REPORT OF THE

INDEPENDENT INQUIRY

INTO THE TREATMENT AND CARE

OF DORIS WALSH

SEPTEMBER 1997

ACKNOWLEDGEMENTS

We would like to thank Anna Little and Jayne Norman for their sterling work in taking down the evidence and preparing the transcripts from which we worked. Their efficiency and accuracy was impressive.

We were also grateful for the facilities made available to us during our investigations.

Without the indefatigable and infinitely patient Jane Mackay our difficult task would have been that much more so. We were fortunate to have her "on board".

INDEPENDENT INQUIRY - MRS D WALSH

Membership

Jane Mishcon	Barrister Chair of the Inquiry
Lotte Mason	Consultant in Mental Health Social Work
Shirley Stanner	Senior Nurse
Dr Donald Dick	Consultant Psychiatrist
Jane Mackay	Inquiry Co-ordinator

Independent Inquiry Mrs D Walsh

Terms of Reference

1. To examine the circumstances surrounding the treatment and care of Mrs Walsh by Health and Social Services. This will include examining the quality and suitability of her care, in view of the patient's history, and assessed health and social care needs (including risk assessment).

2. To examine the extent to which Mrs Walsh's care corresponded to Statutory obligations, relevant Department of Health guidance and local operational policies.

3. To examine the extent to which Mrs Walsh's care plan was adequate and appropriate to her needs and was monitored and reviewed effectively.

4. To examine the quality and extent of collaboration and communication between the agencies, (Coventry Healthcare NHS Trust and Coventry Social Services, Coventry Housing and Environmental Services Departments) involved in the care of Mrs Walsh or in the provision of services to her.

5. To review the recommendations of the internal inquiry and advise whether such recommendations are realistic and achievable.

6. To consider other relevant information relating to the care and treatment of Mrs Walsh which may be in the public interest.

7. To prepare a report for Coventry Health Authority and make recommendations .

March 1997

INTRODUCTION

Just before 9 am on Friday the 28th July 1995, Doris Walsh set fire to clothes in the cupboard in the hall of her flat because she wanted to put a stop to the voices which had been tormenting her for some time and which she believed were coming from the cupboard. These voices were telling her that she was evil and were making accusatory comments about her which had a sexual innuendo.

The fire spread quickly, producing thick smoke which soon engulfed the corridor outside Doris's flat, as she was in the habit of leaving her front door open.

Doris went next door to her neighbour Thomas Redshaw's flat for help. Thomas and his 13 year old son Richard - who had stayed overnight with his father - had apparently been having breakfast when the fire started. They let Doris in, but unfortunately their front door was left open and, therefore, let the smoke into their flat. Thomas Redshaw telephoned the emergency services. All three were overcome by the toxic fumes of the fire. Doris Walsh survived, Richard and Thomas Redshaw did not.

Doris Walsh was charged with the manslaughter of Thomas and Richard Redshaw because she admitted that she had deliberately started the fire. On the 7th October 1996 the Judge directed the jury to find her not guilty by reason of insanity.

On the 5th August 1995 Doris had been admitted under section 3 of the Mental Health Act (MHA) to Reaside Clinic (a Medium Secure Unit) where she has remained ever since under the care of Dr. Bea Brockman. Following her trial she has been there under a Hospital Order (Section 37 MHA) with a Restriction Order (Section 41 MHA).

Doris Walsh had suffered from episodes of depression since shortly after the birth of her daughter, about 30 years ago, but at that time did not seek any professional help. By the mid-1970's she was attending her GP with complaints of depression and was prescribed anti-depressants. Her first encounter with the psychiatric services was in 1975, when at the age of 31, she took an overdose of 40 anti-depressant tablets together with alcohol. The psychiatrist who saw her on that occasion diagnosed:

> *"Mild depressive neurosis which is caused by frustration with the routine life of a housewife."*

He did not consider that any psychiatric follow up was necessary.

Over the next ten years, Doris suffered from recurrent bouts of depression which necessitated treatment on several occasions as an outpatient at Walsgrave Hospital. Doris was seemingly well in between these depressive episodes.

Her first admission to hospital was in August 1986 when she was 43 years old. Between August 1986 and July 1995 she was admitted to Walsgrave Hospital on six occasions, all of them as an informal patient. She was never compulsorily detained under the Mental Health Act.

There are 13 documented episodes of serious depressive illness in the 20 years between 1975 and the fire in 1995. Seven of those episodes were associated with evidence of delusional thought when Doris believed that she was being persecuted.

Prior to the fire, Doris had been an informal inpatient at Walsgrave Hospital between the 9th June and the 7th July 1995. She had been admitted to Walsgrave Hospital after her father dialled 999 to call an ambulance after she had cut her ankle badly, having kicked a china cabinet.

The Duty Doctor who admitted Doris took a detailed history from her which included that she had been hearing voices for the past two weeks telling her that she was evil and she had been tormented by the voices constantly for the last week.

She told us when we spoke to her that she had been hearing voices for a year.

The nursing notes show that for the first three weeks or so Doris remained isolated and detached on the ward, although there appeared to be a gradual improvement. She was allowed home for the weekend of the 30th June to the 2nd July and returned as planned on the Sunday evening, saying that the weekend had gone well. She was therefore allowed home the following weekend from Friday the 7th July until Sunday the 9th July, and a Discharge Planning Meeting had been arranged for Thursday the 13th July to discuss her discharge from hospital and plan her aftercare in the community.

Doris did not return on Sunday the 9th July, nor the following day.

On Tuesday the 11th July, Doris's Named Nurse contacted the Community Mental Health Team (CMHT) and requested that someone should visit Doris to find out what had happened to her and how she was, as Doris did not have a telephone for the ward to contact her .

Doris Walsh lived on the tenth floor of a Council tower block of flats designated for single people over 40.

Two social workers from the CMHT went to visit Doris that morning.

They reported back to the ward that Doris was tearful and a little angry, speaking of an assault on her which had occurred some time previously. She told them that she did not want to go back to hospital because *"if I came back they'd keep me"*. She told the social workers that she had run out of medication and she agreed to contact her GP that

afternoon for a further prescription. The social workers suggested that Doris might benefit from counselling from one of their team and they told her that they would refer her for allocation to someone, but that she may have to wait a while before anyone would be able to contact her. They left their names and the telephone number of the CMHT should she want to contact them.

Doris Walsh received no further contact from any professional prior to the fire on the 28th July 1995.

We have no doubt that, although she started the fire deliberately, Doris Walsh had absolutely no insight at the time as to the possible consequences of her actions in so doing. The fact that two people died as a result of her actions still overwhelms her two years later - for a long time she refused to accept that anyone had in fact died.

We also have no doubt that the deaths of Richard and Thomas Redshaw have had a most devastating effect on their family. We know this from talking to Fay Redshaw, Richard's mother, Thomas's former wife and her eldest son Mark Roberts, Richard's half brother.

From talking to the Redshaw family and from reading the media coverage of the fire itself and Doris Walsh's trial, we know that the last two years of unanswered questions have done nothing to ease their pain and have, quite understandably, only fuelled the feeling that caring for mentally ill people in the community is an unacceptable risk.

Two years after this tragic event, Fay Redshaw still had many unanswered questions about the events surrounding the fire and the rescue of her loved ones. Her questions should not have gone unanswered for so long. Most of them are not questions concerning issues within the remit of the Inquiry Panel, but are questions that any mother/wife should have had answered or explained as soon as possible after the event.

Most of Fay Redshaw's unanswered questions relate to the rescue of the victims of the fire rather than to the appropriateness or otherwise of the care and treatment given to Doris Walsh and the circumstances which led to her starting the fire. These questions continue to haunt her and she has therefore been unable to come to terms with her loss. She was in fact offered psychiatric support following the tragedy but was unfortunately referred to the very same team that had cared for Doris Walsh. Understandably Mrs Redshaw felt unable to take this up given the circumstances and was offered no alternative.

We have to say that we feel that some of the media coverage of this incident and Doris Walsh's trial only helped to fuel the family's emotions - the local newspaper reported on more than one occasion that Fay Redshaw had described Doris Walsh as an "evil monster". Fay told us that this was not her attitude now. She told us:

"She was just a patient really, wasn't she? She is mentally ill. You know if people have major surgery and they go into hospital and they don't get the aftercare, and over 60 people die as a result of it, there would be a public outrage, but because these are mental patients, I feel that they just want to throw a blanket over it and I have always felt that they thought I would just go away in a corner and die like a wounded animal. I was never going to do that. I wanted to know .... I want to know why my son is in a cemetery. I want to know why he died and how he died."

Richard and Thomas Redshaw were not the only victims of the fire on the 28th July 1995. Fay Redshaw and the rest of her family are victims too. So is Doris Walsh.

We cannot promise to answer all of the questions that are raised by these tragic events but we hope that this Report and the recommendations which we make might go some way towards preventing a similar tragedy in the future.

NARRATIVE

Doris Walsh was born on 27.2.44. She has two sisters and a brother as well as two half-sisters. There is a family history of depression and a maternal uncle who committed suicide.

Doris married at the age of 20, giving birth to a daughter two years later. She began to suffer from depression in about the early 1970's and was prescribed anti-depressants by her GP.

Only recently whilst at Reaside Clinic following the fire Doris told staff, apparently for the first time, that she had been violently raped by someone she knew quite well after about six years of her marriage. She apparently blamed herself to some extent and determined never to let anyone know in case it caused trouble for herself and the man involved, who was a family man. She was terrified that her husband would find out and kill her attacker. She said that when she became depressed, she often believed that she had let the truth out and that at any moment someone would come and tell her that her husband had been arrested. When not depressed, it seemed she remembered no details of the rape, only that it happened.

This event, which apparently triggered her depression, may explain and add significance to the paranoid features of her depression which emerged over the years.

In July 1975, at the age of 31, Doris took an overdose of 40 tablets of Amitriptyline (an anti-depressant) together with four pints of beer. She was admitted to Gulson Hospital in Coventry where her stomach was washed out. She was seen by a Consultant Psychiatrist (CP1) who was of the opinion:

> *"Mild depressive neurosis which is caused by frustration with the routine life of a housewife."*

She was discharged the same day and the discharge letter to her GP stated that it was not considered that anti-depressants were needed, nor was any medical or psychiatric follow-up.

This was Doris Walsh's first encounter with the psychiatric services.

Doris continued to be seen on occasion by her GP for depression and in November 1978 he referred her to a Consultant Psychiatrist (CP2) at Walsgrave Hospital, Coventry, stating:

> *"This woman has a long history of anxiety and depression and has been admitted for an overdose in 1975. Her depression and anxiety has flared*

up again recently and there is a hint of some paranoid features. I have put her on Lentizol (a slow-release form of Amitriptyline) 50mgs nocte as a temporary measure. I would value your opinion on diagnosis and treatment."

Doris was seen again by this consultant psychiatrist, who wrote to her GP (GP1) on 16.11.78:

"... She tells me that she has been depressed for about 3 months and has felt very guilty for various sexual misdemeanours, because of this she feels that people are talking about her. She says that the depression has been helped by the Lentizol which she tolerates very well.

She tells me that her childhood was made very unhappy by her father being aggressive towards her mother. She, herself, feels aggressive now, particularly towards him, but also towards herself and her husband. She says that her life situation is quite happy, except that for several years she has been frigid for reasons she cannot really quite understand but, possibly, a link to her hostile feelings to her father.

She seems to be a hard working, conscientious lady. ...

I would suggest that we double the dose of Lentizol to 100mgs nocte, and that for her paranoia and aggression she has Thioridazine 50mgs t.d.s.

She tells me that she has not been thinking of suicide recently. I think the outlook should be pretty good. I will be seeing her again in 6 weeks."

This was an early indication that Doris's depression brought about feelings of guilt and paranoia. It was also the first indication of her becoming aggressive when she became unwell. Also, in the knowledge of what Doris said recently about the rape in the late 1960's, her indication that she had been frigid "for reasons she cannot really quite understand" may also be an indication of Doris's reluctance to talk about what was really going on inside her head.

On review on 28.12.78, the psychiatrist reported to her GP that Doris was saying that she was very much less depressed and paranoid. He therefore did not think that there was anything else that needed to be done and suggested that she carried on with her medication for three months or so and then gradually tailed it off. He believed that the prognosis should be reasonably good.

However, within about a month on 8.2.79 Doris had made another appointment to see the psychiatrist. She told him that for the most part she had been all right, in spite of not taking any medication. However, she had the odd day when she felt depressed.

The psychiatrist's notes for that day conclude:

> *"Wonders whether she will ever be aggressive.*
> *Also wonders whether hypnogogic hallucinations (which occur when one is falling asleep) she had when she was bad will come back."*

This was the first indication that Doris did not always take the medication she had been prescribed.

1980-85

The GP records contain the following entries over the next couple of years:

> *"19.2.80: Might be getting depressed again!*
> *4.3.80: Paranoid and depressed.*
> *4.3.81: Panicky.*
> *24.8.81: Wants to talk to the psychiatrist "privately"."*

Following this last entry, her GP wrote to the consultant psychiatrist :

> *"You may remember this woman. She came to see me this morning and began by saying that "I am not depressed but I want to see the psychiatrist I saw before." After a considerable chat I got no further information but I suspect it may have something to do with her sexual problems in the past. Sorry I have no further information to add."*

The psychiatrist saw Doris and on 24.9.81 wrote to her GP:

> *"... At interview she was very miserable and described a lot of guilt feelings centering, I think, around her inability to assert herself with people. She is guilty about drinking too much, and possibly feeling that she might adversely affect her daughter's future. In actual fact her life situation seems to be a potentially very happy one, in which she has a good home, plenty of money and good support from her rather shy husband. I would have thought the best thing to do is to give some anti-depressants. You will probably recall that she has a very strong family history of depression and suicide and I would tend to see the present picture as a depressive illness more than anything. I have given her Mianserin 20mgs 3 times a day, and fixed up to see her in 6 weeks."*

The psychiatrist reviewed Doris on 30.12.81 and on 4.3.82 when she reported that she had felt pretty good for the past few months on Mianserin (an anti depressant), and Duphaston (which had been prescribed for her pre-menstrual irritability) and the psychiatrist therefore

returned Doris to the care of her GP, suggesting a continuation of the Mianserin for 2-4 months and the Duphaston for about another year. The psychiatrist's notes for 4.3.82 record:

"She says that normally she is depressed at this time of the year."

By September 1982, having not been on medication for a few months, she was depressed again and her GP started her on Mianserin 20mgs t.d.s. as well as Duphaston. By November of 1982 her GP had increased the Mianserin to 30mgs t.d.s., but by 19.11.82 it was necessary to refer Doris back to the psychiatrist as her depression had increased in intensity. By this time, Doris was being looked after by another GP (GP2) in the same practice.

The psychiatrist saw Doris and on 19.11.82 wrote to her GP:

"... She is very depressed with a lot of obsessional, aggressive thoughts. This attack seems to have come on for no very obvious reason. It is very disappointing that she has not responded to the adequate dose of Mianserin that she has been taking for the past 2 months. I have changed it to Lentizol 100mgs at night. She has responded to this in the past and hopefully will do so again. She is finding it very hard to cope at the moment and I would suggest that she stays off work for at least 2 or 3 more weeks. I will be reviewing her in 4 weeks time."

The psychiatrist's notes state:

"Still frightened that she might be aggressive."

This was an indication that Doris's depression did not always respond to medication (assuming that she was, in fact, taking it).

The psychiatrist reviewed Doris on 26.1.83 and 10.3.83 by which time she was reasonably cheerful but had now developed panic attacks, particularly at work. He also referred her to a volunteer group which held relaxation classes for phobics. On review on 18.5.83, Doris was still depressed and anxious and unable to work. The psychiatrist once again changed her medication.

At review on 6.7.83 the psychiatrist noted:

"Was a lot better until one week ago.
? Relapsed following a row with her mother-in-law.
Is going to the relaxation classes ...
Describes an incident when she thought an engineer at work had tampered with her machine ? Fact ? Paranoia."

By review in August 1983, Doris was fairly cheerful but talking more and more in a paranoid way, and the psychiatrist therefore added Flupenthixol (an anti-psychotic with some anti-depressant properties) to her medication. On review on 28.9.83, Doris appeared to be saying that she had made up her mind not to go back to work and the psychiatrist queried whether this was because of paranoia.

On 2.11.83 his note records:

> *"Talks of recurring thoughts about a time when she picked a bloke up and he beat her up. This is associated with a lot of allied thoughts (? obsessions) that my husband might go out and murder him. Lives in dread of people finding out."*

This may be an early reference to the rape which Doris described at Reaside following the fire.

By the middle of February 1984 Doris was telling the psychiatrist that she was better than she had been for a long time. The psychiatrist, therefore, discharged her back to her GP with the advice she continued on Flupenthixol and Duphaston, but that it should be possible to try to get her off the Phenelzine (anti-depressant) in 3 or 4 months' time, providing that she had kept free of depression until then. The psychiatrist did not arrange to see her again following this discharge but said he would do so on request. He thought the outlook was "*guarded*".

1985-90

The GP records show that Doris continued on medication and was apparently well over the next 2 years. The next entry of recorded depression was in August 1986 where she was said to be depressed with "*slight paranoid ideation*".

Doris was seen by the Doctors' Deputising Service on 16.8.86. The doctor who was called out made the following notes:

> *"On examination, auditory hallucinations +.*
> *Thoughts jumbled.*
> *Looks depressed.*
> *Thinks somebody's going to kill her and Police is after her for telling lies*
> *What lies?"*

This is the first mention of auditory hallucinations.

Doris was admitted via the Deputising Service to Walsgrave Hospital as an informal patient under the care of a Consultant in Acute Psychiatry (CP3).

On admission, Doris said that she had felt quite well up until five weeks beforehand when her daughter informed her that she had become pregnant and she became more and more depressed, blaming herself for the fact that her daughter was in trouble. The previous Thursday a young man had been murdered in Coventry and this had made Doris very disturbed as she believed that the police were going to arrest her or someone in the family. She was said to be extremely paranoid about the police. She also said that she had been telling lies to people. She said that her sleep was disturbed and she woke in the middle of the night and her appetite had been poor for the last five weeks and her mood low.

The admitting doctor wrote a long and detailed history, despite being unable to establish any rational conversation with her, as she kept saying *"I should die"*. His differential diagnosis was:

> *"Paranoid state with depressive illness.*
> *Paranoid schizophrenia.*
> *M(anic) D(epressive) Psychosis - of depressive type."*

Doris remained in hospital until 15.10.86, during which time she was treated with anti-depressants and anti-psychotics and also a course of six ECTs (Electro Convulsive Therapy). At the beginning of the admission she was expressing very strong paranoid ideas, with delusions of reference. She believed that people were talking about her, including the doctors and nurses at the hospital, saying that she was a prostitute. She apparently felt very guilty, saying that when she was 28 she had cheated her husband by having affairs. She isolated herself on the ward. She showed improvement following the course of ECTs and gradually said that she would try to join in with discussion groups. She continued to feel guilty about her daughter, believing her daughter's problems were due to her own illness. It was noted that she seemed to be more willing to give information on a one-to-one basis than in groups.

Doris was admitted to the Day Hospital on 23.9.86 and in late September she was given leave to go on holiday with her husband to Anglesey, which went very well. She was therefore discharged on 15.10.86. She was reviewed in the Outpatient Clinic on 24.10.86 by an SHO to the consultant psychiatrist, who concluded in the Discharge Summary:

> *"We will probably maintain her on a low dose of anti-depressant for a considerable time as we feel that as she has a strong previous history of depression and has sensitive personality this would possibly prevent a further episode."*

The SHO reviewed her regularly until mid-May 1987 when she was exhibiting no signs of depression nor psychotic symptoms and he discharged her back to the GP. She had, however, asked him in January 1987 about whether her illness would recur and he told her that they could not be sure that it would not recur. She said that she thought she could now recognise the onset. Her medication on discharge to the GP was Prothiaden (anti-

depressant) 50mgs at night, which the SHO advised could gradually be stopped over the next few weeks.

Within a month the GP notes record that since the tablets had been reduced, Doris was becoming more depressed and paranoid. He therefore increased the Prothiaden to 75mgs at night and added Stelazine (anti-psychotic) 5mgs at night. The GP notes for 14.7.87 record:

> *"Still very depressed and she says that she is afraid of everything including talking to people. Ref. Psychiatrist (CP3)."*

There is no record that Doris was in fact referred to the Consultant Psychiatrist in July 1987.

The GP records show that repeat prescriptions of Prothiaden and Stelazine continued throughout 1987 and 1988 and into 1989. Otherwise Doris appears to have remained well. A note on 5.5.89 states that Doris was saying that Stelazine slowed her up but when she stopped taking it she felt very anxious.

By mid-July 1989 Doris was complaining of morbid thoughts, guilt and feelings of worthlessness. Once again she was not sleeping or eating and was very depressed with paranoid ideation. A GP at her practice referred her back to Walsgrave Hospital. His referral letter stated:

> *"She is desperate again with an exacerbation of her depressive disorder. She has recurrent morbid thoughts of her previous affairs which she thinks her daughter knows about. This in turn has upset her husband who she thinks will murder her daughter. She has ideas of reference and paranoia - the neighbours know about her sordid past and are talking about her. They also tell her stories which indirectly she knows are about her. Yesterday she spent all day talking to the Samaritans. She is not sleeping or eating at the moment and is very tearful ..."*

Doris was admitted to Walsgrave Hospital on 18.7.89, again as an informal patient. The history taken on admission records that for some four weeks she had been getting lower in mood and not sleeping well and not eating. For the last two days she had been feeling like harming herself. She felt that her husband and daughter were both turning against her, but she blamed herself for this. She had no self-esteem, believing she was worthless.

She said she had never had auditory hallucinations. However, she told the admitting doctor that the previous Friday a neighbour had been talking about a TV programme about women who had had affairs and the neighbour had said she would like to hurt the woman on the TV. Doris felt that she was really talking about her. She was also rebuffed by a woman in a launderette and believed that she wasn't allowed to dry her clothes because she had been nasty towards her daughter who had been talking about her. The doctor's impression was of a *"very severe psychotic depression"*.

It emerged that Doris had stopped taking her Stelazine one week prior to the onset of symptoms.

This is another example of Doris not always taking her medication, and rapidly becoming ill without it.

The diagnosis was made of *"Manic Depressive Psychosis, depressed type, with paranoid features".*

Doris once more had a course of ECT treatments and after the first one made a dramatic improvement and, therefore, the treatment was stopped after three ECTs. As she was due to go on holiday to Norfolk with her husband during the first week in August, she was discharged on 26.7.89 and reviewed on 1.8.89 by the psychiatrist, who noted:

> *"In view of recurrent depressive psychosis and a strong family history of depressive illness would need to be on Prophylactic anti-depressant drugs for some years. "*

On 31.7.89 the psychiatrist referred Doris to a social worker (SW1), stating that she was recovering from depression and would need support at home, plus day activities. The social worker visited Doris at home on 1.8.89 and discussed what he could offer her. Doris said that she would like him to visit for a while and would consider a Day Centre. The social worker recorded:

> *"Impression of a caring family but not much communication."*

On 15.8.89 the social worker took Doris to the Queen's Road Day Centre. She said that she liked it and would start there next week. She said that she was feeling better but the social worker recorded that she seemed fairly tense.

Within 10 days Doris was back at the Day Hospital.

This is evidence of how she would hide her feelings and symptoms from the professionals involved with her and also how her health could deteriorate very quickly.

On review by the psychiatrist on 22.8.89 Doris had shown evidence of depression again, with feelings of guilt *"about things I haven't done"* ...

She was, therefore, referred for treatment at the Walsgrave Psychiatric Day Hospital.

Doris admitted that she really hadn't felt well since her discharge from hospital the previous month. She admitted that she had lied about her mental state, so that she could be discharged and not detained.

This situation is the same as that which appears to have occurred in July 1995.

She said that she was well until Stelazine was stopped. She said that for the past year she had not really felt a real person and that for the past month had felt that her surroundings were not real.

Doris said that she had felt low and depressed on holiday in Norfolk with her husband but had tried to keep it from him. When she came back she could not continue hiding it for any longer. Her mood had deteriorated and she had considered cutting her throat with an electric knife the previous day. She could not see the future. She was repeating her guilty thoughts about the affairs that she had had 20 years ago.

ECT treatment was started the next day and she had a total of six ECTs, but this time she took much longer to improve on this treatment.

Whilst attending the Day Hospital in September 1989, Doris was encouraged to consider group therapy or one-to-one for cognitive therapy and counselling. She was also advised to consider assertiveness training. Although doubtful at first, she started on the self-assertiveness course in November 1989.

Doris recognised that apart from one episode of depression a long time ago which had come with no precipitating factor "*out of the blue*", there had always been some stressful event which triggered her depression. She also professed to a lot of faith in Stelazine, although it was explained to her that taken long term it could have side effects. Lithium (a mood stabiliser) was considered but rejected as (a) she had never had any hypomanic episodes and (b) she had not had a severe enough frequency of relapse.

Doris was encouraged to join a social club and make friends as she needed a social outlet outside the immediate family.

Doris was discharged from the Day Hospital on 18.12.89.

1990

Doris was reviewed in the Outpatient Clinic on 12.1.90 by a SHO to the consultant psychiatrist. She appeared quite low in mood, as if about to cry at any moment but said that she had just been nervous about attending Outpatients in case the psychiatrist reprimanded her for discontinuing the assertiveness training group. She admitted to having about two days a week when she didn't feel very happy, but denied any feelings of guilt or self-blame or any suicidal ideation. She was offered a place at the Day Hospital but she said that she would prefer not to take it up. The SHO expressed his concern about her and asked her to see him again in a week's time, but she said that she would prefer to see him in two weeks as it would make her husband worried as well. She

assured him that if she had any further problems, or her condition deteriorated, she would contact him earlier. Meanwhile, she would continue with Prothiaden 100mgs at night.

The SHO saw Doris again on 26.1.90 when she was still feeling low, describing it as *"I am in a cloud"*.

By the time of the next review on 9.2.90 Doris claimed to be feeling *"not too bad at the moment"* and said that she was almost 97% back to normal. She did, however, admit that she was spending most of the time just doing housework or sitting and smoking. The SHO remarked in a letter to the GP:

> *"I felt that her affect was rather strange, that she seemed almost detached and flat."*

He tried to persuade Doris to go to Queen's Road Day Centre.

Doris continued to be reviewed on a weekly basis in Outpatients and she reported feeling *"all right"* although she admitted having some bad days - occasionally feeling suicidal - once or twice a week. Once again a SHO to the consultant psychiatrist, wrote to Doris's GP:

> *"My impression is that Mrs. Walsh always seems very quiet and almost on the verge of tears when she comes to see me. I feel that she keeps a lot of feelings to herself and tends to play down her symptoms."*

In his notes he wrote:

> *"I am concerned as I feel she is likely to deny how she feels and today was virtually admitting to having some suicidal thoughts."*

The SHO appears to have recognised Doris's tendency to hide her true feelings and symptoms. This was clearly written up in the notes and was there for anyone in the future to read should they access her records.

The SHO arranged for her to start attending Queen's Road Day Centre on a regular basis one day a week and she was due to start the following Thursday. As a precaution, the SHO arranged for Doris to see the psychiatrist the following week. The psychiatrist was of the opinion that Doris was coping reasonably well, but in view of her previous history it would be better for her to continue on anti-depressant drugs for a few months at least. He issued her with a prescription for Dothiepin 150mgs by night for two weeks and he wrote to her GP asking for him to continue with the repeat prescriptions as her Outpatient review would be less frequent in future.

The social worker noted on 27.2.90:

"Mrs. Walsh discharged from Day Hospital 3 weeks ago as she seemed to be well.

Phoned Mrs. Walsh. Said she was all right and is planning to attend Queen's Road ...

Nothing further needed at present."

The social worker closed Doris's file at this stage.

On review on 3.4.90, Doris was feeling quite well although she occasionally felt down, feeling at her lowest in the mornings. Her appetite and weight remained stable. She had started attending Queen's Road Day Centre once a week, and seemed to enjoy it. The SHO expressed concern that she was not really doing enough with her day and that she just tended to do housework and sit and smoke at home. Doris seemed to think that she should stay at home because of her 24 year old daughter who also lived with her.

Doris continued to make a slow but fairly steady improvement and attended Queen's Road once a week. She still had occasional periods where she felt weepy and irritable. When seen at the Outpatient Clinic by the psychiatrist's SHO on 21.8.90, Doris reported that she had felt well until three weeks ago when she started to suffer from disturbed sleep, getting up several times in the night. Four days previously she had begun to become worried when her daughter fell ill and was admitted to hospital. She felt that she was to blame for her daughter's illness and all her past regrets and guilt feelings came back.

The SHO's notes record:

"Feels as if the kettle is sending her messages from the Police - kettle makes clicking noises - that they are trying to tell her that she will be arrested for past misdeeds."

At this appointment she was described in the notes as very agitated, tearful, worried, sitting tensely on the edge of her chair. The SHO noted that she looked depressed but Doris was denying that she was so. She said that she was finding it difficult to control her anger. Once again she was blaming herself for her daughter's problems.

The notes record that she was determined not to relapse and was denying the fact that she was suffering from a relapse of her depression.

Doris was reviewed on 24.8.90 when she said that she was feeling tired and was still agitated, very depressed and tearful. Her husband had reported angry outbursts and irritability. The SHO discussed the situation with the psychiatrist and Doris was referred to the Day Hospital on 29.8.90 and was regularly reviewed by the consultant psychiatrist and his team over the next month.

The notes clearly describe a pattern which repeated itself when Doris was becoming unwell. We would just wish to "flag up" here that Doris was described by the social workers who visited her on 11.7.95 as "tearful" and "a little angry".

On 23.9.90 Doris was re-admitted as an informal patient to Walsgrave Hospital under the psychiatrist. She had apparently smacked her daughter on the head over the weekend, following an argument when she had asked her daughter to do some of the housework. Her daughter had threatened to call the police and her husband had telephoned the hospital and arranged for her admission.

When seen by the psychiatrist, she was very agitated and tearful, saying that she needed help. She said that she had been spiteful to her husband and had to make things up to her family.

She was expressing ideas of reference - she strongly felt that motorists were hooting at her; she felt that someone was going to stop her and her husband from being together at Christmas; she thought that someone would stop them going to Jersey on holiday and she thought that it might be the police. She also thought the police would stop her husband from going on holiday to Ireland. She could not explain why the police would do this.

She felt that number plates on cars carried special messages for her e.g. WOR meant *"whore"*. She was convinced that this was a message meant specifically for her. She felt that someone may lock her up because she was wicked.

Doris said that it had been for over a year that she had felt that the police were going to harm her. She said that a year ago, whilst on holiday in Norfolk, she had overheard someone say that the Coventry Police would be keeping an eye on her and her husband. She said that the voice came from a man who was telling these things to a barman. She had had this feeling on and off since then.

Doris said that she felt angry with herself for looking for excuses. She said that she did not want sympathy and felt that she did not deserve help from anyone.

She admitted to disturbed sleep but denied suicidal ideation and denied any auditory hallucinations in the recent past.

She also said that she felt that she was being observed at home some times because she heard the electric kettle clicking and thought that the house was bugged. Sometimes she felt that the radio was referring to her and that the DJ was calling her names. She also felt that she was being tape recorded. She thought that the police had put a goat in the garden shed and related this to the fact that she used to call her mother-in-law "a goat".

Doris also believed that the doctors were part of the whole set-up. She felt that the doctors had been planted by the police, but she felt that she had nothing to hide or lose

now and so she was going to tell the hospital staff all of this. She had never felt her husband was part of the plot.

This is evidence of increasing paranoia.

Doris agreed to have a further course of ECT treatment.
She had a total of seven ECTs during this admission and made a gradual improvement and was discharged on 29.10.90 to attend the Day Hospital, where she did very well and was discharged on 12.11.90 with Outpatient follow-up.

The Discharge Summary was not sent to Doris's GP until 14.2.91, three months later.

On Outpatient review on 11.12.90 Doris was said to be feeling well apart from occasional anxious feelings. She continued on the same medication.

1991

On review on 15.1.91 Doris was once again feeling depressed. She had herself reduced the dose of her Prothiaden from 200mgs to 100mgs before Christmas and started to feel low shortly thereafter. She also became irritable, she was not sleeping well and her appetite was reduced.

This was the pattern for Doris becoming severely unwell. She again appeared to decline rapidly when not taking the full prescribed dose of her medication.

She was once again hearing clicking noises coming from the kettle and felt that the Police were after her again and that people were following her. Her strong guilt feelings had returned and she felt that she did not deserve any happiness.

She was advised that she should be referred back to the Day Hospital but she refused. The psychiatrist's SHO therefore increased her medication.

He reviewed her again on 23.1.91. Although she was looking slightly better she was still very depressed, especially in the mornings. She was still complaining of disturbed sleep and early morning wakening although her appetite had improved. She described a feeling of being unreal - of emptiness. She was still hearing the clicking noises coming from the kettle and felt that it might be a message, but she had no idea who might have been sending it. Once again she refused admission to the Day Hospital. A SHO to the psychiatrist, therefore arranged for an early consultation with the consultant psychiatrist's senior registrar.

The senior registrar saw Doris on 13.2.91 and found no improvement. Doris was still very tearful, feeling that she had done something wrong which was affecting her and her family. She felt that she should move away from her family in order to save them. She believed that people may be trying to upset her by playing music outside her window and was still

worried about the clicking kettle. She was not sleeping or eating and was not sure that things would ever change. The senior registrar managed to persuade her to attend the Day Hospital and have further ECT treatment.

Doris attended the Day Hospital on 18.2.91 but refused ECT treatment. She was accompanied by her husband who reported that her behaviour had been very disruptive and aggressive over the past weekend. On Friday Doris had gone out for a drink with her brother and when her husband returned home he found her crying, curled up with a hot water bottle, with the stereo on very loud. She was very aggressive towards her husband.

On Saturday she had spent most of the day crying.

On Sunday she went to the pub at lunchtime and returned home four hours later with a male acquaintance of theirs, having had quite a lot to drink.

Doris told the SHO that she felt as if people were out to get her and that she was "*fighting all the time*" and that her family didn't like her.

She said that in the past the Sun Newspaper had been out to get her, but she also felt as though some people wanted to help her, as messages would come over the radio by way of songs with "love" in the words, which were meant to be a comfort to her. Doris admitted that she had been drinking on a regular basis recently to help her feel better but it usually made her feel worse.

Doris was adamant that she did not want to have any ECT. She also refused admission or any attendance at the Day Hospital, preferring to go home.

The letter written by a SHO to the psychiatrist on 19.2.91 states:

> *"We have the overall impression that Doris shows features of depression with some psychotic symptoms and we feel that the diagnosis is of depression with psychotic symptoms but looking over her past history we cannot rule out-affective type disorder, however, we do know that in the past she has improved and the psychotic symptoms have been relieved when the depression is treated and we thus feel that the main diagnosis is of depression with psychotic symptoms."*

As Doris was adamant that she did not want admission, the doctors agreed that they would continue treating her as an Outpatient for the present time.

Doris was seen again by the SHO on 19.2.91 when she was accompanied by her daughter. She was tearful and still felt that her family was against her. She described her feelings:

> *"As if I am on the outside trying to get in".*

The SHO also had a private word with Doris's daughter on that occasion who became very upset and tearful when he explained to her the nature of her mother's depression. She appeared to be having difficulties in coping with her mother at home and often felt that her mother blamed her for her illness. The SHO felt that the daughter needed some sort of support and referred her to the Crisis Intervention Team.

On 21.2.91 the SHO saw Doris again, this time accompanied by her husband. She was still low and tearful but said that she was feeling better. Her husband said that she had been quieter and less argumentative. She was started on Lithium Carbonate 250mgs at night.

On review at Outpatients on 26.2.91 Doris was feeling much the same and was still tearful and low. She was feeling that her house was no longer her home and was also feeling *"derealisation."* She once again refused to be admitted to hospital. The dose of Lithium was increased to 500mgs. It was noted in the clinical record that Doris was due to see a Community Psychiatric Nurse (CPN) the following day.

We could find no evidence that Doris ever saw a CPN.

Doris was reviewed in Outpatients again on 5.3.91 and was tearful, saying that she was starting to feel as if she could not be bothered to do anything. She wanted to get out of the house - feeling that she would be better away from the family. She was waking twice during the night and also talked about going out for walks alone. She once again adamantly refused to be admitted to hospital but said that she would think about attending the Day Hospital. Her Lithium dosage was increased to 800mgs.

Doris was seen again the following day on 6.3.91 and initially appeared a bit calmer but was still experiencing derealisation. She was still feeling that her home was not her home. She said that she did not feel depressed, she was just feeling nothing and was empty. She was waking through the night and at 05.00, although her appetite was normal. She was still feeling that people did not like her.

She again refused attendance at the Day Hospital and was adamant that she did not want ECT, but agreed to think about it.

Two days later on 8.3.91 Doris was reviewed again and was still low and tearful. She agreed to start a course of ECT the following week.

The consultant psychiatrist's team were clearly doing all they could to support Doris at this time, seeing her at least twice weekly in the Outpatient Clinic.

Doris failed to attend for her ECT on an Outpatient basis on 11.3.91. She did, however, attend the Outpatient Clinic the following day, and following an outburst during which she was very agitated and upset, she eventually agreed to be admitted to hospital on an informal basis for treatment.

She told the SHO on 12.3.91 that she had not attended for ECT treatment because she was afraid that when she was asleep someone would try to get secrets from her. She was expressing suicidal ideas - she had thought about taking tablets over the weekend and the previous day had thought about jumping in front of a bus.

She was expressing paranoid thoughts and became very agitated.
The SHO recorded in the notes for 12.3.91:

"If attempts to leave will request detain under 5(2) → Section 2 ".

Doris settled in on the ward but remained very low, stating that she felt that her family and her home were not real any more. She remained an inpatient until 22.4.91. and received a total of eight ECT treatments during this period.

On 4.4.91, she went absent without leave with another (male) patient. She had apparently done this before during the week. The following morning her daughter telephoned the ward saying that Doris was at home but reluctant to talk to the staff as she was worried that the staff would tell her husband that she had been with another man. She was reassured that this would not happen and she said that she would return to the ward, but she did not.

Doris's husband went up to the hospital and spoke to the psychiatrist. He was very concerned and tearful as Doris had apparently disappeared in the past. The psychiatrist gave Mr. Walsh his home telephone number and told him that he would visit him at home over the weekend if problems arose. The police were informed that Doris was missing. One of the nurses also visited the address where it was believed the male patient lived but did not trace them.

Doris returned in the morning of 6.4.91 and said again that she felt that she did not belong at home any more. The importance of continuing to take her medication was emphasised to her and she said that she was willing to stay in hospital now.

Doris apparently had sold her wedding and engagement rings and jewellery. She said that she did this to get money for food and cigarettes. She said that the relationship with the other patient made her feel happy.

Doris was advised that some work should be done with her and her husband regarding their relationship in the future.

Doris's husband was also seen by the psychiatrist's SHO and agreed that they should be looking to the future rather than dwelling on past events. He said that he had bought back her wedding ring.

Doris continued to improve and was allowed weekend leave which went well and following a ward round with the psychiatrist on 22.4.91 she was discharged from the hospital with an appointment to see the psychiatrist in the Outpatients Department in four days' time. Her discharge medication was Lithium 800mgs at night and Dothiepin (same as Prothiedin, i.e. an anti-depressant) 75mgs in the morning and 150mgs at night.

It is worth noting that Doris was reviewed only four days after her planned discharge in 1991. Yet when she took her own discharge in 1995, a review was not planned for some four to six weeks.

When reviewed on 26.4.91 by the psychiatrist, she was still displaying depressive symptoms.

On 30.4.91 Doris's husband telephoned the psychiatrist, apparently distraught, stating that Doris had gone missing since that morning and had taken her bank books with her.

On 3.5.91, Mr. Walsh told the psychiatrist that Doris had telephoned the afternoon before but had put the phone down on hearing that the police had been informed that she was a missing person.

On 8.5.91 Doris contacted Social Services saying that she had left her husband and had no intention of returning. She had slept rough the previous night (with the male patient referred to earlier) and was requesting advice about housing, etc. She was advised to see the Homeless Officer and told that if she had a problem obtaining emergency accommodation, she could come back to see the Duty Social Worker with a view to contacting the Cyrenian Women's Hostel in Chester Street or Listening Post (a voluntary organisation). She was also requesting support to go and collect her belongings from the matrimonial home, which was given. The Social Services file was closed the following day.

On 4.6.91, the psychiatrist wrote to her GP:

> *"You would have learnt that Mrs. Walsh left her residence on 30 April but returned back to her husband about 10 days ago.*
>
> *She had been irregular with her medication during the time she was out of Coventry and on returning back. Though she takes Dothiepin, and that too in an inadequate dosage. She had stopped taking the other drugs including Lithium.*
>
> *She was reluctant to come and see me at the Clinic in spite of considerable persuasion by her husband, and eventually at his request, I telephoned her and arranged to see her at the Outpatient Clinic on 4 June.*

She still presents with moderate depressive symptoms but part of the depression is because of the tension that exists between husband and wife as both parties have seen their Solicitors with an idea of pursuing a divorce. However, they both are ambivalent about going through the divorce.

Mrs. Walsh, though depressed, did not present with any paranoid symptoms. However in view of her vulnerability the possibility of giving her anti-psychotic drugs should still be considered. In the meantime, however, I have advised her to recommence Lithium Carbonate 800mgs nocte and have advised her to take Dothiepin in the dosage she has been on in the past, that is 75mgs mane and 150mgs nocte. If her symptoms continue it will be advisable to start her on Thioridazine 25mgs nocte.

I am sending a note to a social worker in my team, to arrange conjoint therapy as Mr. & Mrs. Walsh have difficulty in adjusting to each other and their marriage is under considerable strain."

The same day the psychiatrist wrote to the social worker asking him to arrange to visit Doris and her husband for counselling.

The social worker telephoned Mr. Walsh on 5.6.91 who said that Doris was intending to leave him and did not want to talk to a social worker.

On 11.6.91, the social worker made a home visit at the Walshes' request. Doris had returned home the day before, after being with her male friend who had used her money. Doris's husband was very angry and hurt - Doris was suffering guilt and confusion. They said that a divorce was going through but they wanted to try counselling.

On 14.6.91 The social worker made a further home visit to begin individual work with Doris. She was feeling better and wanted to talk. They discussed her low self esteem, which was linked to childhood experiences. They also discussed her getting control over her life and finding a job.

On 18.6.91 the social worker made a further home visit and held a joint interview in which they discussed the areas of tension.

On 20.6.91 the social worker paid a further home visit when Doris was seen on her own. She talked of her need for attention and excitement. She had got a job and was very pleased about this. She was feeling more confident. She was going to keep fit classes. She wanted to make a new start. However, there was a problem in her relationship with her daughter.

On 25.6.91 the social worker paid a further home visit and held another joint session. It was admitted that they did not communicate well. Doris's husband said that he wanted to support Doris's new self, but she was not sure.

On 27.6.91 the social worker saw Doris on her own, focusing on her growing identity - her rights and assertiveness. She was beginning to feel good about herself, enjoying talking about these things which she never had before. She was confused about what she wanted from her husband.

On 2.7.91 the social worker held a joint interview and encouraged communication but it got no easier. There was a lack of trust and Doris and her husband had never talked to each other about feelings. However, they thought that joint sessions were helping.

On 4.7.91 Doris was seen by the social worker on her own. She was pleased with herself, enjoying her job and was beginning to get out and about more. The social worker confronted her about her relationship with the male patient and she admitted she did not know what she wanted.

On 9.7.91 at a joint session, it was revealed that they had told their Solicitor that they were not going ahead with the divorce. There were some positive changes in their relationship, yet communication was no easier.

On 12.7.91 Doris was seen on her own and was still dissatisfied with her future prospects but felt that she could settle with what she had. Her confidence was growing and she didn't think that her husband realised that the change must affect him.

On 18.7.91 Doris was again seen on her own and talked about herself, her childhood and her need to be close to someone. She did not think that she would get depressed now that she was more liberated.

On 23.7.91 the social worker paid another home visit and was told by Mr. Walsh that Doris had left the previous day - he assumed to go back to her male patient friend. He was upset and angry and hoped that this time she would stay away.

On 26.7.91 the social worker paid a home visit to see Doris as had been planned. She was not there and had not left a message for either him or her husband.

On 29.7.91 the social worker telephoned Mr. Walsh who was upset but now suspected that Doris had not stopped seeing her male friend.

On 1.8.91 the social worker telephoned Mr. Walsh again. He hadn't heard from Doris. He was coping and did not need the social worker's support. He would ring if necessary.

On 1.9.91 the social worker had received no word from Doris and he therefore closed the file.

The detailed entries above demonstrate that the social worker attached to the consultant psychiatrist's team, was obviously extremely supportive of both Doris and her husband over this difficult period, seeing them on a frequent and regular basis following the referral from the psychiatrist. It is unfortunate that the consultant psychiatrist's referral to the Community Psychiatric Nursing Team in August 1994 (after the social worker had moved following sectorisation) was not met with the same response.

It is believed that Doris then lived at an address in Leamington Spa with her male friend whom she had met in hospital.

1992

On 17.2.92 Doris was admitted to hospital in Warwick having taken between 10 and 14 Prothiaden tablets 24 hours previously. At the time of the overdose she claimed to have wanted to die, but the next day woke up and informed her neighbours of her overdose. There were no medical complications. She was reviewed by the Psychiatric SHO who felt that she was not actually suicidal and was fit for discharge. She was offered psychiatric follow-up but declined it and she was therefore discharged the following day with no follow-up.

There is an entry in the GP notes for 14.7.92:

> *"Depressed. Objectively flat. Staring ahead.*
> *Not always responding to my questions.*
>
> *Offered admission. Declined by patient.*
> *Offered referral tonight. Declined by patient.*
> *Patient denies O/D intents."*

On 21.7.92 Doris was taken by ambulance to the Accident & Emergency Department of Warwick Hospital after having a panic attack whilst out shopping. She said that she was feeling depressed at the moment but had no suicidal intentions. The Accident Officer wrote to her GP (in Leamington Spa) to inform him that he had advised Doris to see her GP for referral to a psychiatrist.

Doris attended her GP that day with her partner who said that she had tried to throw herself out of a window over the past few days. She told her GP that she was supposed to take Lithium but wasn't because it made her feel *"knocked out."*

This is another example of Doris becoming ill when not taking her medication.

Doris however agreed to go for an assessment at the Central Hospital, Warwick.

On 31.7.92 Doris's GP visited following a telephone call from her partner, saying that Doris had been threatening to go to the police station although no-one knew why. He was keeping her in as she had tried to walk to Coventry earlier in the week. She said that she would climb out of the window if she couldn't go and he therefore wouldn't let her go for walks outside the flat. She did not threaten to jump from the window and denied any suicidal intent. The GP's note concluded:

> *"On examination fairly normal affect at present. Not obviously depressed. Story has a hypomanic flavour to it. Flatly refused admission. Not sectionable. Finally agrees to restart Lithium 400mgs II daily."*

On 21.8.92 a Clinical Assistant in Psychiatry at Central Hospital, Warwick, wrote to Doris's GP:

> *"I saw this 48 year old lady in the Outpatient Clinic on 18th August 1992. She appeared very vague and didn't really want to tell me very much about herself. She did tell me that he had seen her 2 weeks ago when her partner had called him out but she couldn't remember why.*
>
> *Mental state examination revealed an appropriately dressed lady who was not very spontaneous and cried on occasion. She seemed quite low in mood but denied any active suicidal ideation. She was unwilling, or unable, to describe her thoughts and denied any abnormality of perception. Despite trying for some time, I was quite unable to persuade her to communicate any of her problems to me but she did say she wasn't keen on attending the Outpatient Clinic again. I have therefore discharged her to your care with 75mgs of Prothiaden nocte".*

This is yet another example of Doris being unwilling or unable to describe her thoughts or to communicate any of her problems to the professionals looking after her.

By the end of August 1992, the GP notes recorded that Doris had reduced her dose of Dothiepin/Prothiaden because she disliked sedation. She was advised to return to a full dose.

This is another example of Doris's non-compliance with the correct dosage of medication.

By 4.9.92 Doris's GP had written to a psychiatrist at Yew Tree House in Leamington Spa:

> *"I would be grateful if you would consider this 48 year old lady for attending at Yew Tree House. She has a long past psychiatric history which seems to be mainly based on manic depressive psychosis. She has*

had several admissions in the past and has had ECT on several occasions. In 1990 she was on a combination of Prothiaden and Lithium but stopped the Lithium of her own accord because she felt that she did not like the side effects. She has been on our list now for just over a year but has only presented with problems over the past 2 months. Her consort reports that she has been depressed and very unpredictable. He reports that she has been threatening to throw herself out of the window and that she has been trying to go out and walk on foot to Coventry and keeps wanting to go down to the local Police Station although she does not actually know why. He is confining her to the house in order to prevent her wandering off and her behaviour is at times becoming rather aggressive and unpredictable probably as a result of this confinement.

I have seen her on a few occasions over the last few weeks. On each occasion she has admitted that her mood has been down at times but has certainly presented with a classically depressive outlook. She denies any suicidal intent and reports that she only threatened to escape from the house by a window because of her consort's imprisonment of her and that she was not actually trying to throw herself from the window. There were no obvious delusions. Her presentation was if anything more slightly hypo-manic than depressive. She flatly refused to consider admission despite pressure from her consort and her daughter. She was not sectionable.

Although she is not sectionable, I am sure that her behaviour is causing her relatives considerable stress and distress. ... Mrs. Walsh has agreed to restart her Lithium in a dose of 800mgs daily (on which she was previously stable). However, the relatives are so extremely stressed and would be grateful for any help that would be offered. Although Mrs. Walsh refuses to consider admission, she has agreed to consider attendance at Yew Tree House on a daily basis and I am sure this would also provide some relief to her family."

There is a note in the Coventry Social Services file dated 14.10.92 that Doris had contacted them saying that her relationship had broken down and she had gone to live with her father back in Coventry. It was apparently only a one-bedroom maisonette. A social worker contacted Church Housing who had a bed-sitter vacant in Hillfields which Doris said she was prepared to consider. They also advised her to visit either the Benefit Shop or the DSS. The file was closed on 19.10.92.

On her return to Coventry Doris registered at the GP Practice of a Coventry GP (GP3) who was in practice with his wife. They are both Section 12 Doctors **(approved as having special experience in mental disorder).**

The Coventry GP first saw Doris on 15.9.92, his record for that visit shows that she gave him some details of her past medical history including the medication which she was on and the note ends:

"NO Auditory Hallucination".

On questioning, the Coventry GP could no longer remember whether that entry had any particular significance.

1993

Doris did, in fact, remain living with her 80 year old father in his one-bedroomed maisonette and by February 1993, he wanted her out. She contacted Social Services again on 16.2.93 seeming anxious and sad. A social worker wrote that day on Doris's behalf to the Allocations Officer and then closed the case.

Doris contacted the social workers again on 12.3.93 saying that she had been advised by the Housing Department that they would be in contact with her within two weeks about an offer of council housing. Doris wondered whether a social worker could find out the current position. A social worker telephoned the Allocations Department who said they were about to send a letter to Doris with an offer of council accommodation.

Doris appeared to have no hesitation in contacting social workers when it came to her housing needs. She did not, however, contact them in July 1995, despite the two social workers who visited her on 11.7.95 leaving a contact number.

The Coventry GP's notes record feelings of depression on 22.3.93, but these appear to be linked to the fact that she was still living with her father and sleeping on the floor.

On 20.4.93 the GP notes record that she was hot and panicky and having difficulty sleeping.

Doris moved in to her own flat at 60 Alpha House, Barras Green, Coventry on 29.4.93. This flat was on the 10th floor of a 15 storey block of flats, allocated for single occupants over the age of 40.

On 30.4.93 (the day after she moved in to her new flat) Doris turned up at the Outpatient Department at Walsgrave Hospital and told the Duty Doctor that she felt awful and very depressed. She described her mood as dropping over a two month period since she had stopped taking Lithium and that she had felt even worse over the last two to three weeks, with very poor sleep, early morning wakening, reduced concentration and low mood with vague paranoid ideas.

Once again, a rapid decline when not taking her medication.

Doris was admitted to Walsgrave Hospital and treatment with anti-depressants and Lithium was continued.

Whilst Doris was still an In-Patient on the ward on 20.5.93 it was discovered after a phone call to her GP's Surgery (GP2), that Doris was no longer a patient there and after some enquiries it was discovered that she was now registered with another GP (GP3).

The change of GP was recorded in the notes. However, the Hospital continued to correspond with her GP (GP2) until February 1995! The Coventry GP (GP3) told us that he would eventually receive all the correspondence sent to her GP(GP2), but he apparently made no attempt to contact the Hospital and point out their continuing mistake. This is despite the fact that he was meeting the consultant psychiatrist every few weeks .

Whilst in Hospital, Doris expressed some concern at her alienation from her family, especially from her daughter. She appeared to be very isolated out in the community.

Doris remained on the Psychiatric Ward until 11.6.93 when she was discharged to the Day Hospital, being discharged from the Day Hospital on 26.7.93.

The Discharge Summary **(sent to her GP(GP2) but not until 6.8.93. It was received by her GP(GP3) on 17.9.93**) concluded:

> *"Doris improved slowly initially on the ward and then at the Day Hospital and on 26 July we were pleased to discharge her taking only Dothiepin 150mgs nocte. We have arranged to see her in the Outpatient Clinic in about 3 weeks. Prognosis must depend on her continued use of Prophylaxis and will remain guarded giving her having had a number of episodes of illness and the family history".*

On her discharge, Doris was said to be doing up her flat and was very pleased with it. She was advised to continue her medication.

At an Outpatient Review on 17.8.93 Doris was again said to be pleased with her flat and her daughter and grand-daughter had come to stay for the weekend and it went well. They were due to return in a couple of weeks time.

Doris was told to continue taking Dothiepin 150mgs at night for six months and one could then see whether or not it could be tailed off. It was however emphasised to her that it was important to take it for that length of time to avoid a relapse.

Doris was seen by the consultant psychiatrist at Review on 22.11.93. By this time she was only taking Dothiepin 50mgs which was what her Coventry GP (GP3) had prescribed (presumably because he did not get the discharge letter until two months after Doris was discharged as it was not sent until some time after her discharge and was sent to the wrong

GP Practice). The psychiatrist wrote following this review, but again his letter was sent to her GP(GP2) and was not received by her GP(GP3) until 26.1.94. In the letter the psychiatrist said that since Doris seemed to be managing on 50mgs it would not be necessary to increase the dose. However, he hoped that she would continue to take this dose for another six months.

The psychiatrist's letter also stated that Doris had still not come to terms with her divorce and consequently became tearful whilst discussing this issue. She had also started an industrial sewing course and this had stopped her from becoming pre-occupied with the past.

In fact, before he received this letter, her GP(GP3), on 17.12.93, increased the dose of Dothiepin to 75mgs.

1994

Doris was reviewed by the consultant psychiatrist in April 1994 and he wrote to the GP (GP2) on 14.4.94 (received by GP(GP3) on 20.5.94):

> *"Mrs. Walsh is symptom free but because of the severity of her illness I have advised her to continue on Dothiepin 75mgs nocte and shall review her again 5 months time."*

On 13.6.94 Doris suffered a sexual assault near the tow-path of Coventry Canal. She was in the habit of riding her bicycle to a place near a bridge over the Canal where she would sit and do her tapestry. She was approached by a man who asked to look at her tapestry and when she refused he put his hand on her left breast. She slapped his face and he then punched her in the face. She tried to walk away from him but he ran after her, knocked her to the ground and then threw himself on top of her, putting his hand over her mouth and throat with one arm and punching her with the other. He then indecently assaulted her.

Doris reported the matter to the police and was medically examined by a Police Surgeon. We were given access to the statements which she made to the Police following this attack.

We have no reason to doubt that this incident occurred and every account given of it since by Doris has been consistent. This attack had a deep and lasting effect on Doris and she now sees this incident as the beginning of a downhill spiral towards the events of July 1995. It was this incident which was troubling her in the weeks preceding the fire. She did not, however, appear to have mentioned this incident to either the psychiatrist or her GP.

The psychiatrist saw Doris again on 16.8.94 when she was said to be feeling angry and frustrated but not depressed.

The psychiatrist decided that Doris would benefit from the support of the Community Psychiatric Nursing Team and wrote to them on 16.8.94 as follows:

> *"I would be grateful if you could visit Mrs. Walsh in order to provide support and counselling. She has a long history of depressive illness necessitating admission to hospital many times since her first admission to Gulson Hospital under the care of a consultant psychiatrist in 1975. Her last admission was in April last year when she presented with severe depression and following her discharge spent considerable time at the Day Hospital.*
>
> *Since her discharge she has managed to enrol herself in an industrial sewing course which was over some weeks ago. As a part of this course she had a placement in a factory but found it tiresome and hence she stopped going for the placement.he feels tearful whenever she talks about her problems and though she denies that this is due to reflection of her failed marriage which was a consequence of her manic phase of her illness, she nevertheless does not admit to feeling truly depressed. She explains her feelings as being angry and frustrated as she is unable to make any progress in her life. Although she has finished her sewing course she continues to be interested in tapestry work and other types of needlework. She increased her Dothiepin from 75mgs to 150mgs but found it too strong and hence consequently has reduced it back to 75mgs nocte.*
>
> *I am sending a note to her GP(GP2) suggesting an increase of the Dothiepin to 100mgs.*
>
> *I would welcome your help in supporting and counselling her particularly as she is now reluctant to attend the Day Centre and is reluctant to be referred to a group for therapy stating that she is too shy to talk about her problems."*

It was not until 18.10.94, two months later, that this letter was even acknowledged by the Team! Even then it was only a standard letter which was sent to the psychiatrist thanking him for referring Doris Walsh to their Service. The letter continued:

> *"Unfortunately we are unable to see them at the present time but have placed their name on our waiting list. We will contact this client with an appointment date as soon as possible.*
>
> *However, should their circumstances change and you feel that their case has become more urgent, please contact the Service again."*

In November 1994, Doris was mugged by youngsters who stole money and personal belongings and threw soil at her.

This incident compounded her feelings roused by the sexual attack 5 months earlier and apparently triggered the depression which led to her admission in June 1995.

According to their records, the Team sent another standard letter to Doris on 7.11.94 telling her that she was on their waiting list and on 29.12.94 they wrote to her saying that she had two weeks in which to respond as to whether or not she wanted to remain on their waiting list.

1995

On 24.1.95 a Community Mental Health Nurse sent the following to the psychiatrist:

> *"Thank you for referring Doris Walsh in August 1994.*
> *We have been in contact with Doris Walsh enquiring as to whether they continued to need our Service or not.*
>
> *As they have failed to contact us within the 2 weeks as requested, we assume that they no longer wish to be seen.*
>
> *We are now removing Doris Walsh from our waiting list.*
>
> *If you consider that they need to be seen again please forward a new referral."*

We are concerned that this appears to be a standard letter with Doris's name filled in.

We have learned from the Reaside Clinic notes as well as from Doris herself when we saw her that Doris felt let down by the Community Services when she was not offered their support in 1994 following the consultant psychiatrist's referral to them. We are extremely concerned that the psychiatrist's referral did not lead to support for Doris in the community.

We are also concerned that for a whole year from 1.2.94 to 24.1.95, Doris was not actually seen by the GP(GP3) or his wife at the surgery, despite the fact that she attended on nine occasions in this period to collect her prescriptions of Dothiepin. Apparently, the prescription would just have been handed to her at reception and neither of the doctors actually saw her.

The consultant psychiatrist saw Doris for the last time on 10.2.95. He subsequently wrote to her GP(GP2):

"Mrs. Walsh, though denying being depressed, becomes tearful if one discusses the past few years. She states that when she remembers events of the past 4 years, she often gets angry and frustrated, otherwise she feels able to cope.

In view of the long history of depression, it will be advisable for her to continue on Dothiepin 75mgs nocte as a prophylactic agent, at least for a period of 2 years. I am discharging her back to your care."

Between 24.1.95 and 8.6.95 Doris attended the GP's (GP3) surgery on six occasions for various physical complaints. Despite these occasions (when she was seen and examined by her GP or his wife), Doris does not appear to have mentioned any problems with her mental health.

On 8.6.95 Doris went to the surgery requesting a repeat prescription. There is nothing else recorded of note for that day. Her GP told us that Doris had never given any indication that she was feeling depressed on that occasion.
However, the very next day Doris was back in hospital again.

On the evening of 9.6.95, Doris had been admitted to Walsgrave Hospital with an ankle injury. She had cut it badly when she had apparently kicked a china cabinet and her father then called for an ambulance. She was transferred to the Assessment Unit where she was seen by the duty doctor. The duty doctor took a most impressive detailed history from Doris which recorded that she had been depressed since November 1994 following a mugging incident, when some money and personal papers were stolen from her, and she had soil thrown at her. The depression got progressively worse until she had started hearing voices some two weeks previously. These voices were male and female voices, speaking in the second person, telling her that she was evil.

The note records that Doris had been "*tormented by voices constantly for the last week*".

Doris told us when we saw her that she had been hearing voices for a year.

Her appetite was poor and her sleep was difficult due to the voices. Her self-confidence was deteriorating and she was unable to enjoy anything or to see the future. She had been having suicidal thoughts for several weeks and had been thinking about taking tablets, but kept telling herself that she had everything to live for.

She described elements of thought insertion, making her want to throw herself out of a window.

She felt that something dreadful was about to happen and that people were against her.

Once again Doris also said that she had not been taking her medication.

The duty doctor's impression was that Doris was suffering from a recurrence of depressive illness with a severe depressive episode with psychotic features.

Doris apparently realised that she was mentally ill with depression and needed help, and she agreed to be admitted as a voluntary patient.

The duty doctor accompanied Doris to Sheriff Ward (also known as F2) where she was admitted at about 20.15 under the care of a Consultant Psychiatrist (CP4), Acute Psychiatry.

Sectorisation had been gradually introduced during 1993 and 1994. Initially all old patients remained under the care of their previous Consultants, but some time in 1994 it was decided that if a patient following discharge had remained symptom-free for three months, they would automatically transfer to the new consultant team. As a result of these changes, the consultant psychiatrist (CP3), who had known Doris for a considerable time, was no longer the Consultant responsible for her care. The junior doctors would also have been new to Doris and most of the nurses, although the Ward Manager was known to Doris from her previous admissions.

Doris was assigned a Named Nurse.

The Admission Details were completed by a Registered Nurse who recorded the circumstances and events leading to admission:

> *"Due to auditory hallucinations, she became annoyed and upset and became quite hostile towards self and kicked the china cabinet in. She went to her Dad to ask for help and he rang the ambulance - they took her to General, had her right ankle bandaged, then she was transferred to Assessment Unit, assessed by the duty doctor and sent to F2 (also known as Sheriff Ward) for admission."*

The section relating to the patient's understanding/perception of admission was completed as follows:

> *"She is quite aware of auditory hallucination and that she needs help. She is glad to come with ambulance."*

The section for the patient's experiences prior to admission stated:

> *"Doris claims she has been hearing voices which she is fed up with and cannot cope with. She has not been eating regularly and has not been sleeping properly because of the voices who tell her "she is evil"."*

The nursing notes reveal that Doris spent much of her time sitting alone in silence, although there was no further complaint of auditory hallucinations, and no external

evidence of such hallucinations. She remained low in mood, at times quite tearful, and admitted to feeling depressed.

Doris received no visitors at all during the five weeks she was in hospital.

On 13.6.95 Doris wanted to go home to fetch some fresh clothing. The nursing notes record that she did not have a Community Care Worker, but that she did not wish to have one.

Doris continued to isolate herself for most of the time and still remained depressed for the first couple of weeks. She, however, appeared to sleep well at nights.

On admission Doris's name was filled in to a standard printed "Assessment Care Plan" which should have been reviewed, according to a hand-written addition to it, on 12.6.95, 72 hours after her admission.

This very basic and standard Care Plan (which was obviously identical for everybody on admission) was not in fact reviewed within 72 hours. There is a form entitled Initial Assessment which states on the face of it that it is:

> ***"To be completed within 72 hours after admission, identifying psychological, social and physical problems/needs of the patient"***

The form in respect of Doris was not in fact completed until 17.6.95, eight days after her admission. It was filled in by one of the nurses on the night shift, who told us that she had been going through Doris's notes and noticed that the Initial Assessment had not been done, and it was already eight days after her admission. No-one had asked her to do it, she took it upon herself because she felt that she should do so.

The nurse's assessment contained the following comments:

> *"Psychological:*
>
> *Doris remains very negative in her outlook. Continually states that she feels "fed up". Mental state generally low, but auditory hallucinations that had bothered Doris are diminishing. Becomes distressed when talking about attack on her and has felt "on edge" ever since. Denies any suicidal feelings.*
>
> *Social:*
>
> *Sees her outlook as gloomy, appreciates that she has an illness that is causing upheaval to her life. Has tried to hold down several jobs but feels safest while in hospital."*

On 19.6.95 one of the nurses described Doris as

"guarded in manner and very flat in affect".

Another entry, by the nurse on night duty, describes Doris as follows:

> *"Appears to be interacting with others, but on observation does not partake so much as listen to others' conversations. No auditory hallucinations to note."*

By 25.6.95, the nursing notes were recording that Doris was beginning to be awake in the early hours of the morning.

She continued to isolate herself until the end of June, although she began to interact well with one particular female patient.

Doris was given weekend leave from Friday, 30.6.95 to Sunday, 2.7.95. She returned on Sunday evening, saying that she had had a good weekend.

There is no independent account of that weekend leave and therefore we cannot confirm if the leave did in fact go well.

Doris appeared to be much brighter in mood after her weekend leave and was socialising better with the other patients. There were no entries that she was waking in the night.

On 6.7.95 a Care Plan form was filled out for Doris which indicated that she was soon to be discharged from hospital to the Community within the next two weeks. The hand-written date on the form (which it is assumed was the intended date of discharge) was 20.7.95.

The plan was to prepare Doris for discharge and for a discharge plan/formula to be prepared by two weeks time.

In fact the After Care discharge planning meeting was to be arranged for the following week, and we are told that it had been intended to hold it on Thursday, 13.7.95.

Doris was allowed weekend leave again the following weekend from Friday, 7.7.95 to Sunday, 9.7.95.

Doris did not return to the hospital on the Sunday, nor the following day.

On Tuesday morning Doris's Named Nurse contacted the East Sector Community Mental Health Team (CMHT). An Approved Social Worker (ASW1), was manning the duty desk that morning. He was informed that an informal patient had not returned from weekend

leave, although she was due to be discharged soon. As Doris did not have a telephone at home, the ward were not able to contact her, and therefore the CMHT were asked to go to Doris's home to see if she was all right. The ASW told us that all he was told about Doris was that she had been admitted to hospital a few times for depression.

The ASW visited Doris, with another ASW(ASW2), that morning. They found her front door wide open. **(Doris told us that she had been in the habit of leaving her front door open for some time. She told us she tried to think why she should leave her front door open, and could only think that she was hoping someone would call.)**

The social workers found Doris well presented and the flat tidy. They sat and talked to her for between half an hour and an hour and she told them that she was happy living in her flat and that her daughter and grand-daughter used to visit on Sunday for lunch.

Doris told them that she did not wish to go back to the hospital, even for the discharge meeting.

The note made by the Named Nurse of the report by telephone of the social workers following this visit records that Doris had said to the social workers "*If I came back they would keep me*" despite the social workers explaining to her her rights as an informal patient. This (to us) significant statement does not appear in the written up notes of the social workers.

During the social workers' visit, Doris apparently became tearful and a little angry, and told them about the sexual assault on the towpath.

Doris apparently had indicated to the social workers that she did not wish to be referred for any kind of day care, and the social workers therefore suggested to her that she might benefit from some counselling. Doris seemed receptive to this idea, so the social workers told her that they would arrange for one of the Team to visit her, but that it would take some time before an appointment could be arranged.

Doris told the social workers that she had no medication, and they offered to take her to the hospital to collect a prescription, but Doris said that she would go to her GP to get one that afternoon.

The social workers gave Doris a number to contact them if necessary and left.

The ASW(1) telephoned the Ward following this visit and ASW(2) wrote a detailed note later that day.

The note taken by Doris's Named Nurse of the ASW's(ASW1) report to him was as follows:

"Two ASW's visited Doris this am at ward's request. Doris was tearful and a little angry apparently. Stated she has no medication but is going to see her GP, (GP3) , to obtain some this pm. Spoke of an assault which occurred 4 years ago to S/Ws and stated "If I came back they'd keep me" despite explanation of her rights as an informal patient. Please inform medics of this news this pm."

The nursing notes show that the contents of this note were discussed with the consultant psychiatrist's SHO and that at 4pm the GP's surgery (GP3) was informed of Doris's discharge against medical advice and also informed of Doris's current medication.

No attempt was made to get Doris to sign the prescribed form for discharge against medical advice.

The GP records show that Doris did in fact collect a prescription from the GP's surgery later that afternoon. She told him that she had been on weekend leave from the psychiatric ward and did not want to return. She also said that she had lost her appetite **(this can be a sign of depression)** and the GP weighed her.
It is not known if she ever "cashed in" the prescription and actually collected or took any medication.

Neither the hospital staff nor the social workers made any attempt to check with the GP to see if Doris had in fact contacted him for a prescription, or to ask him to keep an eye on her. Nor did the GP contact the hospital to ascertain Doris's current mental state, given that she had discharged herself against medical advice.

Because (and despite the fact that) Doris had not returned to the ward, the discharge planning meeting for her after care was not held.

The Discharge Summary was not in fact sent to her GP(GP3) **(this time it was sent to him rather than to her original GP(GP2)** until 28.7.95 **(ironically, the day of the fire)** and was not received by him until 31.7.95. The Summary was prepared by the Clinical Assistant to the consultant psychiatrist(CP4).

The diagnosis was given as "*Depressive Illness*".

The discharge letter to her GP contained the following information:

*"This 57 year old lady (**Doris was 51**) was admitted to the Coventry Mental Health Unit on 09.06.95 on an informal basis under a consultant psychiatrist in Acute Psychiatry(CP4) because she was feeling depressed for the last few months. Her sleep was disturbed and she was not eating well, her concentration was impaired and she was feeling suicidal at times. She had tried to kick a cupboard and had sustained some injuries over her ankle ...*

Mental State On Admission - She was found to be depressed with negative cognition and suicidal ideas but there were no psychotic features and her cognition was intact.

There is no mention of the auditory hallucinations which had been tormenting Doris for some weeks prior to her admission. Indeed the summary states *"no psychotic features".*

After her weekend leave she refused to come back on 11.7.1995 and so she was considered discharged after the Social Worker informed us that she was doing well at home. She will be seen in Outpatients in 4-6 weeks time."

The note taken by the Named Nurse after the ASW's report to the Ward did not state that Doris was "doing well".

As far as we are aware Doris had never been given an Outpatient appointment since she was discharged after the social workers' visit on 11.7.95 and we have seen no record of any letter being sent to her giving her such an appointment.

On 13.7.95 the CMHT held an Allocation Meeting where Doris was discussed. These meetings were normally held on a Friday and the consultant psychiatrist(CP4) would attend them. However on this occasion there was some kind of Team Away Day on the Friday and so it was held on the Thursday. This meant that the consultant psychiatrist was unable to be present, as he had Ward Rounds on a Thursday.

Even though the social workers had not considered the hospital's request for the CMHT to visit Doris as a referral, by the time of this meeting she was considered as having been referred as a 'self referral' form had been completed for Doris by the ASW. Despite this, no further information about Doris was sought and no attempts were made to discover whether there had been any social service involvement in the past. (The social workers clearly had not asked Doris if she had had any contact with social workers or they would have known about the social worker's involvement.)

On 28.7.95 (again ironically the day of the fire) the CMHT allocated one of their CPNs, to Doris. This was just an internal allocation. Doris knew nothing about it.

There was no professional involvement or even contact with Doris between the 11th and the 28th July.

Doris can remember very little about the days immediately prior to the 28th July. She remembers even less about the day itself.

The video camera positioned in the lift at Alpha House where Doris lives shows that at about 7.30 in the morning of the 28th July, Doris made a couple of trips down in the lift, and we believe that she may have gone to purchase something from the shop opposite. She appeared to be confused and anxious on this video (unfortunately the video was not available for us to see but had been seen by others who gave evidence to us. We were supplied with still photographs taken from the video).

Just before 9 am Doris lit a match and threw it into the coat cupboard in her hall, setting fire to a pile of clothes stored there.

She apparently did this to stop the voices which were coming from the cupboard, tormenting her by calling her names and telling her that she was evil.

We assume that, as usual, Doris's front door had been left open, allowing the fire to spread quickly.

Doris apparently went for help to her next door neighbour at number 59. Thomas Redshaw and his 13 year old son, Richard (who had been staying with his father overnight), were apparently having breakfast at the time the fire broke out. They let Doris in and, unfortunately, it appears as though their front door was left open as well, allowing the smoke and toxic fumes to enter their flat.

At 09.01 a 999 call made by Thomas Redshaw was received by Fire Control. He told them that there was a fire in Alpha House.

At the same time the Ambulance Service was alerted. Their records show that they received the first alert at 09.01 as well.

The first fire engine arrived at 09.06 and a second and third a minute later.

One ambulance arrived at 09.07.

Doris Walsh, Thomas and Richard Redshaw were all overcome by smoke.

Doris was found first. She was in the sitting room in Thomas's flat having apparently smashed the window to scream for help.

Doris was found at about 09.15 and the fire fighters who found her handed her over to other members of the team who brought her down in the lift, arriving at the ground floor at about 09.20. She was immediately carried to the waiting ambulance, placed on a stretcher, and the ambulance left at 09.23.

The fire fighters had meanwhile returned to Thomas Redshaw's flat and Richard was found in the kitchen about 3 minutes after Doris had been found and was brought to the ground floor and out into the fresh air at 09.22 .

Thomas Redshaw was also found in the kitchen and was brought out of Alpha House to fresh air at about 09.25 .

Neither Richard nor his father were showing any vital signs.

No further ambulances had arrived on the scene. At 09.24 one of the Fire Service Officers requested more fire engines and another three ambulances. At 09.28 a further call was sent asking for two more paramedic ambulances.

From the moment that Richard and Thomas Redshaw were brought outside the block of flats, the Fire Fighting Team and the Police who were by now on the scene began basic CPR (Cardiac Pulmonary Resuscitation), which is the giving of oxygen as well as heart massage.

Resuscitation attempts were maintained constantly by the Fire Team and the Police until two further paramedic ambulances arrived at 09.36. The paramedics then took over the resuscitation attempts and they carried out intubation, cannulation and intravenous infusions until vital signs were re-established. Thomas and Richard Redshaw were then transferred to hospital in separate ambulances, both arriving at the same time at 10.02. Unfortunately, Richard and his father Thomas never regained consciousness and the following day their life support machines were switched off.

COMMENTARY AND ANALYSIS

Doris Walsh had a long history of mental illness covering over 20 years. One thing is clear in our minds. She is neither "a monster" nor "evil". We have no doubt that she never intended harm to anyone else and deeply regrets that her actions should have resulted in such a tragic outcome.

For the first ten years or so her illness manifested itself mainly in intermittent periods of depression, with strong feelings of guilt. The rest of the time Doris appeared to cope well and lived a normal life. By the mid-1980's, the guilt had developed paranoid features and the depressive episodes were becoming more frequent. Even today the diagnosis is not clear and is still being investigated. (See: The Diagnosis of Doris Walsh's Illness by Dr Dick in the next section.)

There is no doubt that Doris suffered from a long relapsing illness which was difficult to treat, but managed since the mid-1980's as well as possible by the consultant psychiatrist (CP3) and his Team. We have no real criticism of her care prior to 1994.

We have had the benefit of being able to review this case with the benefit of hindsight and after having heard from a wide range of witnesses - from the Health Authority and the Trust; the medical and nursing staff; social workers and community psychiatric nurses (CPNs); the Fire Service; the Housing Department; her Coventry GP(GP3) and his wife; Fay Redshaw and her son, Mark Roberts. We also talked to Doris Walsh herself, as well as her key worker at Reaside Clinic, and the Consultant Forensic Psychiatrist now responsible for Doris's care, Dr. Brockman. We invited Doris's father and daughter to come to see us but received no response from either.

We have also had the benefit of being able to study and thoroughly review all of Doris's medical records (from the 1960s to date), Social Services records, and the Fire Service and the Ambulance records in relation to the fire at Alpha House on 28.7.95. We have also reviewed the notes from the Reaside Clinic which were both comprehensive and illuminating.

We have also been supplied with a wealth of documentation from the Health Authority and the Trust which shows that there are now different policies and procedures and even a new management structure in place since 1995. We are impressed with what is there in black and white, but we have our concerns as to whether or not these admirable policies are in fact being implemented.

There was, for instance, a Coventry Community Mental Health Team Interim Operational Policy in place in January 1995 which makes impressive reading. However, it is clear that it was not being put into practice in the summer of 1995 when this tragic incident occurred.

The Health Service Guidelines HSG(94)27 Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community states the following:

NHS Purchasers should secure through contracting not later than 1995/6 the necessary service provision to support the aims of this guidance and set arrangements to monitor and evaluate the implementation of the guidance.

We also had access to the Contracts of Agreement between Coventry Health Authority and the Trust 1994/5/6. These documents set the requirements for the Trust to meet the specification in the following areas:

- easy access for users to community services
- their care plan reviewed every six weeks
- multidisciplinary approach to care and treatment planning to include social work and GP involvement
- GP should be written to within one week of admission
- a full discharge report to be written to the GP within one week.

In the summer of 1995, it is evident that the Trust was not carrying out its contractual obligations nor did the Health Authority pick up these deficiencies in their monitoring of the contract, as far as we could tell.

We repeat that we have had the benefit of hindsight and the ability to look at the last 20 years in one "overview", and we therefore have a fairly clear picture of Doris's evolving illness. We have been greatly helped in obtaining a clearer picture by the detailed and most effective work which has been done with Doris by Dr Brockman and her team at the Reaside Clinic since 1995.

Our duty is to highlight the concerns which we have in reviewing the care and treatment of Doris Walsh over the years prior to the summer of 1995. Unless those concerns are addressed and acted upon, it may not be possible to prevent a similar tragedy happening again in the future.

The tragic events of 28.7.95 could not have been predicted, but the information gathered by those making predictive decisions about risk was seriously inadequate. Nothing can better summarise what we feel than the words of Dr Brockman:

> *"Every assessment is only as good as the information that the professionals elicit.*

Never assume that somebody else's short summary is adequate. My juniors know that I expect them to obtain and read every line in every previous psychiatric record even if it takes you all night with them all over the floor, arranging them into piles, making some sense of the notes that's what you do, because the only way of being able to predict the future is understanding the past.

I don't think there is any magical way of doing this prediction. It is just patient slogging through information from a variety of sources."

We do believe that had Doris Walsh's care in the community been more thoroughly planned and co-ordinated, and information already available used in that planning, the tragic outcome of her story may well have been prevented.

As can be seen from the Narrative, Doris's illness spanned many years and was one of relapsing depressive episodes, with increasing paranoia and increasing frequency from the mid-1980's onwards. We have already indicated that we recognise that this was a difficult illness both to diagnose and to treat and one that was managed by the consultant psychiatrist and his Team from 1986 (when Doris was first admitted to hospital) with considerable care and dedication over the next eight years or so.

However, we do feel that there must come a time when those responsible for a patient's care, stop and say: **"This woman has been ill now for some 15 - 20 years. What is the pattern of her illness? What are we going to do about her treatment in the future?"**

A good time might have been following the introduction of the Care Programme Approach (CPA) in 1991. It would have been good practice to have held a multi-disciplinary Case Conference about Doris, (certainly before 1995) to try to work out the best way forward.

There was both a consistent and a changing pattern to Doris's illness. There is a definite cyclical pattern of relapse in the summer months (June to August), with recurring periods of depression at the beginning of the year (February/March) as well. Doris herself told the Psychiatrist as long ago as 3.3.82 that "she is depressed at this time of the year". There was also a consistent pattern of poor sleep, poor appetite and irritability/aggression prior to relapse. This usually followed Doris either stopping or reducing her medication.

From 1986 onwards there was evidence of increasing paranoia. At first this was mainly confined to believing that other people were talking about her, but by August 1990, Doris's paranoid feelings were projected to inanimate objects, such as the kettle making clicking noises and sending her messages from the Police, number plates on cars carrying special messages for her and the radio referring to her.

It is clear from the letter written by the consultant psychiatrist's SHO on 19.2.91 that the psychiatrist's team were reviewing Doris's diagnosis at this time and that they had not ruled out schizo-affective disorder, although the fact that Doris had improved and the psychotic symptoms had been relieved when the depression was treated, still led them to the view that the main diagnosis was of depression with psychotic symptoms.

As we have already said, the consultant psychiatrist's team did all they could to support Doris in the early 1990's, seeing her regularly and frequently as an Outpatient when she was unwilling to be admitted as an informal patient and constantly changing her medication to see if they could improve matters that way. The psychiatrist also engaged the services of the Social Worker on his team in the summer of 1991, who offered both Doris and her husband considerable support at a difficult time.

However, other than that seven week period in the summer of 1991, Doris was given no support in the community over the next four years, despite her marriage breaking down and a further admission to hospital in the summer of 1993.

We have already commented in the Narrative section about our concern that the psychiatrist's referral of Doris to the community services in August 1994 did not lead to support for her in the community. We are of the opinion that the Community Nurses' failure even to acknowledge the psychiatrist's letter for some two months and then to remove Doris from their waiting list without even finding out what her present circumstances were, was an example of unacceptable and unprofessional practice. Doris was removed from their waiting list, despite the psychiatrist's referral, and without any actual assessment of her needs having been made. No-one knew her current mental state at the time that she was discharged from the list. No-one checked to ensure that she had, in fact, received their letter saying that she would be removed from the waiting list if they did not hear from her within two weeks. It is clear from our discussions with the CPN who signed the letter to the psychiatrist informing him that Doris had been removed from their waiting list - and, coincidentally the CPN allocated to Doris on the very day of the fire on 28.7.95 - that the main aim of the community nursing team at that time was to reduce the length of the waiting list by any possible means. It appeared as though they viewed their responsibility as being to reduce their workload to a manageable amount rather than to deal with the mental health of their community.

We are aware that the team had a heavy workload and are also aware that sectorisation and the formation of the Community Mental Health Teams (CMHTs) were being introduced at the end of 1994/beginning of 1995, and that this caused further pressures and disruptions for the community nurses, but we still feel that there can be no excuse for effectively rejecting a patient with mental illness who had been referred to them by her Consultant, without even meeting her or carrying out any kind of assessment of her needs.

The CPN told us that:

"We, as a team at that time, did not feel responsible for the client until we actually made the contact with the client."

We are told that the CMHT practice has been changed and contact is now made within two days of referral (that day if urgent) and that the majority of clients are seen within a week. We sincerely hope that this is the case.

We have to say that we also regret that the consultant psychiatrist did not follow up his initial referral to the Community Services in a more robust way. He must have felt that Doris needed support in the community in August 1994 when he wrote his referral letter, but he appears to have taken no further steps to ensure that she was offered adequate support in the community. We are concerned that he discharged her back to her GP's care in February 1995, apparently in the knowledge that she did not have the support of any Community Worker. He had been informed (assuming he received the letter from the CMHT) at the end of January that the Community Nurses were removing Doris from their waiting list. The GP however was not so informed.

We are also concerned that Doris's GP could have allowed a period of over one year to go by without actually seeing Doris face to face and assessing her state of health, although we acknowledge that this was in 1994 and therefore had no direct bearing on the fire incident. He told us that he had no way of knowing whether Doris had in fact "cashed in" her prescriptions and was therefore taking her vital medication.

We are aware that many hospital psychiatrists are reassured by the fact that their Outpatient clients regularly attend their GP's Surgery to collect their prescriptions. The psychiatrists most probably assume that if the patient is attending the Surgery, they will be seen by the GP who could then pass on any concerns they might have about the patient to the psychiatrist. If a patient merely collects a prescription from the surgery reception, without any regular review by the doctor, it well may be that far too long a period of time can go by without any medical practitioner seeing the patient at all.

We are concerned that, despite Doris attending her GP's Surgery on six occasions in the first six months of 1995, when she actually saw the GP on each occasion and complained of a range of physical symptoms (which may have had a psychological origin), he appears to have been unable to detect her serious mental deterioration, even on the day before she was admitted to hospital, having been tormented by voices for the last few weeks. We are aware that Doris is able to conceal symptoms of her mental illness when she wishes, but the GP and his wife are both Section 12 doctors who are called upon to carry out assessments for detention under the Mental Health Act, and should therefore be better equipped than most GPs who have no psychiatric training to recognise signs of deteriorating mental health.

We are also amazed that the hospital could continue to correspond with Doris's previous doctor for some two years after she had been registered with another Coventry GP - despite the change of GP having been recorded in Doris's hospital notes on 20.5.93. We

are perhaps even more amazed that the second GP appears to have taken no steps to correct the mistake, either in writing, or during his frequent meetings with the psychiatrist.

Another area of concern is that the hospital does not automatically inform a patient's GP of their admission to hospital and discharge letters are not sent to GPs very often until several weeks after the patient's discharge.

Doris's Final Admission to Walsgrave

Doris was admitted to Walsgrave Hospital on 9.6.95. There was now a new element which had been introduced to her mental illness - that of auditory hallucinations. It is clear from the detailed history recorded by the duty doctor on her admission, confirmed by the duty doctor in her oral evidence to us, that Doris was very seriously unwell at this time.

Her GP was not contacted at all by the hospital. We feel that it would have been at the very least helpful to have (a) found out when the GP had last seen Doris (b) what medication she was on and whether or not she had been taking it regularly and (c) to have informed him that she had been admitted to hospital again.

Doris was allocated a Named Nurse on her admission. We see the role of a hospital Named Nurse as follows:

(a) To co-ordinate the patient's nursing care.

(b) To make or to at least contribute to the patient's Care Plans.

(c) To ensure an adequate assessment of the patient's nursing needs is carried out.

(d) To pursue the possibility of working with family members while the patient is in hospital.

(e) To assess the level of family and/or social support available to the patient before any weekend leave or discharge was planned.

(f) To involve the Community Team in the planning of the patient's after care.

(g) To provide the relevant community agencies with all essential clinical and social information relating to the patient's admission to and discharge from hospital so as to ensure the continuity of care. This would normally take place within the framework of the discharge planning meeting in conjunction with a Community Key Worker. However the responsibility of the Named Nurse should only cease when the transfer of care has been effected.

We have to say that there is little evidence to show that Doris's Named Nurse either carried out any of the tasks outlined above, or formally delegated them to others. We put this down to a lack of formal Clinical Supervision and/or clear guidance as to how the role should be interpreted and carried out.

The main and essential Care Plan was overdue by seven days when the registered nurse on night duty recognised the omission and acted independently to formulate a plan. We feel that this was an admirable effort, but given that she was a Night Nurse who began her shift at 21.00, her knowledge of Doris was limited to those very few hours that Doris was not asleep. It also meant that, of necessity, she had to formulate the Care Plan without the benefit of a multi-professional team approach which would have been available to either the Named Nurse or Associate Named Nurse.

We also believe that too much attention was paid by the nurses on the ward to the supposed reduction of auditory hallucinations as a means of assessing Doris's progress. She was deemed to have improved because she claimed that she was no longer hearing voices and showed no obvious signs that she was doing so. The nurses told us that they did not ask Doris directly whether or not she was still experiencing auditory hallucinations. For some reason they felt that this was inappropriate and that Doris should be left to volunteer such information herself. We have to say that we found this a surprising attitude. It may be explained by the fact that we found no evidence that proper systems of clinical supervision were in place at that time. Two nurses interviewed by us said that they received no clinical supervision. Doris was also displaying a wide range of other symptoms - she remained isolated almost throughout her time on the ward and she began to experience early morning awakening towards the end of her stay - which do not appear to have been given sufficient weight in any assessment of her improvement.

The nursing documentation which we reviewed was of a poor standard. Both the format and the content lacked clarity. There was no framework which recorded the process of how assessments were made, decisions taken or risk factors considered. There also appeared to be too little shared assessment between medical and nursing staff.

The medical documentation we reviewed was also of a poor standard. The Discharge Letter of 28.7.95 in particular contained errors and omissions which could have had a significant effect on Doris's future care.

Doris returned from the first weekend leave and said that it had gone well. As far as we can see, no-one sought to corroborate this in any way. It may well have been a very good weekend for Doris, however there is no way of knowing since Doris received no visitors throughout the whole of her five week stay in hospital. Neither her father nor her daughter visited her as far as we are aware and we know that Doris told the nursing staff that she was unwilling for either of them to be involved in her after care planning meeting. This we feel should perhaps have prompted the hospital staff to have dug a little deeper into the question of whether or not the weekend leave went well. Perhaps they did, but it

certainly is not clear from the notes that they did. It is however fair to say that Doris did appear to be brighter following that first weekend leave.

On the 6.7.95 (the day before Doris was allowed home for the second weekend leave) a Care Plan form was filled out for Doris. This was, once again, a standard printed form, similar to that filled in on the day of her admission, which only required her name to be inserted at the appropriate place in the form.
We deplore the use of this kind of standard "form for all".

This is clearly a form to be used for the final Care Plan before discharge. Under the heading "GOAL" it stated:
(The words in bold were those that were added to the standard printed form)

> "(A) Prepare **Doris** for discharge according to the disposition made by the multi-disciplinary team.
>
> (B) For **her** to feel prepared and able to accept discharge formulation with a positive/realistic and constructive outlook.
>
> (C) For discharge plan/formula to be prepared by **2** weeks."

The part of the form headed "NURSING INTERVENTION" stated:

> "A. For allocated Nurse (A/N) to discuss and explain Care Plan to **Doris** and record response and outcome.
>
> B. For A/N to spend time with **her** as and when appropriate and jointly agreed.
>
> C. To help enable **her** to discuss/ventilate areas of concern/perceived help/formulation of discharge plan and perceived follow up care. Record outcome and response.
>
> D. For A/N to direct **her** to appropriate multi-disciplinary team (MDT) Resource e.g. Social Worker, CPN, Health Visitor and if appropriate for A/N to liaise with MDT to discuss discharge aftercare provision and record outcome.
>
> E. For A/N to assist **her** by education/information and importance of on-going medical treatment. Compliance effects/side effects of prescribed medication.
>
> F. For A/N to promote effective constructive strategies or increase appropriate coping strategies by utilising a problem solving approach.
>
> G. For A/N to discuss with **Doris** proposed goals for period of weekend or extended leave and gain feed-back after period of leave.

H. For A/N to initiate termination of Nurse/client relationship without appearing to reject her by always orientating discussion with client towards his/her eventual discharge and the stages of Nurse/client relationship (From independence - inter-depend - inter-dependence).

I. For A/N to liaise with Ward Clerk pertaining to discharge sick note. For Community Key Worker to be aware of discharge date (inform Social Worker, GP, of OPD (Out Patient) appointment.
J. On discharge date ensure all property is returned to her that discharge medication has been prescribed sent to the Pharmacy and explained to. Evaluate daily."

This form stated that Doris was soon to be discharged from hospital to Community Care within the next two weeks and a hand written "20.7.95" followed that comment, presumably indicating that Doris's intended date of discharge was to be the 20th July 1995.

Doris was allowed home for weekend leave the day after this Care Plan was initiated and she never returned to the hospital. Therefore none of the goals set out in this Care Plan were ever put into action.

No-one, therefore, prepared Doris for her discharge. No-one discussed with her any areas of concern or need or perceived follow-up care. No-one directed her towards the multi-disciplinary team. She had no Community Key Worker.

There is evidence that (contrary to what she told us about feeling let down by not being given one) Doris told the nursing staff that she did not want a Community Worker. Even so, we feel strongly that the question of Doris having a Key Worker should have been pursued. It is well known that patients are often very negative in their responses when depressed and we believe that a 'NO' given in such circumstances should not be taken as a definitive answer. Doris's Consultant for her last admission to Walsgrave Hospital, told us that Doris was much more amenable towards the end of her stay on the ward and, therefore, may well have been persuaded to accept a community worker (as indeed she clearly was on 11th July when she indicated that she would welcome counselling support from the CMHT).

We were told that in fact an After Care / Discharge Planning Meeting was due to be held on Thursday 13th July. This would have been an appropriate date, given that it was one week before her intended date of discharge.

We are extremely concerned that this After Care Planning Meeting was not held when Doris failed to return to the hospital following weekend leave. In our opinion, it was even more important to hold such a meeting in the light of her failure to return to the hospital as well as the lack of knowledge as to her present state of health. Every effort should have been made to procure Doris's attendance at such a meeting, but even in the event of her failing to attend, we feel that it should have gone ahead.

Although we were impressed at the speed with which the two social workers responded to the hospital's request to visit Doris on the morning of the 11th July, we also have some grave concerns about how they interpreted and carried out their role following the contact from the hospital.

The ASW told us that he did not consider the hospital's request for someone from the CMHT to visit Doris as a referral to the CMHT. We think this was a wrong assumption on his part, and indeed the Assistant Director of the Social Services Department confirmed to us when we saw him that this should have been considered as a referral. He said that " *any contact to the CMHT should be considered a referral*". It is also quite clear that Doris's Consultant and the nursing team considered that they had made a referral to the CMHT.

We feel that the social workers should, at the very least, have done the following after they saw Doris:

(a) They should have checked to see when Doris was due to be seen in the Out Patients Department.

(b) They should have checked that she had obtained medication from her GP.

(c) They should have ensured that someone who knew Doris visited her as soon as possible (or arranged to take her to the hospital to see someone).

(d) They should have enquired as to what after care arrangements had been made for Doris.

Whether or not the social workers regarded this as a referral, we feel that they should have been given - and therefore should have asked for if it was not given - more information about Doris's medical history and family background. All they appeared to know about Doris was that she had been admitted for depression and had not returned after weekend leave.

They held an Allocation Meeting two days later and by this time Doris was certainly considered to have been referred to the CMHT (as a self-referral) and yet they purported to allocate Doris to an appropriate member of the Team without any relevant information as to her real needs and without obtaining her existing social services records. We do not feel that this was good practice.

As we have said above, we were impressed with the speed at which the social workers responded to the hospital's call about Doris, but in an ideal world we would have preferred that somebody visited Doris who actually knew her.

The failure (referred to earlier) of the Community Nursing Team to accept its responsibility under the Care Programme Approach, when the consultant psychiatrist referred to Doris to them in 1994, contributed to the difficulties experienced by the social workers who visited Doris on 11.7.95. According to Coventry Community Mental Health Team's Interim Operational Policy (January 1995) Doris would have met the criteria for Category A intervention (at that time, the highest category). A Community Needs Assessment should have been carried out and Doris should have been allocated a Community Worker. Had this been done, matters may have been quite different when she failed to return to the hospital after weekend leave in July 1995.

The two ASWs had totally insufficient information about Doris to make a meaningful assessment. They made no enquiries prior to their visit to ascertain whether or not Doris was known to the Social Services Department or the CPN Service. It appears as though they did not ask her either. They found Doris tearful and angry and in the relatively short time that they were with her, she told them about the sexual assault that she had suffered the previous year. They reported those facts back to the nursing staff at the hospital. We believe that someone at the hospital should have picked up that these symptoms were similar to those Doris was displaying at the time of her recent admission (when she was clearly seriously unwell) and were not consistent with the picture Doris had been portraying in the last week or so of her stay on the ward.

No-one seems to have picked up from the past medical notes (a change in Consultants may have made the difference here as the psychiatrist (CP3) had known Doris extremely well, whereas psychiatrist (CP4 did not) or at least acted upon the knowledge that Doris was prone to hide her real feelings and symptoms from the professionals.

After the social workers reported back to the hospital, all the hospital staff did was to contact the GP's Surgery to inform him that Doris had discharged herself against medical advice and to tell him what medication she was taking. She had recently been prescribed a new (to her) anti-depressant, Sertraline, which replaced the Dothiepin which she had been on for years. As far as we are aware, nobody checked later with the GP to find out whether or not Doris had contacted him for a prescription (she had told the Social Workers that she had run out of medication).

No-one at the hospital knew if she either had or was taking any of the medication which was essential to control her mental health,(she had a history of rapid deterioration when not on medication) nor did they ensure that Doris was being monitored by her GP in the community.

She had not been discharged back to the care of her GP - merely discharged from being an inpatient in hospital.

Although it is not in the social workers' written note, the Nursing note records the telephone conversation from the ASW as saying that Doris had told them that she did not want to go back to the hospital because "*They will keep me in*". No-one seems to have

picked up on this statement, which is a strange one, considering the nursing staff told us that Doris knew that she was due to be discharged in the near future and the note in the nursing record of the social worker's report to them states that they said that they had explained to her her rights as an informal patient. The named nurse acknowledged that it was a strange comment and that was why he had noted it.

One of the matters which caused us the greatest concern is that, because Doris had discharged herself by not returning from weekend leave, she had not been given an Out - patient appointment upon discharge. The discharge letter (which we have already commented upon in the Narrative) was not sent for some three weeks and mentioned an Outpatient appointment "In 4 to 6 weeks". There is no evidence that anyone contacted Doris to arrange such an appointment. The suggested interval of four to six weeks for an Outpatient appointment after discharging herself from hospital so soon after a serious psychotic breakdown we find completely unacceptable. There is no evidence that Doris was ever informed of any such Outpatient appointment, and we are disturbed by the fact that one was not being considered for such a long period of time.

Given that Doris had not been medically discharged and was not being seen or supported by anyone at all in the community, we believe that she should have been given an Out-patient appointment within two weeks at the latest, and preferably within a week.

Had she been given such an Outpatient appointment, we are confident that Doris would have attended it. There is no indication of a failure on Doris's part in the past to attend any Outpatient appointment given to her and she herself told us that she would have gone had she been given one.

We also regret that her GP did not contact Doris in the knowledge that she had discharged herself against medical advice and was on new medication, the effects of which had not been assessed.

As it was, Doris was discharged from the hospital into the community with no support and no means of monitoring her at all.

- There was no After Care Plan although she was entitled to one.
- She had no Community Key Worker although she was entitled to one .
- She was given no early Out Patient appointment.
- The GP was not asked to keep an eye on her (he had not even been told that she had been admitted to hospital a month before).
- The GP did not take it upon himself to contact her in any way to see if she was all right
- She had not been allocated to a member of the CMHT despite (in our opinion) having been referred to them by the hospital
- No-one even knew if she had any medication or if she was taking it.

The organisation and practice of the Psychiatric Services which we have been investigating suggests that, in 1995 at least, there was a very poor understanding of the purpose and aims of a modern Community Mental Health Service. What we have seen is a fragmented service in which the parts function independently from each other, with poor communication and no real sense of responsibility for meeting the needs of those who are suffering from mental illness in all its forms in the community for which it is responsible.

We acknowledge and welcome the fact that protocols developed since August 1995 for community interventions have been considerably revised and certainly make good and reassuring reading. But, in order for proper community care to succeed, the community workers must be made sufficiently aware of them and be sufficiently trained to carry them out. There must be an adequate monitoring system in place to ensure that good protocols result in good practice.
We also feel that we must express our deep concern about the failure - in general and not only as is evident in this particular Inquiry, of inter-agency working to provide effective care in the community.

It seems that while the multi-disciplinary professionals profess to work within the framework of community care, they have not fundamentally changed their practice since the introduction of the Care Programme Approach. They still consider their responsibilities remain within their own sphere of activity instead of the service as a whole.

If 'Care in the Community' is ever going to work well for both those who suffer from mental illness and the other members of their communities amongst whom they live it is essential that the problems which seem to arise all over the country over the co-ordination of multi-disciplinary care are addressed and resolved as a matter of urgency.

Most importantly, an effective system for inter-agency working must be provided. Clear roles of responsibility for the patient as between the hospital and the community services must be identified, particularly during the crucial few weeks following discharge from in-patient care. Another area of concern is around the transfer of care by the hospital to the GP.

At present, it is all too easy to say *"I no longer have responsibility for this patient. He/she is someone else's responsibility now"*, based merely on the assumption that someone else has assumed such responsibility. They may not have done, and there should be clear guidelines as to the transfer of care/responsibility between the various multi-disciplinary agencies who are involved in a patient's care. If necessary the Department of Health should be invited to give clearer guidance as to where the lines of responsibility should be drawn.

Although it is not strictly within our remit, we are acutely aware of Fay Redshaw's concerns about the rescue of her son and former husband.

We hope that setting out all of the facts as we know them concerning the rescue by the Fire and Ambulance Services may have answered some of the questions which have been haunting her for the last two years.

It appears as though the fire fighting teams did a sterling job, rescuing all three of the fire victims within the space of about five or six minutes and attempting valiantly to resuscitate Richard and Thomas Redshaw, despite there being no vital signs present when they were brought out of Alpha House.

We were however concerned that only one ambulance was sent initially. This was a serious fire in a tower block. The first ambulance arrived at 09.07, left at 09.23 and arrived at the hospital at 09.25. It was not until 09.36 that two further Paramedic Ambulances arrived at Alpha House, leaving at 09.59 and arriving at the hospital at 10.02.

We do not know and therefore cannot say whether or not the earlier arrival of a further Paramedic Team would have made any difference to the outcome for Richard or Thomas Redshaw.

We did not actually interview anyone from the Ambulance Service. They sent us the computer print-out of the Incident and copies of correspondence they had had with Fay Redshaw. Although we did not talk to anyone from the Ambulance Service, we understand from their responses to Fay Redshaw's questions about this matter that it is standard procedure to send only one ambulance unless they are informed that there are a number of casualties. We do not know whether any other ambulances were actually available prior to 09.36, although we do know that the same ambulance which conveyed Doris to hospital returned to Alpha House and took one of the Redshaws. In the end five ambulances were sent to Alpha House once it was known that there was more than one casualty.

All we can do is to express our concerns that a second ambulance did not attend at Alpha House until some 35 minutes after the emergency call was first received.

We also feel that it is necessary to say a few words about the Housing situation, since the media has expressed some concern about housing people with mental illness in a tower block such as Alpha House.

We were pleased to have the opportunity to speak to a Senior Officer of City of Coventry, Housing and Environmental Services Directorate, who was in 1995 the Allocations Officer for the Housing Department and another manager from the Housing Department.

From them we learned that when Doris had filled in the application form for council accommodation, there was a section where the Applicant can put down any factor they

wish to be taken into account in the allocation of housing, and Doris had stated that she suffered from depression. We learned that that in itself was not considered to be so fundamental as to warrant special attention. She would have also indicated the area in which she wished to live. Alpha House met all the criteria for Doris.

Alpha House is a block which is reserved for single people over the age of 40. Apparently there was at that time a higher proportion of women than men in Alpha House, which was unusual.

Because of codes of confidentiality, the only time that the Housing Department would actually be aware of anyone having any kind of psychiatric problem, would be if housing became part of a Care Plan for any individual and the Housing Department were therefore invited to help with accommodation by the team caring for them. As far as we are aware, there was nobody with a mental health problem known to the Housing Department who was living in Alpha House at that time. The Senior Officer told us:

> *"Of our over 40s blocks I think Alpha is probably the nicest one, the quietest one."*

No-one had at any time complained or even remarked about any untoward behaviour on the part of Doris. The Manager from Housing and Environmental Services told us that as far as he understood, Doris was not known to the Department in any way that was different to any normal tenant. They had intermittent contact with her regarding repair enquiries and she had never caused them any problems at all.

As far as the Housing Department was concerned, there was no-one else in Alpha House with a mental health problem and no-one who caused them any problems because of his or her behaviour.

In the course of our investigations, we visited Alpha House and were shown an identical flat to that of Doris Walsh on the 9th floor, the floor below hers. We have also seen a video taken by the Fire Service after the fire, which shows that Doris's flat was comforting as well as comfortable and obviously well looked after.

Doris herself told us that she was happy with her flat in Alpha House.

The only thing that concerned us was the knowledge that Doris was in the habit of leaving her front door open and she told us that she was not sure why she had been doing it, but she thought that it might have been in the hope that somebody might drop in. It is true that a tower block can be a lonely place, but so can any place where somebody who feels isolated has to live alone.

We found no evidence that mentally ill people were being housed in Alpha House either consciously or even unconsciously. We do not feel that Doris's particular accommodation had any influence on the outcome.

THE DIAGNOSIS OF DORIS WALSH'S ILLNESS

In trying to understand the nature of her illness, with the advantage of hindsight, we have studied Doris Walsh's general practice and hospital notes over many years. We have questioned doctors, nurses and social workers who have been responsible for her treatment throughout her illness and also those who have been responsible more recently at Reaside Clinic, the Regional Secure Unit where she is at present an in-patient. We were also able to interview Mrs. Walsh herself to seek clarification of what we had learned during the course of our inquiry.

The nature of the mental disorder which led to the events of 28.7.95 is clearly not straightforward. When first seen by the psychiatric services in 1975 at the age of 31, her presentation with depression and an overdose was seen as a mild depressive reaction to the routine life of a housewife. The evaluation at the time was more of a screening following overdose and did not reveal a number of personal and family difficulties. Later it emerged that Doris Walsh had an episode of depression in her late teens and another after the birth of her first child. Even then, she had a reluctance to reveal much about herself or her family. A fuller evaluation with support and advice at this time might have helped Mrs. Walsh to cope more effectively later on when more serious depressive illness emerged.

Three years later in 1978, she was referred as an out-patient to a consultant psychiatrist (CP2), for depression with some guilt laden ideas of reference. She responded to treatment with anti-depressants within two months.

Three years later, in 1981, the psychiatrist again treated her for a recurrence of depression, with some misuse of alcohol and self referent guilt about her daughter. Symptoms resolved within three months. They recurred a year later in 1982 and she is described this time as having obsessional, aggressive thoughts, "for no good reason". Again the depression resolved within a few months but she was left with some panic symptoms in the following year and was still described as paranoid in August 1983. With a change of medication, she was observed to be very well by February 1984.

From then until the summer of 1986, she was psychiatrically well. The notes of a number of attendances at her GP's surgery, during this period make no mention of active psychological symptoms.

In July 1986 now aged 42, she was admitted for the first time to a psychiatric unit, under the care of a consultant psychiatrist in Acute Psychiatry (CP3). Although depression was a feature, the paranoid symptoms were now much more prominent than formerly and were not all fully congruent with depressed mood. She believed that the police were going to arrest her for murder and had ideas of persecution. There were no hallucinations. It was noted that she had been brought up in a disturbed family atmosphere with very high expressed emotions, that she was a shy and introverted person and that there was a family

history of depression. She spent two months in hospital, made a good response to ECT and medication with both anti-psychotic and anti-depressant medicines. By May 1987, she was judged well enough to be discharged from out-patient care with a recommendation that medication could be stopped in a few weeks. However Doris's health showed signs of deterioration without medication and she therefore had to remain on it.

The next admission was more than two years later, in July 1989, again with depression, guilt and some suicidal ideas for a recurrence which developed over four weeks. She was quite strongly paranoid believing that her husband and daughter had turned against her and that her neighbours were aware of her (as she saw it) shameful past. This time the delusional thinking seems to have been congruent with her depressed mood. She responded well to a small number of ECTs and anti-depressants alone. Followed up in the Day Hospital, she improved steadily over the next nine months.

There was another relapse, leading to admission in September 1990, this time with more elaborate paranoid ideas in addition to depression. She interpreted a clicking noise from her kettle as a bug planted by the police and that a car registration number WOR meant that she was a whore. This time the illness did not respond completely to ECT, anti-depressants and anti-psychotic medicines. Despite changes and increases in medication, she was described as disruptive and aggressive at home in the early part of 1991. There were delusional ideas about the Sun newspaper and songs which contained the word "love". By March, she was again in hospital depressed, agitated and reluctant to comply with treatment. The diagnosis of schizoaffective disorder was seriously considered. She responded well to another course of ECT and was prescribed Lithium carbonate and the anti-depressant Dothiepin. She and her husband were referred for conjoint therapy with a Social Worker.

Eighteen months later, in April 1993, Mrs. Walsh was once more admitted under a psychiatrist with a two month recurrence of depression. There were some ideas of reference but no hallucinations or elaborated delusional ideas. She had stopped Lithium and her marriage had ended. She recovered on the anti-depressant Dothiepin by itself, and after out-patient follow up for a time, she was referred for community nursing support at home by the psychiatrist, in August 1994. This did not happen but she continued to see the psychiatrist in the out-patient clinic until February 1995 when she was discharged back to her GP.

The last admission to Walsgrave Hospital was on 9.6.95. She was depressed and despairing but there was a new feature of hallucinatory voices tormenting her with accusations of evil over the past two weeks. Later Mrs. Walsh told us that she had been hearing the voices for the previous year, not longer, but had been unable to talk about them with the doctors and nurses. As far as can be seen from a careful study of the records, this is the first time that hallucinations played a major part in her illness. It marks a significant change in the presentation of her illness. At Reaside Clinic, she has further described how she came to believe that the mental health team were intent on destroying her and were directing powerful rays at her from concealed places, such as vents in the

ceiling. She concluded this because she occasionally smelled burning flesh. She also felt that the doctors and her family were accomplices and were party to her persecution. Her inability to trust anyone at the time, which she confirmed to us when we saw her, seems to explain why she resisted accepting professional help even when seriously troubled.

At Reaside Clinic, painstaking assessment and investigation has led Dr. Brockman and her colleagues to question what contribution a family history of either depression or epilepsy or both, might have made to Mrs. Walsh's illness. Further investigations are planned, in particular neurological evaluation and a trial of treatment for brain dysfunction, to see if the mental disorder may have had an organic basis. The hallucinations of smell are not characteristic of functional mental disorder but are to be found in forms of epileptic activity especially involving the temporal lobe. The full diagnosis is not yet established.

Comment

The attacks of depression over the years were seen, by the psychiatrist (CP3), who was mainly responsible for her care, as recurrent episodes of depressive disorder with mood congruent disturbances of thinking, not of systematic paranoia. She was oversensitive and had ideas of reference. Between attacks she was able to cope with her life and was often described as very well, although there were a number of difficulties and events in her life which made her unhappy. After a time she seems to have had a residue of ideas of reference even when not depressed. She was first admitted to a psychiatric unit at the age of 42, having had five previous episodes of depression which lasted for a few months and responded well to anti-depressants. In the next nine years, she had a further five admissions to hospital, never under a compulsory order. The symptoms usually responded quickly to anti-depressants and drugs used for delusional thinking. She was kept on maintenance drugs on most occasions but was only followed up in the outpatient' clinic, with the GPs prescribing but uninvolved in treatment. She did not have the benefit of a community based mental health worker, except for some focused support from the original social worker.

The illness changed during 1995 with the new development of auditory and olfactory hallucinations and systematised delusional thinking which was independent of depressed mood. The clinical team to which she had been assigned as the result of organisational change does not appear to have recognised the change. It seems to have carried on as before and not seen her as someone needing indefinite close follow up whether she was in hospital or at home. The diagnosis of schizo-affective disorder or of concurrent paranoid psychosis has since been debated and now the possibility that an organic brain disorder might have been contributed is being investigated.

It has been clear to us that Doris Walsh did not suffer from an unremitting mental disorder over the years. She was an ordinary rather reserved person who had worsening episodes of depression every few years, which were well managed by the psychiatric services. At the age of 51, she developed florid psychotic symptoms which made her take desperate actions when tormented by voices. There is nothing in her records or from what we know of her to suggest that she was driven to harm anyone. On the contrary, she seems to have believed herself to have been the object of the persecution of others.

Dr Donald Dick

RECOMMENDATIONS

1. The Trust and Local Authority must ensure that an effective system of clinical supervision is in place for medical and nursing staff and other professionals involved in patient care at all levels.

2. Protocols should be drawn up clearly defining the expected roles of the ward-based Named Nurse and the Community Key Worker.

3. As part of the Continuing Professional Development of Nursing Staff, all nurses should be adequately prepared and trained for the responsibilities of the role of Named Nurse and Community Key Worker.

4. Any other professional who undertakes the role of Community Key Worker should have similar preparation and training.

5. Any patient under long-term psychiatric care (whether in hospital or not) should be subject to regular multidisciplinary review.

6. On every admission the Ward Doctor and the Named Nurse should fully acquaint themselves with the patient's previous clinical notes and detail any relevant information from the past medical history into a new case review which should then be recorded in the notes for the current admission.

7. The Nursing Care Plan should be formulated within 72 hours. If not, the reason for not doing so should be detailed in the notes.

8. The Treatment Plan (which is the responsibility of the RMO) should be formulated at the first ward meeting after admission, which should be multi-disciplinary wherever possible.

9. Printed standard forms (such as Appendix 4), where only the patient's name is inserted, should no longer be used for the Main Care Plan or the Discharge Care Plan. Such Care Plans should be personalised to the individual concerned.

10. The Trust and Local Authority should devise a fully integrated record-keeping system which allows any clinical worker (with a reason to be so) to be fully informed about the patient's circumstances, illness, Treatment and Care Plans.

11. The Trust and Local Authority should devise a system for the prompt dissemination of all relevant information between the various professionals responsible for a patient's care.

12. The patient's GP should be notified of any admission or discharge within 24 hours. Upon any discharge, GPs should be promptly informed of the details of any After Care Plan and the patient's current medication.

13. The Discharge/After Care planning meeting should be held in all cases where a patient discharges themselves against medical advice.

14. In all cases where patients discharge themselves against medical advice, there should be:

(a) an attempt within 48 hours to contact the patient, preferably by someone who knows the patient.

(b) an out-patient appointment offered no later than 14 days after leaving hospital.

(c) notification to the patient's GP within 24 hours.

(d) an immediate referral to the Community Mental Health Team or notification to the CMHT if already involved.

15. Any Discharge Summary should be dispatched within 7 days, having first been checked by the patient's Consultant for accuracy.

16. An independent account of any leave of absence should be obtained wherever possible from members of the patient's family, or the Community Worker.

17. Following any referral to the CMHT, contact with the patient must be made in the time specified in the contract. A patient should not be rejected in any way by the Team without face to face contact having been made and an assessment having been carried out.

18. There should be a formal handover when responsibility for the care of the patient transfers from one agency to another (e.g. hospital team to community team or primary health care team). This should be in writing. If there is to be shared responsibility between agencies, the individual roles of responsibility should be clearly identified. Building Bridges page 22 para 1.5.10

19. A patient should not be allowed to collect prescriptions for psychotropic medication for longer than 3 months without being personally reviewed by a Doctor.

20. Social workers should regard any request for assistance as a formal referral. Wherever possible they should ensure that they have adequate background information before making contact with the client.

21. Services independent of the clinical team involved should be provided for the support and counselling of families of the victims of a serious incident, such as a homicide or suicide.

22. Counselling should also be available to any professional involved in a serious incident.