support'. There is no evidence that PAS had considered this at all. To the contrary, there is positively no mention of alcohol in any of the counselling session notes or in correspondence to the GP. If PAS were not equipped to assess this problem then they were in the inquiry's view

obliged to refer to an agency that could – such was the extent of the drinking at that time. Alcohol and substance abuse services are present in South Tyneside and could have been contacted. The failure to do so or even to refer back to the GP was again a fundamental failure of assessment.

In the inquiry's view, the alcohol misuse was of such fundamental significance to Craig Sexton's behaviour and mental state that the failure to address it meant that it was highly unlikely that any particular intervention was likely to be effective, as the element of alcohol abuse contributing to his problem was not in the minds of anyone providing assessment and treatment.

The inquiry also doubts whether the client centred approach was the most appropriate treatment for Craig Sexton at that time. The *National Service Framework for Mental Health* (Department of Health, 1999) and *Treatment Choices for Psychological Therapies* (Department of Health, 2001) provide useful guidance. The referral from GP (ST1) clearly identified problems of chronic anxiety and alcohol misuse.

For depression, recommended treatment is 'by structured psychological therapies, such as cognitive behaviour therapy..' It notes that 'However, non directive counselling is less effective'.

For anxiety disorders it is noted that 'panic disorders respond to both cognitive behavioural and antidepressant medication with more sustained recovery following psychological treatment. Simple phobias respond best to exposure treatments. Cognitive behavioural therapy is also indicated for social phobia and generalised anxiety disorder.'

It is also noted under 'anxiety disorders' that 'anxiety can mask an underlying depression, and may have a physical cause, such as alcohol or substance misuse.'
It is the inquiry's view that given the presenting symptoms in November 2001 the most appropriate treatment which was likely to have the best long terms benefits

would have been a cognitive behaviour approach. This was not undertaken by the personal advisors service and again this was a lost opportunity.

The inquiry noted that the records of the counselling sessions were limited and vague. Craig Sexton's continuing contact with his GP during the period of counselling concerning his ongoing anxiety and panic attacks confirms the Inquiry's view that the sessions were of extremely limited benefit.

## THE PERIOD FROM EARLY 2004 TO JUNE 2004

### A Factual information for period from early 2004 to June 2004

Craig Sexton did not attend his GP in South Tyneside between September 2002 and 19th January 2004. On 19th January 2004 he reported continued problems with anxiety which restricted his capacity to socialise. It was noted 'still v.v.shy – doesn't go out of home' His GP (ST2) suggested a re-referral to the personal advisors service at his attendance on 19th January 2004 and Craig agreed to consider this.

Medical records from North Tyneside General Hospital indicate that Craig attended accident and emergency on the morning of 17th February 2004 at 9am, reporting that he had taken an overdose of Fluoxetine and Paracetamol the previous day. He was assessed and on medical advice was discharged home 'in good condition' and advised to see his own GP for further help. It is recorded that he had a "moderate BECKS score". There were no physical needs identified at this time. On 18th February 2004 the self harm and liaison psychiatry team at North Tyneside General Hospital wrote to the mental health liaison team based in South Tyneside to confirm that the South Tyneside team would send Craig a follow up appointment, having alerted them to the fact that he had taken an overdose. A copy letter was also sent to Craig's GP (ST2).

On 23$^{rd}$ February 2004, Craig returned to his GP (ST2) reporting that Lynda Lovatt had thrown him out. He was looking for a flat. He reported that he had taken an overdose of Fluoxetine and Paracetamol the previous week. His general practitioner referred Craig back to the personal advisors service (PAS). Craig Sexton was not seen by the PAS until 25$^{th}$ May 2004. Correspondence confirmed that an initial appointment had been sent by PAS to Craig Sexton on 4$^{th}$ March 2004, with an appointment for 25$^{th}$ March. This appointment was accepted by Craig on 10$^{th}$ March. On 22$^{nd}$ March, the appointment was cancelled due to 'unforeseen circumstances' and on 2$^{nd}$ April, PAS wrote to GP (ST2) cancelling all counselling for the time being due to 'long term sick leave'. On 13$^{th}$ April a new appointment was sent to Craig Sexton for 25$^{th}$ May.

Craig saw GP (ST2) on 22$^{nd}$ March 2004, when he reported that he was moving to North Shields. It was noted that he was not suicidal and that he was due to see the counsellor that week. This referred to the original appointment for the 25$^{th}$ March which was cancelled by the letter sent on 22$^{nd}$ March and which by then he had not received

On 14$^{th}$ April 2004, now living in North Shields, Craig Sexton had a new patient medical in his new North Shields general practice. His GP (NT3) noted the history of a recent relationship breakdown and overdose. It was noted that he appeared very nervous, was not sleeping well and his appetite was poor. He had previously seen a counsellor in South Shields and was still awaiting a new follow up appointment there.

He was reviewed by GPNT4 (another doctor in the practice) on 20$^{th}$ May 2004 (wrongly recorded in the medical notes as 2$^{nd}$ May) when his antidepressant was changed from Fluoxetine to Paroxetine.

On 25$^{th}$ May 2004, Craig Sexton was seen by the personal advisors service (PAS) in South Shields. At this assessment various assessment documents were used. Included was a therapy assessment form. The inquiry notes that this document was not completed fully. On 26$^{th}$ May 2004, a letter was sent from the

personal advisors service in South Tyneside to Craig Sexton's new GP (NT3) in North Tyneside. It was noted that he had moved from South Shields to North Shields and was registered with the new GP and in view of the fact that he was now living outside their area PAS could no longer help. The letter said that Craig Sexton was extremely anxious and unable to sit still throughout the whole session, unable to stay talking on one subject and constantly pulling at his clothes and stretching his arms out. He had previously taken an overdose but had no intention of repeating it. He was said to be very upset by the end of his relationship with Lynda. GP (NT3) was urged to arrange to see Craig Sexton 'very soon'.

Craig Sexton was seen in his general practice on three occasions in early June 2004.

On 4th June, it is recorded by GP (NT3) that Craig Sexton had been more agitated in the previous two weeks and had not been sleeping. He appeared restless. It was questioned whether this was a reaction to Paroxetine and his antidepressant was changed to Citalopram. It was noted that he would require a referral to a counsellor. He was to be reviewed four days later.

On 8th June 2004, Craig reported to GP (NT3) that he was feeling a little more relaxed now but he was still not sleeping much. His appetite was poor. This time there was a positive reference to referring him to a counsellor and Citalopram was continued.

On 10th June 2004, a referral was made by GP (NT3) by letter to a community mental health worker (a community psychiatric nurse) attached to the same practice, seeking further advice on the management of Craig - 'I should be most grateful for your further advice regarding this young man, there is some information in his records from South Shields which you might find of further help'. In view of later developments there was no specific response by the community psychiatric nurse to that letter.

On 15th June 2004, Craig Sexton returned to surgery when he was seen by a locum GP. It was noted that although he appeared restless and agitated he stated he was much calmer and coping better. Craig reported that he was feeling ‘on an even keel’. There was no suicidal ideation. It was noted that he now had his own flat. The case notes stated ‘awaiting counselling’ which appeared to be a reference to help requested by GP (NT3) from the community psychiatric nurse. Craig reported that he felt more agitated on having to visit his GP.

**B Interview evidence for the period from early 2004 to June 2004**

Craig Sexton’s family only became aware of problems between Craig and Lynda on 13th February 2004. This was Lynda Lovatt’s birthday and Craig Sexton’s mother had telephoned with the intention of informing them that they had sent birthday cards. Craig Sexton informed his mother at that time that Lynda had left him and was at her mother’s house. At the same time, he reported that he had been sleeping downstairs and that Lynda Lovatt had wanted him to move out of the house. They recalled that on 16th February 2004 he went to see a flat. On 16th February 2004 he took an overdose of Paracetamol and antidepressants. He reported this on 17th February when he visited his parents’ home. His sister took him to hospital in North Shields where they remained for three hours. His sister recalls that he reported that he had wanted to die because of the separation but had then appreciated how silly he had been and had realised that he wanted to live for his children. His family recalled receiving an appointment letter from a South Shields hospital after his contact in North Shields. This letter was in response to an accident and emergency assessment which had been carried out when he had presented having taken the overdose. The North Shields hospital had reported this episode of deliberate self harm to the South Shields hospital who in response had offered the appointment. As Craig Sexton was by that time planning to move to North Shields and had already seen his GP (ST2) the appointment was cancelled by the family. He reassured his family that he would not take an overdose again. The family concentrated on helping him plan for the future and to accept that Lynda did not want him. To this end they

supported his move to North Shields. Craig Sexton lived with his parents in North Shields for several weeks before he was allocated a council flat which they then all helped clean and decorate in preparation for the children visiting. Craig and his father drove to South Shields several times to collect his belongings.

The family was aware that during this period Craig Sexton stopped drinking. They commented that he was in a world of his own and he would frequently walk for miles during the day and at night. They noted he was not communicating. He was eating well but not gaining weight. They noted poor concentration and he reported poor sleep. They recalled his breaking down in tears while talking of missing his children. At the same time they recalled that whilst decorating the flat with his family he was able to laugh between periods of distress. The family thought that he had accepted the situation and was planning for the future and having contact with his children.

He invited Lynda to come and see the flat. Craig Sexton's family recalled that Lynda Lovatt brought the children over one Saturday and stayed a few hours before leaving Craig Sexton with the children overnight. They believe that Craig Sexton found it hard to cope with both children and only had them both to stay once. Subsequently he had his daughter stay with him on his own. On the next occasion that both the children came to stay overnight – 11th June - he could not cope and he took them back early.

Lynda Lovatt's family was aware of Lynda's increasing dissatisfaction with the relationship. Lynda's mother said that in the autumn of 2003 Lynda had told her that she was intending to finish with Craig. She also said that in the year before their ultimate separation Lynda Lovatt had gone to see a counsellor. She had been feeling as though life was passing her by and was conscious of her limited social life. She had had an evening out with Craig Sexton and they had nothing to say to each other and they had come home early. Her mother said that Lynda Lovatt felt tied down with Craig at home. On her visits to her mother's house she would appear reluctant to return to her own home. In the autumn of 2003 when telling her mother that she had decided to finish with Craig she had stated that

she was “not having him in her bed” and CS had gone out and bought himself a camp bed. All sexual contact had apparently ceased. Lynda Lovatt had told her mother that she had told Craig that she wanted to finish with him but he would not move out of the house. On the day that they finally separated Lynda Lovatt’s mother reported that she had been out shopping with Lynda. Lynda had returned home to find Craig Sexton drinking and “in one of his moods”. Lynda had gone out to collect the children but on return Craig Sexton was “shouting and balling, and terrifying the children”. Lynda Lovatt told her mother that Craig had threatened her in the kitchen, telling her to “go back to her fucking mother”. Lynda Lovatt telephoned her mother and said she was on her way round. She visited Craig Sexton the following day to collect belongings when he asked her to return and she refused. She went to a solicitor to arrange his access to the children. She also went to the local council to arrange for accommodation for Craig Sexton to move into. Lynda Lovatt’s family were aware that after visiting one flat he had taken an overdose.

During the period of separation, Lynda Lovatt’s family had observed Craig Sexton and some of his visits to the children in South Shields. On such occasions he was included in the family dinner but eventually Craig Sexton began to “get at her” and be “nasty” to her such that Lynda Lovatt stopped cooking for him. They felt that Lynda was clear in her mind that the relationship was over but Craig would not accept that it was over. Lynda Lovatt’s family said that the separation had been as amicable as possible. At no time did they ever think there was a risk to Lynda or the children.

The inquiry team interviewed GP (ST2) in relation to Craig Sexton’s contact with primary care in January and February of 2004. She confirmed that he had deteriorated following the break up of his relationship with Lynda Lovatt. It was felt that his problems remained primarily anxiety based. His GP confirmed that she would have had access to secondary mental health services and a psychiatric assessment if it had been felt necessary. It appears that a positive decision was made that re-referral back to the personal advisors services was appropriate. He was not thought to be suffering from a severe depression at this

time. His use of alcohol was not explored and GP (ST2) said that she did not think it was a problem. His GP was aware that it may take a couple of months for Craig to be seen by the personal advisors service. His GP confirmed that they had good contacts with the personal advisors services and secondary mental health services.

The inquiry also interviewed staff from the personal advisors service, including senior members of staff and clinicians directly involved with Craig Sexton.

PAS1 described structures in place to ensure appropriate supervision of students. She confirmed that PAS3 was perceived as a competent student. PAS1 described the process by which Craig Sexton's re-referral would have been considered. It was allocated to a member of staff who subsequently went off sick. It was confirmed that a letter was sent to Craig Sexton cancelling the initial appointment and that when the sickness absence was understood to be long term the personal advisors service wrote to GP practice managers to inform them of the clinic cancellations. There was a process in place to reallocate the referral to a rotating screening clinic. The referral was not put back into the rotating screening clinic until mid April because it was felt that the member of staff might return to work. Once they went back into the rotating screening clinic these appointments were prioritised. It was confirmed that major psychiatric disorders where there was a risk of suicide, harm to others/self or neglect would have prompted a referral to a community mental health team and that such a person could be seen on the same day.

When eventually seen in the personal advisors service, Craig Sexton's initial assessment was carried out by PAS3. She was a social work student who at the time was coming to the end of her placement with the personal advisors service. She confirmed that her initial training had taken the form of observing other practitioners before carrying out joint assessments and then carrying out assessments on her own. PAS3 recalled her contact with Craig Sexton. He was very agitated in his manner. He was constantly stretching and pulling at his clothes. He talked about the end of his relationship and his lack of understanding

of why the relationship had ended. Craig Sexton informed her that he had moved to North Tyneside. PAS3 sought supervision with PAS4 and another colleague who supported her in her decision to refer him back to his GP in North Shields. Risk assessment included a CORE assessment. PAS3 confirmed that she explored the risk of suicide with Craig Sexton and that he had responded that he would not act in this way as he loved his children too much. PAS3 accepted at interview that she had not completed the therapy assessment form fully.

**C Commentary on the period from early 2004 to June 2004**

In the wake of the separation from Lynda Lovatt, Craig Sexton's mental state deteriorated. This appears to have been a fluctuating picture. At times he would present and report some improvement. Professionals involved in his care understood his deterioration in the context of the separation from Lynda Lovatt.

The inquiry considers that the decision by GP (ST2) to refer Craig Sexton to the personal advisors services again was an appropriate response. On this occasion, Craig Sexton was presenting with problems associated with the ending of a relationship. This re-referral was timely.

It is clear however that there was a prolonged wait before he was actually seen by the personal advisors service. Even if the original appointment had been kept – for 25th March – this was over a month and the inquiry consider that in view of the recent overdose GP (ST2) should reasonably have arranged to see Craig initially every week or at least two weeks – particularly as she had anticipated a wait of a couple of months before he would be seen by a counsellor. In fact, GP (ST2) did not see Craig Sexton until one month later.

As far as the personal advisors service (PAS) is concerned, the inquiry notes that staff levels since the incident have improved so that more counsellors are now linked to specific GP practices. At the time measures were in place to deal with emergency situations and in view of inevitable staff absences the personal

advisors service could not be criticised for a delay of three months before the initial appointment. During this time frame, Craig Sexton also moved from South to North Shields and registered with a new GP who did not have the benefit of the existing working relationship that GP (ST2) had with PAS.

The inquiry accepts that the decision by PAS to not offer intervention in South Shields was appropriate given his move to the North Shields area. It accepts the evidence from PAS witnesses that Craig Sexton's move to North Shields outside the PAS area was not the sole reason for declining to help. Had there been other factors present – such as an existing relationship with a particular counsellor, a particular wish from the client to stay with PAS or had there been a real acute emergency situation - then PAS could continue to help even though the client has moved out of the area. None of those considerations applied in the present case. Craig Sexton was happy having by then moved permanently to North Shields to liaise with his new GP and practice counsellor, he expressed no wish to stay with PAS and was not considered a current risk to himself or others and he had no desire to travel to South Shields for counselling.

There is, however, no policy in place to manage the transition of patients between adjacent primary care trusts. This should be reviewed. The personal advisors service chose to communicate with Craig Sexton's new GP by means of a dictated letter. The inquiry considers that this introduces an unnecessary delay in communicating information about a distressed patient who was thought to require interventions. It accepts that PAS appropriately considered that there was no imminent risk but the tone of the letter to the GP clearly indicates some concern and need for 'urgent' intervention. A simple telephone call to his new GP would have been more appropriate and more effective in ensuring prompt attention and appropriate referral to a community psychiatric nurse.

The inquiry again notes that neither the personal advisors service (PAS) nor his GP (ST2) at this time further explored his alcohol abuse. This is despite the fact that it was recorded by GP (ST1) previously that Craig had been using alcohol problematically. Following the initial record of alcohol misuse (80 units) there

was no system in place either to review that record or routinely review a patient's alcohol consumption. In either case the initial failure to follow up the alcohol problem was compounded by subsequent inactivity. It was overlooked, ignored or simply thought to be insignificant – all of which are unacceptable.
Similarly there is no evidence from the records that the PAS even considered enquiring about alcohol use. The assessment form was poorly completed and, whilst there is no specific reference to alcohol or substance use, the 'box' for addictions was not completed. This indicated a regrettable failure on the part of PAS to appreciate the significance of alcohol abuse in a patient's assessment.

When Craig Sexton was seen by the personal advisors service he was assessed by a trainee counsellor – PAS3. Her decisions that day were made after discussion with supervisors who were available to her. It has been noted that the original therapy assessment form was not fully completed. This raises general questions about the level of supervision offered to this trainee at that time. Although it was said that she was at the end of her placement with PAS it was clear that she had limited experience of interviewing and assessing clients by herself. A greater degree of supervision and checking the completion of documentation was to be expected.

## THE PERIOD LEADING UP TO LYNDA LOVATT'S DEATH – 17TH AND 18TH JUNE

### A Factual information for the period 17th and 18th June

The inquiry had access to police evidence and witness statements taken in connection with the criminal proceedings against Craig Sexton. It was established that Craig had sent a number of text messages to Lynda following the separation in February and in particular in the period immediately prior to her death.

One text message was considered important and witnesses were asked about it. It was sent on 12th June 2004. It said;

'I don't want to see u or your fuckin kids again your a fuckin slut burn in hell'

It was also apparent that Craig Sexton kept a wall chart in his bedroom. It was a in the form of a calendar with the days of the month crossed off and various handwritten observations noted. In interview Craig stated that the chart was kept mainly to mark off the days he had managed to not see the children. It also recorded telephone conversations to and from Lynda as well as visits to and with the children and Lynda.

Important notations were as follows:

| | |
|---|---|
| Friday 4th | I ring Lynda asking if she has got someone (she is hesitant saying she would not tell me even if she did. I ask to see the kids on sat – she says no but says I can come over on Sunday |
| Sunday 6th | Take kids to Morpeth (get tea Fish and Chips) |
| Friday 11th | rings in morning saying going to Metro centre . she hangs up<br>Rings back 20 mins later – I FIND OUT TRUTH AT LAST |
| Sat 12th | take kids back 3.30 (give albums back)<br>Text – I never want to c u or your fucking kids ever again you fucking slut burn in hell |

There were other random remarks noted on the chart:

'What's the fucking point of all this bullshit you loser'
'The worst mother bar none'
'Lazy bastard'
'Money grabbing bitch'
'She's a liar and a slut'
'Never said sorry'
'Doesn't care what happens to the mother of her kids'

'I can't ever go back over'
'Don't give up this time coward'

GP (NT4) who visited Craig Sexton at home on 17th June stated that he did not go into the bedroom and did not see this chart. All of the four crisis assessment and treatment service (CATS) clinicians who visited Craig in his flat stated that they did not see it and did not go into Craig's bedroom. Craig Sexton's family who did see Craig in his bedroom confirmed to the inquiry that they were aware of the chart and its contents and the text that Craig had sent Lynda, but they had not mentioned it to the GP nor to the CATS.

On 17th June 2004, GP (NT4) telephoned the CATS at 5.45 pm. He spoke with the triage nurse, CAT1. She noted that Craig Sexton had broken up with his partner in February of 2004 and that he had been treated with antidepressants. In the preceding two or three days he had deteriorated although the exact precipitant to the deterioration was not known at that time. He was agitated and depressed (with a full range of symptoms/markers) he was suicidal. It was reported that Craig had written notes but he was unwilling to elaborate on any plans. Craig's parents were very concerned and would wait in the house with him. It was agreed that an urgent assessment would be carried out by the CATS before 10.00 pm.

At 8.00 pm, two CATS clinicians attended Craig Sexton. He was assessed in his home by CAT2 and CAT3. Craig Sexton's father was present. A summary of the assessment was made using standard documentation. A FACE risk profile was completed. It is recorded that Craig Sexton spoke of the idea of killing himself and he felt this way because he had lost everything including his children and partner. He had discovered the previous week that his partner had started seeing someone else and was finding it increasingly difficult to deal with that situation. Craig Sexton had thought of jumping off a cliff but he did not know when he would do it. He had been ruminating on thoughts of the break up. His sleep was said to be poor but he was reported to be eating fine. Having previously been drinking six to eight cans a day he had, since the split in

February, not been drinking alcohol, just milk. He denied feeling angry but at interview he did appear angry towards his partner and the separation. It was thought he exhibited lowered self esteem. He was thought to be hopeless.

He spoke of having tried to contact his ex partner the week before and discovered that she was out with another man. It is recorded 'won't accept this'. He was worried about the loss of his role as a father and his ex partner's new relationship. He reported that he felt his ex partner was neglecting the children and he was angry towards her.

His background history of receiving counselling was identified. He reported that his overdose in February was impulsive. He reported that he was training to try and become physically fit to get his partner back. He expressed his dissatisfaction with medication which he had stopped taking. It was noted that he had supportive parents.

At interview he complained of being depressed but laughed at times when talking about suicide. He was preoccupied with his separation from his ex partner and children. There was no evidence of any psychotic symptoms.

A formulation was completed. His presentation was understood in the context of a break up of a relationship a number of months previously. The history of the overdose in February was noted. The recent deterioration over the previous seven days was understood in terms of his discovering that his ex partner had a new relationship. He was thought to have a low self esteem and poor coping strategies. He was thought to be suffering from a reactive depression on the background of his poor coping strategies.

The outcome of this assessment was to accept Craig Sexton for home based treatment. He and his father were given the crisis assessment and treatment service (CATS) emergency contact number (the carers line). It was agreed that Craig would stay overnight at his parents' house and a medical review was

arranged for the following morning at 10am at his parents' house. There was no record of how long this visit and assessment by CATS lasted.

On 18th June 2004 at 10.15 am, the nurse consultant CAT3 and CAT1 visited Craig Sexton at his home again. Having spent the night at his parents', Craig had returned to his flat but when his family visited they were concerned and using the telephone number given to them the previous evening they phoned CATS and asked for an earlier visit to see Craig at his flat. It was noted that Craig was quick to engage at this assessment and initially stated that he was wasting the CATS time and that he was alright. He spoke about the loss of his relationship with his ex partner and children. He blamed himself and felt guilty but was unable to see any future without his ex partner or children.

He was noted to be agitated and anxious and expressing suicidal ideas without a formulated plan. It was recorded that there were 'biological markers of depression'. His threats of suicide were interpreted as 'projecting anger at family'. It was felt that the family exhibited 'high expressed emotion'. It is noted that the two clinicians spent time with Craig Sexton's parents and his sister explaining the nature of the diagnosis of an adjustment reaction and anxiety, the prognosis and appropriate treatment.

It is recorded that the family were advised on how to help Craig by trying to remain 'normal' and not feeling that they need to be with him constantly. It was planned to provide a prescription for Diazepam 5mg three times daily. Craig Sexton was also advised and he agreed to re-commence his prescription of the antidepressant Citalopram. It was planned that the CATS team would visit and phone Craig Sexton on alternate days. The family had the carers' line telephone number for CATS. In addition, he was offered an appointment with CAT4 at the team's base on Tuesday 22nd June 2004 at 10 am.

Later that day, a prescription for Diazepam 5mg three times daily was issued by the consultant psychiatrist CAT5. It was intended that this would be delivered to

Craig Sexton at home but as a result of subsequent developments it was not delivered. Craig was given it at accident and emergency.

At 2.27pm on 18th June 2004, Craig Sexton with his father arrived by ambulance at North Tyneside General Hospital. Craig was seen by a senior house office (A&E1) in accident and emergency at 3pm. She notes that his family was very concerned about Craig and his father said that he wanted him to be admitted to hospital. It was felt that he was not coping well due to depression. She noted that he was very co-operative and 'communicates well at the moment'. It was said that he was not complaining of anything and he 'seemed alright'. He was assessed further. The presenting complaint of being suicidal was noted. The history of four months difficulty with deterioration over the last week was noted. Craig Sexton again spoke of his feeling that he could not go on without his family and he had no hope for the future. He spoke of his specific plans to jump off a cliff in South Shields and said that it could be tomorrow or it could be next week but nothing would stop him doing it. At interview he was noted to maintain good eye contact but it was noted that he had an odd affect and he did not smile. He was passive and co-operative. He felt hopeless and he had made suicidal statements. A comment was made 'happy to get help' and that Craig said that he was prepared to be admitted but it would do no good because as soon as he was out he would kill himself anyway. In view of her concern for Craig Sexton's suicide risk, the senior house officer at accident and emergency telephoned and discussed the case with the crisis assessment and treatment service team. They agreed to attend and asked her to give him 5mg diazepam, but at that time Craig Sexton refused the medication.

Crisis assessment and treatment service (CATS) records note the contact from accident and emergency, reporting that Craig Sexton had attended accident and emergency with his father. It was recorded that his father was again concerned about his expression of suicidal ideas and his plans to jump off a cliff in South Shields. One of the CATS clinicians (CAT6) discussed the situation by telephone with the nurse consultant (CAT4) who had seen Craig earlier that day. A plan

was formulated to review the situation in accident and emergency. The possibility of offering admission to contain the situation was suggested.

At 7.30 pm on 18th June, two CATS clinicians – CAT6 and CAT7 – saw Craig at North Tyneside General Hospital accident and emergency department. Craig Sexton's father was present. It was noted that Craig Sexton had made a statement about jumping off a cliff in South Shields. Craig had no specific date for this. His father was noted as showing obvious signs of carer stress. Craig was uncertain about continued contact with the CATS. He again spoke of losing his family.

It is recorded that there was a discussion about his distorted thoughts. CAT6 and CAT7 believed that Craig Sexton benefited from this intervention. He assured staff that he would remain 'safe' until the next home visit which was planned for the following morning between 9.00 – 10.00 am. He and his father were reminded of the CATS carer line telephone number. He took a dose of Citalopram whilst the clinicians were present.

Craig was given a dose of Diazepam 5mg at 20.25 hours after having been seen by the CATS team. Craig Sexton and his father left accident and emergency at 8.45 pm.

By the end of the assessment it was noted that he was warm and responsive and engaged with the crisis assessment and treatment service (CATS).

The next record of involvement of the CATS with Craig Sexton occurred at 23.55 pm on 18th June 2004, when Craig Sexton's sister contacted the team informing them that the police had been called to Lynda Lovatt's home. Craig had gone to visit Lynda Lovatt and then had telephoned to say that he thought he may have killed Lynda Lovatt.

## B Interview evidence for the period 17th and 18th June 2004

### Thursday afternoon / evening

Craig Sexton's family provided information to the inquiry on the period leading up to their contact with GP (NT4) and the first assessment by the crisis assessment and treatment service (CATS). They described the week before Lynda's death as 'terrible'. They commented that by this time Craig knew that Lynda was seeing someone else and although he said he did not mind they thought he was upset. They commented that over the Wednesday/Thursday they noticed a huge change in Craig. They were aware that he had sent a horrible text message to Lynda. He had expressed the view that he could not cope with the children and he had dismantled their bunk beds. He had decided to make a break from Lynda and threw her telephone number away but then decided that he wanted to apologise to her for the text message he had sent. His sister had contacted Lynda Lovatt's mother to try and establish some contact between Lynda and Craig. Craig Sexton's father reported that he was constantly talking about Lynda's new relationship. On the day before Lynda's death (17th June) Craig Sexton's parents had visited him in the afternoon and found him "in a state". They had contacted his sister. At that point he was crying and shaking. He was talking of having no life. Craig Sexton's sister noted a chart on his bedroom wall with a grid on it and angry words about Lynda including "slag". She contacted the doctor who arranged for the CATS team who arrived about 8.00 pm. The family reported that they expected Craig to be taken to hospital. The family reported that they wanted him in hospital but recall being told that he was suitable for home visits. They recalled that it was agreed that Craig would spend the night with his parents and an appointment was made for the following morning. They were given advice in the form of a leaflet and a telephone number for them to contact if they were worried. They said they were at that time relieved that something was being done to help Craig by the crisis assessment and treatment service (CATS).

The inquiry interviewed staff who were directly and indirectly involved with the care of Craig Sexton from the CATS as well as his GP.

It heard evidence on the process by which assessments to the service are managed. On each shift a triage nurse is responsible for receiving requests for assessments collecting relevant information and allocating work to members of the team if a referral is accepted. The individual with this role has the responsibility for prioritising the work of the team. In addition they receive feedback following assessments and communicate an action plan to the next shift. The member of staff taking on this role is an experienced nurse. Training in this process is provided to those undertaking it. On average ten such triage referrals are made per shift.

The member of staff who carried out this role in relation to the case of Craig Sexton was interviewed (CAT1).

It is established that the referral in relation to Craig Sexton was taken at 5.15 pm on 17th June 2004.

As a result of the referral the case was allocated and two members of senior nursing staff arranged to visit Craig Sexton. The assessing team were CAT2 and CAT3.

The inquiry heard about the philosophy and purpose of the crisis assessment and treatment service (CATS), namely that it is there to provide an alternative treatment intervention to hospital based treatment. This is based upon a philosophy that being treated at home is a more appropriate model. All members in the team reiterated when asked that they did not see their primary function as reducing the number of admissions to hospital. The CATS team confirmed to the inquiry that if risks could not be managed at home then admission to hospital could be arranged. Admission to hospital is not viewed as a failure. There is also respite provision in a hostel managed by Newcastle Social Services Department to which the CATS has access on a contract basis.

In relation to the first assessment on 17th June by CAT2 and CAT3, the inquiry heard that contemporaneous notes were made of the meeting. Subsequently, a

written formulation is made to summarise the case to allow communication with other members of staff. In addition to an informal interview, a FACE risk assessment profile was completed by this team. It was confirmed that as well as interviewing Craig Sexton the team spoken to his father. Subsequent to carrying out the assessment the two assessing nurses left Craig Sexton's home and spent some time outside in their car discussing the presentation and an appropriate course of action before returning to the flat and agreeing the action with the family.

The inquiry heard that Craig Sexton's assessment was carried out in the living room of his flat. The assessing team was never in Craig Sexton's bedroom nor was their attention drawn to any material in his bedroom.

Specifically, CAT2 recalled Craig Sexton's presentation. In particular it was recalled that he talked of suicide but at the same time he was laughing. His discussion of suicide was linked to the separation from his ex partner. Although talking of his ideas to throw himself off a cliff, Craig Sexton also reported that he believed he did not have the "bottle" or "backbone" to go through with it. He had no specific plan or intention to kill himself that night. It was also recalled that he made the comment that killing himself would not achieve anything. The assessing team felt that there were protecting factors within Craig Sexton's environment and they concluded that he would be safe to remain at home overnight with his parents. Craig Sexton had also spoken of his feelings for his children and it was felt that this would be another factor preventing him from killing himself. The assessing team note that Craig Sexton's family was content to continue to contribute to the care of their son overnight.

Specifically, the assessing team spoke to Craig Sexton's father who expressed the view that Craig's problems were secondary to the break up of his relationship and the loss of contact with his children. He reported that Craig Sexton's mood was low.

The assessing team confirmed that they had made references in their notes regarding Craig Sexton's anger towards his partner and the end of the relationship. CAT2 confirmed that they covered this particular issue during the course of their discussion outside in the car after the initial assessment. Craig Sexton agreed that he felt angry with the situation he found himself in but denied that he felt angry with Lynda. Having identified this 'angry' element in the first part of the assessment, the team returned and explored it further with Craig Sexton.

The assessing team confirmed their plan was to be based around home-based treatment. They formulated that Craig Sexton was not adjusting to the separation from his partner and his new role in life and that he needed assistance in coming to terms with the change in his relationships. A medical review was felt relevant in view of the fact that Craig Sexton had previously been prescribed medication.

CAT2, who confirmed his experience of dealing with people with severe mental illness, expressed the view that Craig Sexton did not present as a man suffering from a severe agitated depression at the time of the first assessment.

It was confirmed that Craig Sexton's mother and sister were in the flat that night but not present during the assessment. At the end of the assessment it was confirmed that the treatment plan was discussed with the family and they accepted the plan that Craig be provided with input at home and be subject to subsequent reviews.

CAT3 confirmed that the assessment of Craig Sexton took place in his flat in the living room and that his mother, father and sister were present. He confirmed that his father remained in the living room whilst the assessment was carried out. His mother and sister remained in another room. CAT3 recalled that this was because the living room was not particularly large. CAT3 recalled that Craig's father said little if anything during the course of the assessment. He also recalled speaking to the family about their conclusions and treatment ideas after they had

carried out their assessments. At the time of the assessment and feedback the family appeared content with the proposals that were being made. CAT3 confirmed that as a result of their assessment they concluded that Craig Sexton was in the process of adjusting to the break up of a relationship and he was having difficulty with this and also having difficulty coming to terms with the fact that his partner was having a new relationship. CAT3 also thought he was slightly irritable and angry in that assessment. Craig Sexton reported he was angry with himself for not making the relationship with Lynda Lovatt work. CAT3 was also of the view that Craig Sexton believed he had been working towards re-establishing the relationship but had realized that he would not get back together with Lynda Lovatt as she had embarked on a new relationship.

CAT3 confirmed that they were not provided with any written material prepared by Craig Sexton nor did they have access to his bedroom. He confirmed that they had assessed the risk of suicide. He confirmed the view that there was not an immediate risk of suicide. He recalled that Craig Sexton was very clear at the time that he had no intention of killing himself immediately. In view of the history of overdose it was felt it was a risk in the future. It was felt that by providing home-based treatment the risk of suicide could be reduced.

CAT3 also confirmed CAT2's account that they had explored Craig Sexton's feelings of anger and that he had articulated that he was in fact angry with his situation and not with Lynda herself. He confirmed that they had explored Craig Sexton and Lynda Lovatt's past relationship looking for any history of violence between them. He confirmed that they were concerned about the possible risk of self harm but the initial assessment by the crisis assessment and treatment service had concluded that this could be managed with home-based treatment.

CAT3 confirmed his experience of dealing with seriously mentally ill people and he confirmed CAT2's impression that Craig Sexton was not presenting with symptoms of a severe depression but with symptoms of an adjustment reaction with depressive symptoms. He also expressed the view that the symptoms he presented with to his GP had developed particularly since the time of Craig

Sexton's discovery that Lynda Lovatt was in a new relationship. He confirmed he had seemed similar presentations in other cases that he had dealt with.

**Friday morning**

Craig Sexton's family told the inquiry that on the Friday morning, having slept overnight at his parents' house, Craig returned to his own flat. His parents later attended and found him kneeling on the floor crying and listening to loud and sombre music. They contacted his sister who telephoned the crisis assessment and treatment service (CATS). It was agreed that the CATS team would visit again. The family was concerned that he would leave and kill himself and they said they barricaded him in to stop his leaving. The family said that they had told the assessment team that they were worried that he would kill himself. By the time the CATS team had arrived again Craig had stopped crying. The family confirmed that after assessing Craig the CATS team had spoken to them when they reiterated their concerns about him. The family at that time wanted him to go to hospital.

Members of the CATS confirmed that the assessment carried out on Craig Sexton on the Thursday morning was precipitated by a phone call from his sister. His sister had telephoned to express her concern about his distressed state and was enquiring about the time of the visit that had been proposed the night before. As a result the assessment was brought forward and carried out by CAT1 and CAT4. CAT4 is the most senior nurse in the CATS team and is a nurse consultant.

This second assessment was carried out in Craig Sexton's flat. All his family was present. CAT4 interviewed Craig and CAT1 made notes of the assessment. The family was invited back in to discuss their plan of action. It was reported that at that juncture Craig Sexton's mother had become upset and left the room and CAT1 had followed her out leaving CAT4, Craig, his sister and his father.

Again the family's concern related to worries about his harming himself. CAT1 said that she felt his mother was content with the proposed plan and the support

being provided. She had no recollection of the family demanding hospital admission. Furthermore, she recalled that CAT4 had offered admission to Craig but he had rejected this. The inquiry heard evidence about the written notes made after the assessment. It is noted that these notes were made by CAT1. Subsequent to Lynda Lovatt's death, CAT4 prepared a statement recording his recollections of the assessment. This written statement expanded upon CAT1's comments - in particular with reference to the presence of biological markers. In expanding upon this he explained that although there was sleep disturbance it was not persistent and not of the form of early morning wakening which is characteristic of depressive illnesses. Though there was some variation in appetite and concentration it was not of a pattern consistent with an endogenous depression.

It was confirmed that the assessment lasted one hour. CAT1 conveyed her impression that the family agreed with the plan of action. She recalled that the family was concerned about Craig Sexton and they were interested in the interventions to be offered. These two clinicians on the Thursday morning were conscious of the stress the family were experiencing but believed that by their interventions and explanations their stress could be reduced. CAT1 confirmed her view that the assessment led her to believe that Craig Sexton was presenting as an anxious man suffering from an adjustment reaction and he did not present as a man with a severe depressive illness.

CAT4 expressed the view that home-based treatment was possibly more successful than hospital-based treatment. He clarified however that inpatient treatment and outpatient home based treatment is perhaps for two different groups. He confirmed there was no pressure to not admit patients.

CAT4 recalled the assessment on the Friday morning. He remarked that the family was anxious and that they were particularly worried about Craig ending his life. CAT4 had no recollection of the family giving an account of the agitated state they had observed earlier in the day when they had been worried he would leave and they had made efforts to prevent his leaving the flat. They did

however express their urgency and concern. CAT4 stated that based on his own experience the anxiety expressed by the family was not unusual and that this warranted support and assistance from the Crisis Assessment and Treatment Service (CATS). In his experience, he reported that with input from the CATS team anxiety in the family can be overcome as the family recognise that the interventions being offered are beneficial. He confirmed that he carried out a thorough mental state examination. He recalled that Craig Sexton was restless and pacing initially and spoke of wasting the CATS team time whilst at the same time reassuring them that there were no problems. This was recognized as denial. With time, during the interview, the assessing team recalled that they enabled Craig Sexton to talk about recent circumstances. CAT4 recalled his exploration of biological markers of depression which he thought were not indicative of a major depressive illness. He recalled his exploration of suicidal intent and that Craig Sexton had reported that he did not really think he could kill himself. There were no psychotic phenomena evident. During the course of the interview his agitation settled. He recalled that Craig Sexton engaged with him during the course of the interview and when offered specific help from CAT4 he appeared positive about this offer.

CAT4 recalled meeting with the family after the assessment. They were told that Craig would be offered short term anxiolytic drug treatment. It was not clear at that point whether there would be particular benefit from antidepressants. He recalled that the family became upset during the course of the feedback session and expressed the view that they were worried that the assessment team did not believe them and that Craig Sexton was minimizing his problems by lying. The family was making it clear that he was intent on killing himself. As CAT4 was aware that the family did not appear reassured by the CATS plan, he told the inquiry that he suggested that perhaps they should look at admission to hospital, but Craig had said that he did not want to go to hospital and that he would prefer to be helped by the CATS team.

CAT4 confirmed that he was not able to make his own notes of the assessment and that CAT1 had completed them, but on discovering that Craig Sexton had

killed Lynda Lovatt he dictated a note of his recollection of the assessment. He expressed the view that the assessment of Craig Sexton would have been ongoing during the course of future contacts. And the plan had been for CAT4 to see Craig for a series of sessions starting on 22nd June. Craig Sexton had appeared happy with that.

CAT4 was clear that, at the time he saw and assessed Craig Sexton on 18th June, Craig was not detainable under the compulsory detention provisions of the Mental Health Act 1983.

CAT4 confirmed that he had explored Craig Sexton's attitude and feelings towards Lynda Lovatt and that Craig denied feeling anger. He confirmed the view of other members of the team that Craig was not presenting as a man suffering from a severe agitated depression. He also believed that he was a man suffering from an adjustment disorder with an altered mood in the context of a pre-existing generalised anxiety disorder.

During the course of CAT4 assessment, he did not enter Craig Sexton's bedroom and it was not drawn to his attention that there was a wall chart in the bedroom. He was not informed of any inappropriate text messages being sent to Lynda Lovatt.

**Friday afternoon**

The family said they visited Craig again later in the day after dinner. They found him playing loud music, crying and kneeling on the floor again. A next door neighbour was present and he called an ambulance for Craig to be taken to hospital. The family wanted him in hospital and thought that was the only way. Craig Sexton's father went to hospital with him. They said Craig was assessed by a nurse and his father told her they were concerned that Craig would kill himself and they wanted him kept in hospital. At this time, Craig Sexton had agreed that he would go into hospital "for his mother's sake". They said they waited for a long time in a room by themselves for the crisis assessment and treatment service (CATS) to come.

During the assessment by the CATS team, his father reported that Craig had again expressed ideas that he would kill himself. Craig Sexton's father could not recall hospital admission being offered. He said that he had asked if it was possible and he was told no. His father recalled that Craig had offered reassurances to the CATS that he would be safe until the next morning. He also recalled Craig Sexton being asked about his feelings towards Lynda, specifically if he was angry about her. Craig Sexton denied any history of violence between them and denied that he had ever threatened Lynda. An arrangement was made for him to be assessed again the following morning, the plan being that he would remain with his parents overnight. They were reminded of the carers line telephone number. Craig took some medication – Citalopram – when the CATS were there and shortly after they left he was given some Diazepam. His father believed that Craig was disappointed to be discharged from hospital.

The inquiry heard evidence from the two members of staff who assessed Craig Sexton in accident and emergency.

CAT6 recalled receiving the referral from accident and emergency and the fact that Craig Sexton was expressing ideas of suicide. It was agreed that the CATS team would attend and assess Craig Sexton again.

In addition, CAT6 contacted CAT4 to discuss the team's previous knowledge of Craig Sexton. CAT4 confirmed that later in the day, after he himself had seen Craig at home, he received a telephone call from another CAT clinician – CAT6. The conversation indicated that the family had taken Craig Sexton to accident and emergency at North Tyneside General Hospital. CAT4 said that he was surprised that the family had not been able to cope with Craig Sexton's continued anxiety and that this in itself might reflect the need for hospital admission. He suggested that this should be considered by CAT6 when Craig was seen. He felt, however, that inpatient treatment would have been an unhelpful environment for the problems that Craig was experiencing at the time. He did not believe that Craig Sexton would have fulfilled the criteria for detention under the Mental Health Act 1983 and furthermore he believed that, if he had been admitted to an

acute inpatient ward where the environment was likely to be disturbed, Craig would have left soon afterwards.

CAT6 reported that it was quite common to see patients at accident and emergency for assessment. There was therefore nothing unusual in seeing Craig Sexton there. The assessment was conducted in the presence of Craig Sexton's father who again repeated concerns about his son's suicidal thoughts. They assessed and intervened for about one hour in accident and emergency. They noted his incongruity in that although he would talk about suicidal feelings he would smile whilst doing so. This was perceived as a reflection of his nervousness. He was thought to be mildly agitated. His father spoke a lot of the time during this assessment expressing his concerns that his son might kill himself. Despite his thoughts of suicide, Craig Sexton did not express a particular intention to act upon this in the immediate future. In addition, the crisis assessment and treatment service (CATS) team noted that he was talking about other things in the future such as seeing his children and contact with his children was perceived as supportive for him. Craig Sexton did not express any ideas of hurting anyone and offered reassurance that he was not planning on hurting himself in the short term. The two clinicians thought that his father was reassured by the further intervention and the reassurance that this intervention would be ongoing. CAT6 said that the question of hospital admission and the pros and cons to this were discussed but Craig Sexton did not think that hospital would help him in any way. The overarching view was that there was no strong indicator that hospital admission was needed at that time.

CAT6 explained that he frequently saw people expressing thoughts of suicide in the context of a break up of a relationship and commented that Craig Sexton's presentation was not an unusual one in these circumstances. It was agreed that Craig's father had expressed a view that his son should be in hospital because of his suicidal thinking. CAT6 stated that if it was felt that the risk of suicide was not manageable with home based treatment then he could and would have been offered admission.

The inquiry heard that CAT7had been aware of Craig Sexton's case and the previous assessments as a result of the hand over meetings which took place on 18th June 2004. He confirmed that they were conscious of the anxiety and tension felt by Craig Sexton's family. He understood the purpose of their assessment was to assess the risk of suicide at that time. He did not believe that Craig Sexton was biologically depressed. He felt that Craig was presenting in the context of a relationship break down and was having difficulties adjusting to that. He was aware of Craig Sexton saying that he would kill himself but also that he was vague as to when that would be. It was concluded that Craig had no active plan in place at that time. CAT7 confirmed there was nothing expressed to indicate a risk to others. He was conscious of an animosity expressed towards his partner but he was mainly preoccupied with his inability to cope with his situation and the future. It appeared that his anger towards Lynda was in relation to his inability to access his children and play a significant part in their care as had previously been the case. CAT7 recalled that towards the end of their assessment Craig Sexton agreed to work with them and that he would take medication as prescribed and he would be agreeable to follow up the next day after having returned to his parents that night. He concluded that Craig Sexton had no plans to kill himself that night. CAT7 recalled that at the end of their meeting Craig's father appeared more relaxed and content with the plan. He recalled that during the course of a discussion about the merits of a hospital admission Craig Sexton refused such admission.

Both CAT6 and CAT7 confirmed that in their view Craig Sexton was not detainable in terms of the Mental Health Act. He confirmed that Craig Sexton did not present as though suffering from a severe agitated depression. It was not felt hospital admission would have been therapeutic given the nature of his problems.

Craig Sexton left hospital with his father at about 8.35pm. He walked home quietly with his father and they ate a meal prepared by his mother. Craig Sexton's parents reported that he was angry with his mother following him around and offering him clean clothes and suggesting that he should have a bath

and a rest. Mrs Sexton retired to bed and Craig returned to his flat. Later Mr Sexton visited Craig Sexton at his flat when Craig reported that he had telephoned Lynda Lovatt. Craig was intent on going to see the children to pick up his Father's Day cards, which he believed the children would have made for him. He was quiet at this time.

To get to Lynda Lovatt's house, Craig would catch the ferry from North to South Shields and then get a bus. Craig Sexton's father accompanied him to the ferry and watched him board at 10.30pm. Mr Sexton told the inquiry that at that point he was conscious that his son may instead go to Marsden Rocks, the cliffs from which he had been threatening to jump. He himself was physically and mentally exhausted and was conscious of the fact that Craig had told them not to follow him. On returning home, Craig's father received a telephone call from Lynda indicating that she would call the police if Craig turned up and caused trouble. She asked Craig's father if he would try to stop him coming. She reiterated there was no chance of them getting back together. Craig Sexton's father did telephone Craig, but Craig said he was nearly there and intended to go.

The next contact Craig Sexton's father had from his son was when Craig telephoned him informing him that he had killed Lynda. His father contacted the police.

The family reiterated that at no time did they ever regard Craig Sexton as a threat to Lynda. Their only concern was that he would kill himself.

### C Commentary on the period 17th and 18th June

The inquiry accepts that there was a significant deterioration in Craig Sexton's mental state and presentation in the days leading up to Lynda Lovatt's death. This deterioration appears to have been precipitated by Craig Sexton becoming aware that Lynda Lovatt had met another man. It appears that up until that time Craig Sexton had been distressed by the separation from Lynda Lovatt and his children, but had placed all of his hopes on re-establishing the relationship. He

had not really accepted the separation as final and many of his efforts in recent months such as stopping drinking, losing weight, trying to get fitter and decorating his new flat were an attempt to secure a future with Lynda Lovatt and his children.

In the week after he discovered that Lynda Lovatt was in a new relationship he sent hostile text messages to Lynda Lovatt. Another manifestation of his anger towards Lynda Lovatt was his writing of derogatory comments on a chart he kept in his bedroom. His family became aware of and concerned about this deterioration in the days leading up to Lynda Lovatt's death and contacted his GP.

Following the earlier referral from the personal advisors service (PAS) in South Tyneside, the GP practice had set in motion a referral to the community psychiatric nurse (CPN) attached to the practice. In view of the fact that that CPN works from the practice, it would have been more effective had GP (NT3) or GP (NT4) spoken rather than just written to their CPN so that any counselling or further action could have been implemented sooner – particularly in view of the contents of the PAS letter dated 26th May 2004 and the urgency referred to.

GP (NT4) responded to the family's urgent request by visiting Craig Sexton at home and having assessed him he made the appropriate decision to refer him to the crisis assessment and treatment service. GP (NT4) acted appropriately and expeditiously. He knew what to do having identified the urgent problem. He knew where to go. He provided appropriate information to the crisis assessment and treatment service (CATS) and supported his patient. This was a good example of the CATS referral protocol working effectively.

Having received the referral from GP (NT4), the CATS team processed the referral appropriately via an established triage system. The referral was appropriately assessed as within the CATS criteria, adequate notes were recorded and information passed to GP and patient about the following action and time scale. Triage ensured that until further help was available the patient

remained in a secure environment. Triage ensured that the case was appropriately referred to the clinicians to make a home visit assessment.

The staff - CAT2 and CAT3 - who assessed Craig Sexton at the first visit were aware of the family's concerns that he posed a risk of suicide based upon his expression of suicidal ideas. They explored his mental state and concluded that he was suffering from an adjustment reaction with some depressive symptoms secondary to the end of the relationship. They explored his feelings of anger and concluded that he was angry at the situation he had found himself in rather than specifically with Lynda Lovatt. When asked directly, he denied any animosity towards Lynda Lovatt. A care plan was formulated and put in place. It was communicated to subsequent shifts in the CATS team.

The notes made by CAT2 and CAT3 were detailed and relevant. The risk assessment was complete and appropriate. The record would benefit from start and finish times being recorded. By reviewing the evidence privately after the initial assessment, the clinicians indicated a thoughtful and considered approach which is to be commended.

The inquiry accepts that on the evidence available there are no grounds to dispute the clinicians' conclusions that at that time Craig Sexton was not detainable under the Mental Health Act 1983. Although his parents may well have preferred that he be admitted to hospital, in the absence of any grounds for compulsory admission, the inquiry believes that Craig was not agreeable to voluntary admission at that time. There was no imminent risk to Craig Sexton and no perceived risk at all to anyone else.

It was reasonable to arrange home follow up for the next morning for a medical assessment. Craig Sexton's safety had been secured as best as possible by providing that he stayed overnight at his parents (very close by), and the family were given details of the crisis assessment and treatment service (CATS) carers line telephone number in case of any concerns.

On the morning of 18th June 2004, Craig Sexton's family became aware of his becoming agitated again and contacted the CATS team, using the carers line telephone number. CATS again responded appropriately to the family's concerns by bringing forward an assessment. Although a medical review, as was planned, would normally involve a consultant psychiatrist, the inquiry heard from the psychiatrist (CAT5) that she was unavailable due to work commitments. She however confirmed, and the inquiry accepts, that the nurse consultant (CAT4) was well qualified to undertake the review. CAT4 and CAT1 therefore attended earlier than originally planned but the evidence from the notes supported by the oral evidence shows that a thorough review was undertaken. Again it would be helpful if the notes included start and finish times but the inquiry was told that the assessment took about one hour.

The presence of a major depressive illness was considered. CAT1 and CAT4 agreed with the initial CATS assessment from the previous evening, that Craig Sexton was presenting with an adjustment reaction secondary to relationship breakdown. In addition, it was concluded that this was on the background of a generalised anxiety disorder. Again the CATS team was aware of the family's concerns and belief that Craig Sexton should be admitted to hospital. A care plan was formulated and discussed with the family and a new treatment plan was formulated including alternate day visits by the CATS team and psychotherapy with the nurse consultant to start from 22nd June.

Craig Sexton's feelings towards Lynda Lovatt were again explored and he did not indicate any thoughts of harming Lynda.

The inquiry considers that the assessment by these experienced clinicians was again appropriate and thorough. The clinicians did not see the disturbed individual that had so concerned the family earlier in the morning. He had calmed down. He did not agree to go to hospital – again despite the family's wishes – but the evidence clearly shows that the clinicians were aware of the family's stress. In view of the family's wishes it would have been helpful to have made reference to the discussions about hospital in the notes. Reassurance was

provided and the new care plan was designed to provide intensive contact with the CATS on a daily basis, together with a planned session of psychotherapy. This, together with the carers line contact, was designed to reassure and assist not only Craig Sexton but also his parents and sister. There were no grounds compulsorily to admit Craig to hospital under the Mental Health Act 1983.

Craig Sexton was taken to accident and emergency later in the afternoon on 18th June 2004. The accident and emergency records indicate that there was a concern for his safety – hence the referral to CATS. They also indicate the family's wishes and Craig Sexton's willingness at that time to stay in hospital. The records are sufficiently detailed and, given the circumstances, commendable. The senior house officer times her attendance in the hospital notes. The record of the CATS attendance is not timed which is contrary to the Nursing and Midwifery Council Guidelines (NMC 2005).

The CATS team again responded to the request for their involvement. He was not seen as quickly as previously but the CATS team reasonably made a decision that he was in a relatively safe environment in hospital and other work had to be prioritised. In advance of their further contact with Craig Sexton the third assessing team had knowledge of Craig by virtue of the handover system which was in place in the CATS team and notes which were available on previous assessments. They also took the step of contacting CAT4 directly by telephone when the issue of admission to hospital was also discussed. This was an example of good practice.

During the course of assessment in accident and emergency, the assessing staff were again aware of the family's worries and anxieties but at the end of their assessment they came to the conclusion that the family were content with the treatment plan offered, which was again adjusted to respond to the continued distress exhibited by Craig Sexton and his family. The issue of hostility towards Lynda Lovatt was again explored and once again there was no evidence of any need for concern in this area. The perceived risk was to Craig Sexton himself. Having spent all afternoon, from 2.30pm, in accident and emergency waiting for

CATS and then another hour with them discussing his feelings it is reasonable to conclude that by 8.30pm Craig Sexton had calmed down sufficiently and had been reassured by the proposed treatment plan that he no longer wished to stay in hospital and had no immediate plans to “jump off the cliff”.

The inquiry noted that the CATS team did not document a history of previous alcohol abuse as has been referred to earlier in this report. They were aware from their initial assessment that he had stopped drinking since his move to North Shields. At this point CATS did not have access to the medical notes nor the personal advisors service notes. The inquiry was told that had the psychotherapy sessions which were planned to start with CAT4 on 22nd June taken place, then CATS would have had access to medical records. The issue and significance of Craig Sexton’s past alcohol use would hopefully have been addressed at that time.

The inquiry observed that the notes made of the assessment at home on the morning of 18th June 2004 included reference to biological markers being present. This raises a concern that a major depressive illness was missed at this time. The inquiry accepts the explanation volunteered by those assessing him that this entry did not reflect the exact nature of the symptoms exhibited by Craig Sexton. It accepts the interpretation of the crisis assessment and treatment service (CATS) team that the disturbance in biological functioning, including sleep and appetite, were variable and was consistent with the formulation made of adjustment reaction.

The inquiry noted that the CATS was acutely conscious of the feelings and anxieties of Craig Sexton’s family. This is apparent from the notes of all three attendances. All of the anxieties expressed were in relation to the potential risk of deliberate self harm. At no time were the assessing team made aware of any concern about the possibility of risk of violence to others.

The inquiry accepts that the symptoms present at the time of the CATS team assessment were understandable in the context of his recent life events. As

such, they were consistent with an adjustment reaction with depressive features. There had been deterioration in Craig Sexton's functioning and an increase in his distress subsequent to his discovery that Lynda Lovatt had a new partner. Clearly, when an individual expresses suicidal ideas the likelihood of deliberate self harm or completed suicide is increased. However, the inquiry panel agree with the views expressed by the CATS team that, in circumstances such as those experienced by Craig Sexton, thoughts of deliberate self harm are not uncommon and do not on their own indicate a high risk of completed suicide.

The CATS team expressed the view that the environment of an acute inpatient psychiatric unit would not have been conducive to assisting Craig Sexton in making progress in adjusting to his loss and new circumstances – even had he agreed to voluntary admission. The inquiry considers that the decisions that were made about the most appropriate environment to assist Craig Sexton were reasonable decisions supported by available evidence. There was no evidence to suggest that the CATS viewed admission to hospital as some sort of failure nor were they under any pressure not to admit patients to hospital. The evidence suggests that their decision not to admit Craig was based upon a view that he would be better off being treated in his home environment and in particular that it was safe so to do. The inquiry is satisfied that there were no grounds to admit Craig Sexton compulsorily under the terms of the Mental Health Act 1983.

## NATIONAL POLICY AND DEPARTMENT OF HEALTH GUIDELINES FOR CRISIS RESOLUTION AND HOME TREATMENT TEAMS

The inquiry reviewed local and national policy and Department of Health (DH) guidelines to examine the crisis assessment and treatment service (CATS) practice and adherence.

### 1. National Service Framework (NSF) and policy implementation guidance

Although the conception of the CATS pre-dates the National Service Framework for Mental Health 1999, the team's objectives are primarily addressed by the following provisions in that framework.

**Standard 4**

All mental health service users on the care programme approach should:

- Receive care which optimises engagement, prevents or anticipates crisis, and reduces risk.
- Have a copy of a written care plan which:
  - Includes the action to be taken in a crisis by service users, their carers, and their co-ordinators
  - Advises the GP how they should respond if the service user needs additional help
  - Is regularly reviewed by the care co-ordinator.
- Be able to access services 24 hours a day, 365 days per year

**Standard 5**

Each service user who is assessed as requiring a period of care away from their home should have:

- Timely access to an appropriate hospital bed or alternative bed or place, which is:
  - In the least restrictive environment consistent with the need to protect them and the public

    - As close to home as possible.
- A copy of a written care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

The National Service Framework for Mental Health was followed by the publication of the policy implementation guide for Adult Care (Department of Health, 2001) which suggests the objectives and criteria for crisis resolution and home treatment teams.

The policy implementation guide states that the crisis team should be able to:

- Act as a 'gatekeeper' to mental health services, rapidly assessing individuals with acute mental health problems and referring them to the most appropriate service.
- For individuals with acute, severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community-based treatment 24 hours a day, seven days a week.
- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible.
- Remain involved with the client until the crisis has resolved and the service user is linked into on-going care.
- If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge.
- Reduce service users' vulnerability to crisis and maximise their resilience.

Fidelity to the model indicates that the following principles of care are important:

- A 24 hour, seven days a week service
- Rapid response following referral
- Intensive intervention and support in the early stages of the crisis
- Active involvement of the service user, family and carers

- Assertive approach to engagement
- Time-limited intervention that has sufficient flexibility to respond to differing service user needs
- Learning from the crisis

2. **Local crisis assessment and treatment service provision**

The population for Newcastle and North Tyneside which constitutes the CATS catchment and which is part of the Newcastle, North Tyneside and Northumberland Mental Health Trust is approximately 460,000. At the time of the incident, the team comprised two medical consultants, one nurse consultant, 27 multi disciplinary clinicians, including three H grade nurses and seventeen G grade nurses, four F grade, and three social workers. At the time of interviewing the team they were carrying three vacancies for senior nursing staff. The team's caseload can vary between 50 to 80 service users at any one time.

The crisis assessment and treatment service (CATS) is staffed using a shift system, with reduced staffing over night. Usually only emergency assessments are seen during the night in the accident and emergency department of North Tyneside General Hospital, although two crisis workers are always available for assessment with back up from the senior psychiatrist on call if required.

The CATS ethos is team working. There are two communal meetings a day to discuss cases, developments and handovers – one at 8.30 to 9am the other at 1 to 2pm – attended by all staff where possible. When patients are seen at home, this will generally be by two clinicians at the same time. Notes are compiled and retained on file. Patients are seen in their home, at the CATS offices or at the accident and emergency department of North Tyneside General Hospital.

The referral rate statistics for the crisis assessment and treatment service (CATS) were unclear as they included all inquires to the team, which explains the lower take up rate.

| | 2003 | 2004 |
|---|---|---|
| Number of cases referred to CATS | 3452 | 3470 |
| Number of assessments undertaken | 1096 | 1129 |
| Number of patients taken on | 486 | 465 |
| Number of referrals resulting in admission | 136 | 129 |

The Department of Health's policy implementation guide suggests the caseload figures for a population of 150,000 to be approximately 20 to 30 service users at one time, with 14 designated named workers. For the CATS area of Newcastle and North Tyneside this would suggest that higher staffing levels are required but this concern was not raised as an issue for the inquiry.

According to evidence given to the inquiry, the CATS takes referrals from primary and secondary care for all people finding difficulty coping with a psychiatric crisis and does not exclude those who are not diagnosed with a severe and enduring mental illness. The team therefore has a broader remit and more involvement with primary care than suggested in the policy implementation guide. This leads to a greater necessity for competent risk assessment and management as they regularly take referrals for people who are not known to secondary or specialist mental health services, making the triage assessment or initial screening an important and responsible factor.

Members of the CATS team showed evidence through their CVs that the recommendations for risk assessment and management training for clinicians at intervals of no more than three years (Department of Health, 2002) were followed routinely. The FACE risk profile assessment and management tool was used by the crisis assessment and treatment service in line with their care co-ordination policy.

All staff directly involved with Craig Sexton were interviewed. They were found to be experienced and appropriately qualified and most had been working with CATS since its inception.

## 3. Commentary – National Service Framework and policy implementation guide considered against local service provision

Crisis resolution consists of four phases: assessment, planning, intervention and resolution.

**Assessment**

Assessment should consist of the following components:

- Initial screening to ensure that the service is appropriate for the patient and if inappropriate a referral to other services to ensure adequate continuity of care.

In Craig Sexton's case this was a two stage process. The referral was initially screened by the triage nurse at 17.45pm on 17 June 2004. Having accepted the referral, she then arranged for two nurses to visit Craig Sexton and carry out the initial crisis assessment. This took place at Craig Sexton's flat within a reasonable time scale. The nurses discussed their assessment and concluded that Craig was appropriate for the crisis assessment and treatment service.

- A physical health assessment where appropriate.

The CATS has capacity to assess physical health needs through its medical review. Craig Sexton was to have this the following day as documented in the care co-ordination assessment. The medical review was planned to consider appropriate medication rather than a physical examination, although this would have been available if required.

- If appropriate, multi-disciplinary assessment of service user's needs and level of risk.

Even though there was a degree of uncertainty pertaining to risk identified in the initial assessment, there was no record of a requirement for any further multi-disciplinary risk assessment at the times Craig Sexton was seen by the crisis assessment and treatment service (CATS). However, Craig was due to be seen by a consultant psychiatrist on the morning of 18 June 2004, but due to pressure of work the consultant doctor was unable to attend and she asked the nurse consultant to attend in her place.

The CATS follows the principles laid out in New Ways of Working in Mental Health (National Institute for Mental Health for England, June 2005) adapted from the document New Ways of Working for Psychiatrists (National Institute for Mental Health for England, August 2004), i.e. the employing trust is responsible for overall patient care; risk assessment is a multi-disciplinary responsibility; there is an obvious team leader and all members of the team are responsible for joint decision making. Evidence received by the inquiry confirms compliance with this process.

- Assessment should actively involve the service user, carers/family and all relevant others e.g. GP.

The triage process in this case had already involved the GP who was able to give the CATS team the relevant information, as dictated on the instruction sheet for referrers and the CATS triage form. The family was present at both home appointments and Craig Sexton's father was present at the accident and emergency assessment. Craig was reported as giving the requested information during the assessment visits and there was evidence documented that the family were involved in the assessment process and care planning.

**Planning**

Produce a focused care plan.

The initial assessors – CAT2 and CAT3 - planned to have a medical review the following day and on the second visit – CAT1 and CAT4 - a plan was discussed for Craig Sexton to have follow up sessions with the nurse consultant. There was evidence of a team approach and team decision making, both between the two clinicians involved at each visit and also by virtue of the twice daily team meetings. The care planning showed sufficient flexibility for the team to respond rapidly to changes in the clinical situation, i.e. the recorded interventions and communications when Craig Sexton, accompanied by his father, attended accident and emergency on 18 June 2004.

**Intervention**

Interventions available should include:

A designated named worker - The team had not nominated a designated named worker responsible for care co-ordination, due to the short amount of time that Craig Sexton had been with them. It was, however, clear from the forward planning agreed at the morning meeting on 18th June, that CAT4 had planned to take responsibility when the psychotherapy sessions were due to start on 22nd June 2004. The team's assessment documentation follows the Newcastle, North Tyneside and Northumberland Mental Health Trust care programme approach policy.

Intensive support – Craig Sexton was offered intensive home support and a 24 hour help line if needed. Plans had been discussed with the family about his staying with them for safety and support. The level of that support was addressed and modified following each visit.

Family/carer support – This was evidenced in the documented notes where a written plan states that the family had been advised on how to help Craig Sexton.

Crisis planning **-** This was discussed with the family and they were given the carers 24-hour helpline number. This was used by Craig Sexton's sister on the

morning of the 18th June, although in the afternoon the family chose to go direct to the accident and emergency department of North Tyneside General Hospital.

Medication – The availability of medication was evidenced in Craig Sexton's care plan where the usefulness of his previously prescribed antidepressant medication is considered and the prescription for Diazepam, an anti-anxiolitic, was planned to be delivered. Medication was again discussed and dispensed during Craig Sexton's visit to accident and emergency.

Medical members of the crisis assessment and treatment service (CATS) were questioned at interview about prescribing policies for the CATS and how patients could be prescribed supportive medication over a short period of time (24 to 72 hours) without being seen by a doctor. However, the nurses are required to discuss the prescription with a doctor, which out of office hours can be dispensed from a stock cupboard. This way of prescribing anti-anxiolitics was thought by the doctor – CAT5 – to be an integral way of working for crisis teams and such drugs are thought to be safe in the short term.

There are now guidelines for non-medical prescribing which will clarify the above position for crisis teams. Training is now available for members of the team to become independent prescribers and this would allow the appropriate nurse to prescribe medication without a written instruction from a doctor but within agreed 'patient group directions' (Department of Health, 2005).

Respite/admission – Was shown to have been considered during a discussion between CAT4 and CAT6 prior to Craig Sexton being seen in accident and emergency.

**Resolution**

The policy implementation guide suggests further interventions aimed at increasing resilience and resolution but due to the circumstances of Craig Sexton being taken into custody they were unable to be implemented. However, future

sessions with CAT4 had already been arranged and documented in the care plan.

**Commentary**

The crisis assessment and treatment service (CATS) showed fidelity to the model for crisis teams which is concurrent with the policy implementation guide, over the brief period of involvement with Craig Sexton. However, it would have been useful to be able to compare the inquiry's findings with other crisis teams.

The suicide rate for people admitted to the CATS is 1:1500. This is the first time that anyone has killed whilst under the care of the CATS which gives a ratio of 1:5000. Unfortunately, these figures have not been compared with a similar team. The inquiry could not find evidence of any type of national benchmarking or leadership for crisis resolution teams.

The monitoring of mental health services is through local implementation teams (LITs) via self assessment which contain position statements that give a limited degree of evidence. The LITs use a self assessment framework to feed progress reports into the National Service Framework for Mental Health.

The Newcastle and North Tyneside CATS measure their achieved objectives through service user questionnaires constructed by service user focus groups and interviews which have provided positive feedback.

The CATS impact on in-patient facilities is measured by several factors: reduced bed occupancy (110% to 73%), increased choice for service users and higher satisfaction rates, out of area treatments from 335 per year to zero, decreased admissions (by 35 – 40%), increase in patient/staff ratio, decrease in length of stay and increased access for non-urgent referrals (Northern Centre for Mental Health, June 2003).

The inquiry checked with several members of the team to identify their motivation for their ‘gate-keeping’ role in relation to acute admission beds. Each member of the team interviewed spoke about wanting to care for patients in their own home or in the least restrictive environment and denied any political pressure to reduce bed occupancy. Some team members spoke of the unsuitability of the acute ward for certain potential patients. There was a feeling that as the ward now accommodates the high risk and/or the severely disturbed patients it is unsuitable for those requiring respite.

The inquiry observed that the members of the CATS who were interviewed had lengthy and wide experience of mental health services prior to their post in the CATS. All team members showed commitment and enthusiasm for their work and care of their patients.

## CONCLUSIONS

1. Historically Craig Sexton's behaviour presented no risk to the safety of Lynda Lovatt, their children or any person. The attack on Lynda and her death was a course of events that was totally unforeseeable. All witnesses, including Lynda Lovatt's family and Craig Sexton's family, stated that the tragic outcome was totally unpredictable and they never considered Lynda to be at risk.

2. Craig Sexton took an overdose in February 2004 at the time of his initial separation from Lynda. In the week before he killed Lynda, Craig Sexton was threatening to kill himself by jumping off the cliff at Marsden Rocks in South Shields. Whilst there was a potential risk that he would carry out that threat, on the evidence there was no reasonable likelihood that he would do so during the period when he was being seen by the crisis assessment and treatment service. In view of the risk that was presented – self harm by Craig Sexton – on the assessment made by the clinicians the decision to proceed with home based treatment was justifiable and reasonable and was fully supported by the evidence. The risk was to Craig Sexton himself. He was not indicating immediate suicide intention. He had a secure home environment and the support of his family. Although his family may have preferred that he was admitted to hospital there were no grounds to do so under the Mental Health Act and Craig Sexton himself refused to consider it on the first two visits. During the assessment on the third visit he agreed to return home with the benefit of medication, staying at his parents overnight and with a further visit from the crisis assessment and treatment service in the morning.

3. At the time of killing Lynda Lovatt the inquiry considers that it was a reasonable diagnostic formulation to consider that Craig Sexton was suffering from an adjustment reaction with depressive features secondary to recent life events. In particular, his presentation in the week leading up to the death of Lynda Lovatt was largely precipitated by the discovery that

she was seeing another man. The crisis assessment and treatment service team identified the presence of a background generalised anxiety disorder. At the time of their assessment, Craig Sexton was no longer abusing alcohol in the problematic way which was evident previously. The inquiry considers that Craig Sexton's presentation subsequent to the death of Lynda Lovatt would have been significantly influenced by the killing.

4. There is no evidence that throughout the period under review there were grounds to detain Craig Sexton under the compulsory admission powers of the Mental Health Act, 1983.

5. There was a lost opportunity to examine Craig Sexton's use of alcohol. On 23rd November 2001, his GP in South Shields had noted that he was consuming 80 units a week and was drinking excessively. The GP had specifically sought advice and support from the personal advisors service (PAS). Neither PAS nor the GP had followed this up. The inquiry is satisfied that Craig Sexton continued to drink excessively until he moved to North Shields in February 2004. The early attention by his GPs and counsellors to the evidence of alcohol misuse, which at times was being used by Craig as a substitute for taking medication prescribed for his panic attacks and anxiety, would have assisted in his receiving more appropriate treatment at that early stage.

6. During the period in South Tyneside there was evidence of some confusion from GP records and evidence in the terminology used in the medical records from 2001 and 2004. The referrals to the personal advisors service were noted as being to the community mental health team (which they were not) and although there was good evidence of a positive working relationship between the GP and personal advisors service, this incorrect identification was at best confusing and at worst indicative of a failure to appreciate the roles of different agencies.

7. In 2002, Craig Sexton was referred to the personal advisors service (PAS). The CORE assessment made by PAS fails to screen for drug and alcohol problems. The assessment made by PAS resulted in use of client-centred therapy whereas a cognitive behaviour therapy would have been a more effective means of dealing with Craig's anxiety and panic attacks and would have been in accordance with the National Service Framework for Mental Health (Department of Health, 1999) and Treatment Choice and Psychological Therapies and Counselling (Department of Health, 2001). The inquiry found the PAS assessment in respect of the 12 sessions in 2002 to be incomplete. The session notes are vague and lacked any critical analysis. They were not helpful and a higher standard is to be expected from the clinician as well as their supervisor. The assessment form from the second assessment on 25th May 2004 was also incomplete and – had counselling continued with PAS – would not have the detailed information that should be expected.

8. The treatment that Craig Sexton received at North Tyneside General Hospital following his overdose on 16th February 2004 was an example of good practice. He was fully assessed, advised appropriately and follow up arrangements were made with his GP and other mental health services. Appropriate records and correspondence were noted.

9. There was a delay in Craig Sexton seeing the personal advisors service from the second referral on 23rd February 2004 until 25th May 2004. This was due largely to staff sickness and the inquiry noted that arrangements were in place to review in the event that the case was or became more urgent. This was not unreasonable. Similarly it was not unreasonable for the personal advisors service to decline to take on the case and to refer Craig Sexton to his new GP in North Shields.

10. There is no satisfactory protocol in place for the transfer of patients involved with primary care mental health services - unlike in secondary care where the care plan should ensure a smooth transfer to the new

service provider.  With patients suffering mental health problems a more formal system would be helpful to ensure that appropriate care and support continues. Although a transition was effected in this case the letter to the GP from the personal advisors service was by itself inadequate. A phone call would have ensured immediate contact but there should ideally have been direct contact with the community psychiatric nurse or another appropriate counsellor in the new area. This would have provided clear confirmation that Craig Sexton's case was being pursued with the urgency that it demanded.

11. Craig Sexton received treatment from a GP practice in South Shields where he was seen by two GPs. After he moved to North Shields in February 2004 he was seen by two GPs and a locum.  GP medical records were all handwritten.  Elements were difficult to decipher and lacked detailed information.  A computerised system should improve legibility. It should also make it easier to highlight significant issues – e.g. alcohol misuse – thereby making it easier to keep track of these issues on subsequent review.

12. The North Shields GP sought to involve the practice community psychiatric nurse appropriately and at the time of crisis on 17th June responded immediately by making a home visit.  The GP was aware of the protocol and procedures for referral to the crisis assessment and treatment service.  The correct assessment was made by the GP and, as the triage record indicates, he provided sufficient detail to the crisis assessment and treatment service to enable them to make an initial assessment and to arrange to visit.

13. The inquiry commends the professionalism and commitment of the crisis assessment and treatment service. Although there is regrettably no evidence of benchmarking with other similar services, it impressed as a well structured, well resourced service and as far as the clinicians involved in the care and treatment of Craig Sexton were concerned well qualified

and experienced mental health practitioners.  The team communicated well within itself and with the patient and his family. It showed evidence of awareness of the patient's problems and the stress suffered by the carers. The assessments were well documented and the decisions were supported by the evidence contained in that documentation. The time spent with Craig Sexton on the three visits was reasonable and there was evidence that the care plan and any future action was reviewed – and changed – as a result of each visit.

## RECOMMENDATIONS

The inquiry makes the following recommendations to the strategic health authority.

### 1. The alcohol issue

There was evidence that two GPs in one practice in South Tyneside and a number of clinicians working in South Tyneside failed to understand the significance of alcohol dependency or misuse in the assessment and treatment of mental health issues. This may well reflect a general problem in primary care services in particular. Current guidance is set out in the Alcohol Needs Assessment Research Project, 2005 and endorsed in Alcohol Misuse Interventions (Department of Health, 2005).

The strategic health authority is recommended to consider these publications and implementation.

### 2. Evidence based practice

Primary care services for mental health patients are relatively new. The inquiry considers that it is vitally important that the patient receives the most appropriate treatment available. This should be evidence based. In Craig Sexton's case, when in 2001 he presented with anxiety and panic attacks he was offered client centred therapy whereas cognitive behavioural therapy had, in the National Service Framework for Mental Health, been identified as the more effective intervention.

In order to ensure best practice which is evidence based, the strategic health authority is recommended to review the interventions which are offered to mental health patients and to consider the benefits that are offered by such interventions.

### 3. Recording and communication issues

Record keeping by most agencies was good. The manual handwritten nature of the GP records could be considerably improved and should be with the benefit of computer technology. Practitioners should be more prepared to pick up the phone, particularly in urgent cases – rather than just relying on a letter. The importance of time recording attendances – particularly in respect of attendances for counselling and assessment has also been noted.

The strategic health authority is recommended to remind practitioners of the guidelines of the Nursing and Midwifery Council.

The inquiry was concerned that there was no satisfactory protocol between services to deal with the transfer of patients/clients who were involved with primary care mental health services. In secondary care, the existence of the care programme approach will ensure that there is continuity of service and treatment as and where appropriate. In mental health cases in primary care, as the present case illustrated, no such care programme approach exists.

The strategic health authority is recommended to develop a transfer protocol for primary care mental health service users.

**4. Crisis assessment and treatment service**

The inquiry was impressed with the crisis assessment and treatment service as and its clinical competence. The inquiry was concerned about some aspects of the prescribing policy whereby doctors could prescribe medication without having seen the patient and considered that for the benefit of all staff and patients a clear protocol should be considered.

The strategic health authority is recommended to review prescribing practice in light of the guidance provided in 'patient group directives' (Department of Health, 2005).

There is no benchmarking of the service against other similar organisations and crisis teams. The inquiry considers that it is important that organisations such as

crisis assessment and treatment service and other innovative services should be critically evaluated.
The strategic health authority is recommended to ensure that benchmarking of the crisis assessment and treatment service is commissioned.

The strategic health authority is recommended that staff are reminded of the Nursing and Midwifery Council guidelines regarding record keeping.

## 5. Personal advisors service

The quality of records and level of supervision in the personal advisors service was not up to expected standard.

The strategic health authority is recommended to ensure that supervision arrangements are reviewed for personal advisors service trainees and junior staff.

## GLOSSARY

**Adjustment reaction –** the psychological reaction to a profound change in a person's life where symptoms of anxiety and depression occur within one to three months of the event and are not severe enough to be classified as a psychiatric disorder and there is no previous psychiatric history.

**Alcohol units –** A unit of alcohol is equivalent to 10g of alcohol. Safe levels of alcohol consumption are 21 units per week for men. Four or more units per day carry progressive health risks.

**Anxiety/panic attacks –** anxiety is a mood state predominated by fear which can range from mild to severe. If anxiety is accompanied by the over-whelming desire to get away from a particular situation, this is termed a panic attack.

**Anxiolytic drug treatment –** medication used to reduce anxiety.

**BECKS score** – the score obtained when implementing the Beck Suicide Intent Scale, which is an evidence based questionnaire to determine the degree of suicide intent.

**Biological markers of depression –** include loss of appetite, loss of sex drive, difficulty sleeping and physical aches and pains.

**Client centred therapy –** an unstructured approach that is non-directive and reflective.

**Cognitive behavioural therapy –** structured approach to therapy which is problem solving and involves thought and behaviour.

**Citalopram –** antidepressant

**CORE assessment –** Clinical Outcomes in Routine Evaluation, is an evaluation, audit and bench marking system for psychological therapy that includes an assessment of risk.

**Care programme approach (CPA)** – provides a framework for care co-ordination of service users under specialist mental health services. The main elements are the assessment, care planning and regular reviews under the guidance of a care co-ordinator who works in partnership with the service user and carers.

**Care co-ordinator –** A mental health professional who has responsibility for co-ordinating a service user's treatment and/or care and ensuring regular CPA reviews.

**Care plan –** a detail of the interventions and services required aimed at special areas of need or risk which are aimed at achieving the agreed outcomes and evaluation at review.

**CMHT –** Community Mental Health Team in secondary mental health services.

**Compulsory admission –** this refers to powers under the Mental Health Act 1983 to detain someone in hospital against their wishes. The most common provisions are under s.2 and s.3. A person can be admitted for assessment under s.2 for a maximum period of 28 days if they are suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period **and** he ought to be detained in the interests of his own health or safety or with a view to the protection of other persons.
A person can be detained for treatment under s.3 for a maximum initial period of 6 months if they are suffering from a mental illness, severe mental impairment, psychopathic disorder or mental impairment **and** his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital **and** it is necessary for the health or safety of the patient or for the

protection of other persons that he should receive such treatment **and** it cannot be provided unless he is detained under this section.

**Community psychiatric nurse (CPN) –** a registered mental health nurse who works in the community.

**Diminished responsibility –** a finding on a charge of murder, that at the time of the homicide the perpetrator was not fully responsible for his actions on mental health/disorder grounds. The finding has the effect of reducing the conviction from murder to manslaughter.

**Diazepam –** a minor tranquilliser or benzodiazepine used in the treatment of anxiety or where a sedative is required.

**FACE risk assessment –** an evidence based risk assessment tool which is a questionnaire when scored will help quantify the level of risk to self or others.

**Fluoxetine –** antidepressant.

**Informal patient/admission –** refers to a voluntary hospital admission as opposed to a formal admission, which would refer to admission under the provisions of the Mental Health Act 1983.

**Nurse consultant –** an experienced clinician educated to Masters level or above and who has specialist clinical expertise.

**Personal Advisors Service (PAS) –** Primary care mental health service for South Tyneside.

**Paroxetine –** an antidepressant.

**Propanolol –** a beta-blocker often used in the treatment of anxiety.

**Psychotic phenomena –** psychotic symptoms including feelings of being controlled by outside forces, hearing, seeing, smelling or feeling things which are not there (hallucinations) and unusual beliefs (delusions). Can also include extreme changes in mood or affect.

**Section 38 –** an interim hospital order made by a court prior to deciding whether to make a hospital order under section 37.

**Section 37 –** a hospital (or guardianship) order where a person is sent to hospital other than being given a prison sentence. It is thought by the court that treatment is likely to alleviate or prevent deterioration in a person's condition.

**Section 41** – is a restriction order which the court are satisfied is required for the protection of the public. Leave can only be granted by the Secretary of State and transfers require Home Office agreement.

**Senior House Officer (SHO) –** a training grade of doctor.

**Suicidal ideation –** term used to refer to thought of committing suicide.

**Triage nurse –** assesses the urgency and appropriateness of referrals, notes the information required and allocates the appropriate workers.

## REFERENCES

Department of Health, 2001: Treatment choice in psychological therapies and counselling - evidence based clinical practice guide.

Department of Health, 1999: National Service Framework for mental health

Department of Health, 2001: Mental health policy implementation guide.

Department of Health, 2002: National suicide prevention strategy

Department of Health, 2005: Improving mental health services by extending the role of nurses in prescribing and supplying medication - good practice guide.

Nursing and Midwifery Council, 2005: Guidelines for records and record keeping.

## BIBLIOGRAPHY

Department of Health, 2001: The journey to recovery – the Government's vision for mental health care.

Department of Health, 2002: Mental health policy implementation guide - dual diagnosis good practice guide.

Department of Health, 2004: Organising and delivering psychological therapies.

Department of Health, 1998: Modernising mental health services - safe, sound and supportive.

Newcastle, North Tyneside & Northumberland Mental Health NHS Trust, 2003: North Tyneside locality crisis assessment and treatment service (CATS) operational policy.

Newcastle, North Tyneside & Northumberland Mental Health NHS Trust, 2005: Policy and procedure on the handling of serious and untoward incidents.

Newcastle, North Tyneside & Northumberland Mental Health NHS Trust, 2005: Accidents and incidents reporting policy and procedure.

Newcastle, North Tyneside & Northumberland Mental Health NHS Trust, 2005: Care co-ordination policy.

NHS Executive, 1999: Effective care co-ordination in mental health services - modernising the care programme approach (policy booklet).

Northern Centre for Mental Health, 2003: More than the sum of all the parts - improving the whole system with crisis resolution and home treatment.

Northern Centre for Mental Health, 2002: Crisis resolution and home treatment for inner city populations: the Newcastle and North Tyneside story by Stephen Niemiec and Mary-Jane Tacchi.

North Tyneside Mental Health Services Directory.

Northumberland, Tyne and Wear Strategic Health Authority, 2005: clinical governance.

Royal College of Psychiatrists and Royal College of General Practitioners, 2005: Roles and responsibilities of doctors in the provision of treatment for drug and alcohol misusers.

South of Tyne and Wearside Mental Health Trust, June 2003 accident and emergency mental health liaison team operational policy.

South Tyneside Mental Health Services Directory

South of Tyne and Wearside Mental Health Trust, 2004: South Tyneside locality community mental health team operational policy.

South Tyneside Primary Care Trust, 2005: South Tyneside primary care mental health services operational policy.

South Tyneside Primary Care Trust, 2004: Risk incident reporting policy and procedure.

The Mental Health Act, 1983.

The Mental Health Act Code of Practice, 1999.