EAST LANCASHIRE
HEALTH AUTHORITY

Inquiry into the Circumstances Surrounding the Deaths of Mr Michael Horner and Mrs Hazel Horner

November 1997

On behalf of East Lancashire Health Authority I would like to express our regret to the family of Mr and Mrs Horner. We would like to thank the Inquiry Panel for their work in conducting the Inquiry and we would like to extend our gratitude and condolences to the family of Mr Williams, who chaired the Inquiry Panel and died shortly before the publication of this report.

We would also like to thank all of the witnesses for talking to and facing an Inquiry Panel which is not an easy matter.

Finally this report identifies a clear action plan and it is our intention that this sad event will be an opportunity to continue to improve mental health services in Blackburn, Hyndburn and the Ribble Valley.

W Ashworth

Chairman

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INQUIRY INTO THE CIRCUMSTANCES SURROUNDING

THE DEATHS OF

MR MICHAEL HORNER AND MRS HAZEL HORNER

Chairman: W. J. Williams, Esq.

EAST LANCASHIRE HEALTH AUTHORITY - NOVEMBER 1997

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Appendices

Italics have been used to draw attention to quotes, dates and extracts and **bold** letters to stress statements or opinion.

BACKGROUND

1. Mr Horner was discharged from an acute psychiatric ward at Queen's Park Hospital on Tuesday afternoon, *26th March 1996.* The following evening he telephoned the ward to tell them he had killed his wife. By the time the police got to his house he had hanged himself. The inquest determined that he had killed himself whilst depressed and that his wife's death was unlawful killing.

2. The East Lancashire Health Authority set up an external Inquiry with the following terms of reference:

To investigate all the circumstances surrounding the treatment and care of Mr Horner and the subsequent deaths of both him and Mrs Horner. In particular to comment on:

the quality of ***professional*** *care the patient was receiving immediately prior to his death;*

the suitability of that care in view of the patient's history and assessed health and social care needs;

the extent to which that care corresponded with statutory obligations, relevant guidance and local operational policies;

the exercise of professional judgement ***with particular reference to the decision to discharge the patient;***

the extent to which carers were involved in the patient's discharge;

the ***adequacy of the operational policy to deal with emergencies relating to mental health care in the community;***

the ***effectiveness*** *of the communication between the various agencies;*

the adequacy of resources in the community to meet Mr Horner's needs;

to prepare a report and make recommendations to East Lancashire Health Authority within six months of the commencement of the Inquiry.

INTRODUCTION

3. Mrs Michelle Wilkins, the elder daughter of Mr and Mrs Horner, was most forthright and helpful in providing the panel with details of her family background.

4. Her parents had been married for 32 years. There were two children: Mrs Wilkins, and her younger sister, Mrs Lisa Rawlinson. She described her father as having strict Victorian attitudes, always expecting perfection and never giving praise. He disliked his wife working even though she felt it necessary to help the family finances.

5. Mrs Wilkins was aware of both verbal and physical aggression by Mr Horner to his wife who, through most of the marriage, was subservient and acquiescent. At times he would not speak to her for long periods. If she was bruised she would use make-up to cover her injuries. It is perhaps significant of the atmosphere in the household that both Mrs Wilkins and her sister left home for university as soon as they could and neither returned to live at home after they graduated.

6. Mr Horner's physical health deteriorated and it was necessary, *in 1994*, for him to retire from his work at the garage where he was a partner. However, he was convinced that he was being cheated by his partners in the dissolution of the partnership. At about the same time, Mrs Horner obtained a more responsible job and as a result their roles were reversed. His wife became more assertive and he was losing the control he had always exercised over his family. He began to threaten suicide, causing his wife to be extremely distressed, although she felt that it was his way of trying to regain control over her.

7. The marriage deteriorated further and they were sleeping separately. Mr Horner became jealous of his wife and believed, without any grounds, that she was having an affair. They were referred to marriage guidance and attended a number of sessions but without making any progress. Mrs Horner would not contemplate divorce because of her religious beliefs and consistently said that she wanted her husband to be treated for what she saw as a mental health problem. Her husband's wish was that she would revert to the quiet, acquiescent person she had previously been.

8. Mrs Horner was a patient of Dr Datta, the family general practitioner, for more than 19 years and never confided in him about her husband's abuse. Nor did she disclose this to Dr Blake, the senior registrar who treated Mr Horner as an outpatient. In a joint interview with her husband and Dr Purandare[1], the senior registrar who treated Mr Horner both as an inpatient and an outpatient, she told him that there was no actual violence in the marriage but her husband did come close to her aggressively, and she was afraid of him. In contrast with this, on *4th March* Staff Nurse Knowles recorded that Mrs Horner said, "....he has been violent towards her and aggressive towards their daughters." Mrs Wilkins told us there was violence between her parents and she instanced a number of occasions. Mrs Horner also told her new general practitioner, Dr Craig, ten days before her death, that she had been both verbally and physically abused.

9. Mrs Horner started separation proceedings when Mr Horner was in hospital and although both daughters telephoned the hospital to offer information, they decided that they could not visit their father because of his treatment of them in the past. These factors no doubt contributed to the view held by the hospital staff that the family, and particularly Mrs Horner, were not significant carers so their views were not sought, although the daughters did telephone the wards we believe that was at Mrs Horner's request and not from the ward teams' initiative and Mrs Horner was not informed of her husband's admission to, or discharge from hospital.

10. Eight medical staff were involved in the care of Mr and Mrs Horner. There were three general practitioners: Dr Datta and his wife, who provided care for both Mr and Mrs Horner, with Dr (Mrs) Datta mainly seeing Mrs Horner, and Dr Susannah Craig who saw Mrs Horner once. Two consultant psychiatrists were involved, Dr David Franks, and Dr Gupta, who performed one domiciliary visit to Mr Horner. There were two senior registrars, Dr Blake, followed by Dr Purandare, and one SHO, Dr Kodali, who was involved only in his inpatient care.

[1] 14th March 1996

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CHRONOLOGY OF EVENTS IN THE ILLNESS OF

MR MICHAEL HORNER

1992	Mr Horner's arthritis diagnosed.
June **1994**	Incident at dance.
July	Saw general practitioner (GP) - first suicide threat.
August 31st	Retired due to ill health.
November	Prescribed medication for depression.
January 5th ***1995***	Mrs Horner went to GP because she 'fell' downstairs.
January 25th	Referred to Dr Franks by GP.
March 1st	Outpatient (O/P) appointment with Dr Blake.
May 1st	O/P appointment with Dr Blake.
May 22nd	O/P appointment with Dr Blake (Mr & Mrs Horner.)
May 30th	O/P appointment with Dr Blake (Mr & Mrs Horner.)
June 3rd	Holiday in Turkey with his wife.
June 19th	O/P appointment with Dr Blake.
June 22nd	O/P appointment with Dr Blake (Mr & Mrs Horner.)
August	Relate counselling terminated after 15 sessions

	over four months.
August 10th	O/P appointment with Dr Blake (Mr & Mrs Horner.)
October 10th	O/P appointment with Dr Purandare.
November early	Mr Horner took 17 Co-dydramol tablets.
November 21st	O/P appointment with Dr Purandare.
December 11th	O/P appointment with Mr & Mrs Horner. Mr Horner's first appointment with community psychiatric nurse (CPN) at his home.
December 19th	O/P appointment with Dr Purandare (Mr & Mrs Horner.) CPN met Mrs Horner.
January 3rd ***1996***	CPN home visit.
January 11th	CPN home visit.
January 19th	CPN home visit. Mr Horner assessed by Dr Gupta after suicide threat, but declined to be admitted.
January 23rd	CPN home visit.
January 31st	Mrs Horner writes to Dr Franks stressing Mr Horner's deteriorating condition.
February 1st	CPN home visit.
February 3rd/4th	Mrs Horner visits her elder daughter.
February 5th	CPN home visit.
February 6th	O/P appointment with Dr Purandare (Mr & Mrs Horner.)

	Decision to arrange admission for assessment.
February 12th	CPN home visit.
February 26th	Mr Horner told CPN he had overdosed the day before. CPN informed GP and Dr Franks.
February 29th	Admitted to ward F4 at Queens Park Hospital (QPH).
March 14th	Mr and Mrs Horner interviewed by Dr Purandare.
March 20th	CPN and occupational therapist (OT) informed of suicide attempt.
March 22nd	Dr Franks chaired ward round.
March 25th	Dr Purandare chaired final ward round.
March 26th	Discharged.
March 28th	12.10 am. Police arrive at ward to confirm deaths of Mr & Mrs Horner.
March 29th	Mr Horner and CPN scheduled to meet at 9.15 am. Mrs Horner due to be moved by Mr Wilkins (son in law) to new accommodation.
April 3rd	QPH reports deaths to East Lancs Health Authority (ELHA)
April 19th	Inquest due to be held, but postponed for QPH to supply the Coroner with statements.
April 23rd	Incident review held by QPH.
May 27th	Trust replies to Coroner's questions.

July 9th	Trust informs ELHA in writing of deaths of Mr & Mrs Horner.
July 10th	QPH informs NHS Executive.
November 28th	Inquest.
March 5th *1997*	Inquiry team holds first meeting.

OUTPATIENT CARE

11. Mr Horner became an outpatient on *1st March 1995* and was admitted as a voluntary inpatient almost exactly a year later, on *29th February 1996.* During that time he was seen by the following Queen's Park Hospital staff:

- senior registrar Dr Ian Blake on seven occasions - four of which were with his wife;
- senior registrar Dr Nitin Purandare on five occasions - three of which were with his wife;
- consultant psychiatrist Dr K. Gupta on a domiciliary visit to his home, and
- community psychiatric nurse Mr Fullalove on ten occasions.

The Drs Datta - general practitioners

12. Dr M K Datta referred Mr Horner to Dr Franks on *25th January 1995,* reporting that Mr Horner's depression had improved with the prescription of an anti-depressant Prothiaden (Dothiepin), but had to be changed to Prozac (Fluoxetine) because he developed side-effects. The Prothiaden seems to have been originally prescribed by Dr Datta on *24th November 1994,* so this probably marks the beginning of Mr Horner's treatment for psychiatric disorder.

13. Dr Datta's notes contain an interesting report of *July 1984* from the BUPA medical centre in Manchester, of a routine health screening paid for by his company. This report said that Mr Horner left school at the age of 15, served a five year motor engineering apprenticeship, and then worked as a motor engineer and service manager until he started his own Citroen dealership with two partners in *1979*. He was described as then *(1984)* having *'no undue work related pressures, although he derives limited satisfaction from his job, and there is occasional boredom.....* he has been happily married for 20 years. His 43 year old wife is generally well. His two children, aged 18 and 17, are in good health.' His previous medical history was normal, apart from minor accidents and injuries. He was described as *'of average build and healthy appearance'* and his physical examination was normal. *'I found Mr Horner to be of stable temperament and in good general health.....his lifestyle is reasonably healthy.'*

14. Mr Horner was also cared for by Dr M K Datta's partner, his wife, Dr S Datta, although she tended to provide much of the care for Mrs Horner.

15. In 1995, Mr Horner had a brief (*from 14th February* to *19th February*) medical admission with chest pain. The discharge letter noted that Prozac had been started two weeks earlier. No cause was found for the pain.

16. The Horners had been on Dr Datta's list for nearly 20 years. Dr Datta knew Mr and Mrs Horner well and he saw Mr Horner frequently during 1995. However, he was largely unaware of any physical violence by Mr Horner on his wife. The GP notes record that she had a consultation on *5th January 1995* because she had fallen down stairs three days earlier - her daughter Mrs Wilkins told us that Mr Horner had pushed his wife downstairs. The notes of *26th May 1995* record that she had seen a psychiatrist (Dr Blake) with her husband. Dr Datta told us that Mrs Horner had *"once complained of a bit of a bruise"* and was *"very timid"*.

17. Mr Horner had looked after Dr Datta's car and was happy at work, where he was a good mechanic, but was upset when he felt he was badly treated by his partners. Dr Datta told us he was unaware of marital disharmony until about 1994 and that Mr Horner had had many physical complaints since then. When he presented with depression at the end of *1994,* he was unshaven when he had normally been smart, and had been weepy at home and threatened suicide. The

question of jealousy or unusual suspicions about his wife never came up.

18. We have no criticism of the care provided by the Drs Datta for Mr Horner, although it seems that Mrs Horner felt Dr M K Datta was too close to her husband, as he used to service Dr Datta's car. This may have led to her transferring to the care of Dr Susannah Craig several weeks before her death.

Dr Ian Blake - senior registrar

19. Dr Blake (now consultant psychiatrist in Burnley) was the first psychiatrist to see Mr Horner after he had been referred by Dr Datta to Dr Franks, with whom he was working as a senior registrar for a year.

20. Dr Blake saw Mr Horner on what was probably *1st March* 1995, although this is recorded in the notes as *20th March* 1995. He took a thorough routine psychiatric history, noting the relatively abrupt onset of his illness in *June 1994* when he was suddenly seized by panic during a dance with his wife, and the next day burst out crying when his car was scratched. Before Christmas, he had experienced difficulty deciding to do things, had felt unhappy, and did not shave for two to three days at a time. His sleep was disturbed with early morning wakening and he felt worse as the day went on. He had gained weight, his libido was poor and he became impotent. He had *"greatly improved"* when Dr Datta changed his prescription of Prothiaden to another anti-depressant Prozac, but he still experienced some anxiety. There was no family history of anxiety, depression or other mental illness. On examination, his mood was normal, and although he had had ideas of suicide in the past, he had never made up his mind to carry this out. Dr Blake concluded that Mr Horner had *"a reactive type of depression with symptoms of anxiety ..... precipitated by a change in his lifestyle."* He advised him to continue the Prozac and considered that nothing more was needed at present.

21. When Dr Blake next saw him on *1st May,* improvement seemed to have ceased and he advised him to continue with the Prozac. He saw him again on *22nd May 1995,* and noted *'great marital disharmony as a result of depressive illness'* and decided to add Lithium (which is usually used to control manic and depressive swings in mood), to boost the action of his anti-depressant. He saw him again a week later, when Mr Horner looked brighter and claimed to feel better. However,

Dr Blake advised him to cancel his planned two week holiday in Turkey, and noted *'I felt that he was being very manipulative with veiled threats if his wife did not go on the holiday.'* He also recorded that they were attending Relate together for marriage guidance.

22. The next appointment was on *19th June,* when they had just returned from their holiday. Dr Blake noted that they had not lived as man and wife during the holiday, and that Mr Horner had *"drunk heavily"* on some nights. He saw him again three days later with his wife (for the first time) and although *'both agreed that things are much improved,'* he also noted that *'she became angry with the Relate counsellor last night.'*

23. Although he planned to see Mr Horner and Mrs Horner separately, every week from then on, he does not record seeing Mr Horner again until *10th August 1995.* This may have been because Mrs Horner had some difficulty in attending during normal clinic hours, and some appointments had been cancelled. Dr Blake noted that Mr Horner seemed well and had *'no biological features of depression but continuing difficulties within the marriage.'* They were: *'not sharing the same bed, getting at each other,* and there were *similar difficulties with married daughters.'* He also noted that the Mr Horner believed Relate had made matters worse. Two weeks later he received a letter from Relate dated *21st August,* stating that *'after a total of 15 sessions over a period of four months, the work became deadlocked, reaching a point where a mutually destructive pattern of interaction had been identified, but sadly, there proved to be no motivation on the part of the clients to change this.'* The Relate sessions were therefore discontinued.

24. At interview, Dr Blake said that he considered all the way through that Mr Horner had a clinical depression, and that he should prescribe medication to improve this. He also felt that he responded to medication. He described Mr Horner as always coming to clinic in a suit, looking more like a businessman than a garage mechanic. He appeared older than his wife. He thought by the time he handed the case on to Dr Purandare that Mr Horner's depression was well controlled on medication. Dr Blake also considered that he received good supervision from Dr Franks, who was very hardworking, always in the unit, checking most things and on top of his job.

25. Dr Blake finished his attachment at Blackburn, and passed the care of Mr Horner on to his successor, Dr Purandare. In retrospect he continued to feel that Mr Horner had been clinically depressed, and with hindsight he thought perhaps his wife had needed to be seen on her own.

Dr N Purandare - senior registrar

26. Dr Purandare took over from Dr Blake in the *autumn of 1995,* and saw Mr Horner for the first time on *10th October 1995,* when he noted that Mr Horner was feeling *'a lot calmer.'* Mr Horner complained that roles had reversed within the marriage, and although Mr Horner said that he no longer argued with Mrs Horner, she wanted to argue with him. The relationship was *'improved.'* Dr Purandare decided to continue the Lithium and Prozac, and suggested a wood carving course and voluntary work.

27. At his next appointment on *21st November 1995*, Mr Horner told Dr Purandare that he felt a lot calmer, although the situation was much the same.

28. However, two weeks earlier, his wife had said that she was going out, and after she left, he took 17 Co-dydramol tablets (pain-relieving medication) and started writing a suicide letter, which his wife never saw. Nor did she realise he had taken the tablets. However, he felt that the prescription of Prozac had helped him to control his anger, as in the past he used to throw things. He admitted to feeling jealous and felt at times that life was not worth living. They had slept in different bedrooms for about six months, and although his wife had asked him to go back, he had not done so. Dr Purandare concluded that *'the depression seems to be mainly related to his relationship with wife, problems with daughter. Manipulative to some extent.'* He decided to refer him to the community psychiatric nurse (CPN) Mr Fullalove, and to see him again in four weeks with his wife.

29. As a consequence of Mrs Horner telephoning for an earlier appointment because of the stresses caused by their continuing marital disharmony, they were both seen on *11th December*. Mrs Horner complained that Mr Horner had stopped taking his tablets and had become more depressed and difficult. He was manipulating her by threatening to take overdoses, and she was finding it difficult

to cope with the repeated suicidal threats, jealousy and arguments. During the interview, they seemed to provoke each other. Dr Purandare noted that he had discussed the case with Dr Franks, and planned that Mr Horner should restart his Lithium and Prozac, but emphasised to them that medication alone was not going to resolve the issues.

30. A week later they were again seen together by Dr Purandare, who had in the meantime discussed the case with Mr Fullalove, the CPN. He noted that Mrs Horner was at the end of her tether and feeling hysterical. The general practitioner had asked her to take charge of Mr Horner's medication and Mr Horner was getting annoyed about this. Dr Purandare planned that Mr Horner should take responsibility for his own medication, and considered that professional advice about their marriage was unlikely to be helpful because Mr Horner was so unwilling. However, Mr Fullalove was to see him on a regular basis for individual psychotherapy and Dr Purandare arranged to see them again in three months time to review progress.

31. On *31st January* Mrs Horner sent Dr Franks a two page typed letter expressing her relief that her husband's appointment had been brought forward from *12th March 1996* to *6 February 1996* (implying that there had been telephone conversations before this). She complained that her husband was becoming more agitated daily, and that he became particularly agitated if she was as little as five minutes late home from work. That evening he had told her that she was late because she had been with someone else. She complained about his agitated behaviour when he was collecting her from work the previous evening, and mentioned the domiciliary visit by Dr Gupta, which had followed Mr Horner telling Mr Fullalove he had bought a rope to hang himself. She said that she could no longer cope with the state of affairs, because Mr Horner's behaviour was so variable when she came home, and the worst of all was the threat of him carrying out his plan to commit suicide. *"I understand that Mike was diagnosed to be suffering from depression and mania. I feel he needs to be cured,"* she wrote. She also mentioned that she had dissolved 200 pain killing tablets after he tried to take another overdose, and she had climbed into the loft to find the rope he had there, but Mr Horner said that he would buy another. She felt that "*there must be some more treatment to go with the Prozac and Lithium Mike is currently taking. He does not seem to be improving.*" She concluded by writing *"I shall be coming to*

the hospital on Tuesday with Mike and hope to be able to see you at his consultation in the hope that you will be able to help."

32. This gives the impression that Mrs Horner was appealing to Dr Franks, as the consultant, to institute some additional treatment because she was getting so desperate about her husband. However, she did not make any mention of his being violent to her.

33. At their *6th February* appointment, Mr Horner reported that he had been *'up and down'* and that he had bought a tow rope two weeks earlier and put it in the loft, thinking that he might need it if he felt like ending his life. He did not mean to kill himself then, he added. (However we now know that he dated his draft suicide note *11th January,* and referred in it to "The date is Saturday *13th.")* He had also told Mr Fullalove about the tow rope. He mentioned that he had also been seen by Dr Datta and then Dr Gupta, and since then he had been all right accepting that *"the marriage is hopeless."* He did not think that they had any relationship. His personal hygiene had deteriorated, and when his wife came home late, he wondered whether she had been with somebody or involved in an accident. He insisted that he had not had any suicidal thoughts since Dr Gupta's visit, and had been taking his medication regularly since *25th November.* He was feeling calmer and was not violent with others.

34. His wife said she could not cope with his outbursts when she came home. In her view he was not getting any better, and she could not see their relationship improving until he did get better. She was not sure about the seriousness of his suicidal ideas, and mentioned that he was not sleeping at night and was banging cupboard doors. Dr Purandare decided to arrange admission to F4 or F3 ward for assessment and a review of his medication. The next day he noted that there was only one male bed available, so decided to arrange admission for early the following week. The GP was informed.

35. On *28th February* Dr Purandare made his final outpatient entry: that a bed had been arranged on F4 and that Mr Horner would come in at 4 pm the next day. He noted that Mr Horner had taken another overdose the previous weekend when his wife had gone to visit their daughter; that he was informing the patient and the CPN of the admission, and that he was to be admitted under the care of Dr Franks

'for further assessment.'

Mr Fullalove - community psychiatric nurse

36. Following his first meeting with Mr Horner on *11th December 1995,* Mr Fullalove wrote to Dr Purandare detailing a comprehensive history and assessment of the problem. He referred to Mr Horner's two previous suicide attempts, and stated that, *"Mr Horner gave the impression of blaming others for his present situation, and claims he hits cushions and walls rather than his wife. However, he refuses to talk more about this at present."*

37. Mr Horner was visited at home by Mr Fullalove on nine more occasions between *19th December 1995* and *26 th February 1996* and by doing so he obtained more information about Mr and Mrs Horner than any other member of the multi-disciplinary team. That information is well documented in his notes and letters to the medical staff. There are references to Mr Horner's physical abuse of his wife - which was admitted by both parties but the degree of violence was contested, his jealousy of his wife, and the verbal taunting of their elder daughter.

Dr K C Gupta - consultant psychiatrist

38. Dr Datta, the general practitioner, was concerned about Mr Horner's suicidal ideas and acquisition of a rope, and as Dr. Franks was away, he asked Dr Gupta to make a domiciliary visit. Dr Gupta saw Mr and Mrs Horner on *19th January 1996* and was told by them that Mr Horner suffered from *"manic depressive illness"* and that he had been seeing Dr Purandare as an outpatient. He noted that the marital relationship had been poor, to the extent that 14 months earlier Mr Horner had thrown out his wedding ring. His wife said that he spoke in a raised or angry voice, had morbid thoughts, and could not be trusted with his tablets. When he was high he was talkative, but when he was low he was very quiet. Dr Gupta noted that Mr Horner had ideas of suicide, although his wife said that he appeared calmer when he was taking his medication, (Prozac and Lithium.)

39. Dr Gupta concluded *'there is no doubt about the diagnosis of manic*

depressive illness' (although this had not been mentioned in the notes by either Dr Blake or Dr Purandare). He also talked about the difficulty of managing the case. Clearly, the Horners believed that this was the diagnosis, and the medication being prescribed (Prozac and Lithium) would tend to support this interpretation. Dr Datta wrote, on *30th January 1996*, that he might suggest to the couple that they separate in an attempt to improve Mr Horner's mental state. He also noted that he had discussed the case with Dr Purandare and was asking him to bring his appointment forward.

Dr D Franks - consultant psychiatrist

40. Dr Franks made it clear to us that although Mr Horner was being seen as an outpatient by his senior registrars, Dr Blake and then Dr Purandare, he was technically under his care. He supervised his senior registrars closely, and they had a regular supervision session of one hour each week when they could discuss any cases about which they were concerned. (Both senior registrars confirmed that Dr Franks was meticulous about keeping these supervision sessions). Dr Franks said he was happy to delegate care to his senior registrars where they had his confidence, which they both did. His policy with inpatients was not to see them in ward rounds because he did not feel that was a good way to monitor and assess. He felt that it was better to see them as individuals when necessary. He felt that the diagnosis for Mr Horner should be considered *"dysthymic disorder"* - reactive depression with depressive mood and anxiety. He thought Mr Horner had had some limited benefit from the prescription of anti-depressants, and he recalled Dr Blake telling him Mrs Horner had indicated that taking Lithium had reduced Mr Horner's argumentativeness.

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IN-PATIENT CARE

41. Mr Horner was smartly dressed and unaccompanied when he arrived at ward F4 as an informal patient at 4 pm on *Thursday, February 29th 1996.* The staff on duty thought he was a visitor looking for someone. When asked why he was unaccompanied, he replied that he was not feeling friendly towards his wife. Student Nurse Howard completed his admission details and care-plan - neither of which were checked or signed by a qualified nurse. His admission caused some concern to Mrs Horner, who did not know of it until later that evening, when she telephoned the ward to establish whether Mr Horner had been admitted.

42. Dr Kodali, SHO to Dr Franks, told us that during the admission interview Mr Horner was a bit low. He was weepy when he talked about marital problems and tearful when he mentioned his grandchild - she understood he was making something for her, but his daughter would not allow him to present it to her personally, because she said it would have a bad effect on her.

43. Dr Kodali also told us that during his stay on the ward she saw him about twice a week, and when they met he was generally helpful. She explained the absence of case notes about these consultations by saying that she normally recorded only significant events. The plan was to observe him without changing his medication.

44. When asked about the suggestion that Mr Horner had planned or attempted suicide while on the ward, she said that any suicidal risk had seemed momentary. She had only recently come to know about the occupational therapy report referring to Mr Horner's suicide attempt. She thought that Mr Horner was suffering from reactive depression because of his marital situation. Compulsory detention had never been considered.

45. When asked about Mr Horner's relationships with other patients, Dr Kodali replied that his friendship with the young patient with learning disabilities whom he sometimes accompanied was *"a father and daughter relationship,"* and there was an elderly woman on another ward he sometimes visited.

46. Mr Horner was discussed in the ward round on *Friday 1st March,* and the nursing notes record the *'need to assess situation re family disharmony.'* A referral to the occupational therapy department was made. That same morning, Mrs Horner telephoned the CPN to ask about her husband's progress and visited him during the evening. On *Monday 4th March* there was the usual ward round, at which it was decided to contact Mr Horner's daughters to obtain their views. Mr Horner was seen by Dr Kodali and the CPN, and he told them he was not ready for discharge yet. Later he was seen by the occupational therapist and agreed a programme of projective art with her. Mrs Horner visited during the afternoon and spoke to Staff Nurse Knowles. This is the only record we have of Mrs Horner being interviewed by nursing staff. During the evening Mrs Rawlinson, telephoned the ward and "confirmed everything her mother had said" about the abuse, aggression and violence that she, her sister and her mother had experienced at the hands of Mr Horner.

47. Mr Horner was visited by the CPN on *Tuesday 5th March* and both Mrs Horner and Mrs Wilkins telephoned the ward. Mrs Horner left a message for her husband and Mrs Wilkins asked to speak to the primary nurse, but she was not on duty. She was told Staff Nurse Horrex would be back on duty on *Thursday afternoon* and was asked to ring then. However she telephoned the next day *(Wednesday)* and as well as leaving a contact number, described her father as possessive, obsessive, controlling, twisted, negative and violent towards her sister, her mother and herself.

48. At the *11th March* ward round it was noted that Mrs Horner had visited regularly and that the occupational therapist reported that Mr Horner was finding it difficult to concentrate. The nursing notes record agreement that Dr Purandare would talk to Mr Horner later that day to clarify the home situation: the medical notes merely record that he would be seen by Dr Purandare.

1. The interview took place two days later. A distillation of that day's medical notes reveals that Mr Horner:

- admitted he had felt very anxious when he went to woodwork, and that he had become angry with a couple of patients on the ward, but felt he could also have a good laugh;
- believed his depression - he had felt up and down - was a lot better now that he

was meeting people and helping other patients by shopping and talking to them;
- believed he was sleeping better than when he was at home. He also felt safe and did not want to return home;
- talked about his irrational jealousy towards his wife and his volatile temper;
- told how he had gone home the previous Saturday to pick up some keys, but did not talk to his wife much because he felt she was putting him down;
- said he did not want to divorce his wife, but she had not yet made up her mind about divorcing him, and
- requested medication for when he became very anxious. Dr Purandare prescribed 25 mg Thioridazine when necessary, up to three times a day.

50. The OT notes of *12th March* record that he had attended the projective arts group, where he described his mood as *"flat and like a half-deflated balloon."*

51. At 5.15 pm the next day, *(14th March)* Dr Purandare met Mr and Mrs Horner. The consultation started with Dr Purandare seeing Mrs Horner alone. They talked about Mr Horner not telling her about his admission; his not taking his medication regularly at home; his jealous suggestions that she might be having an affair; her feeling unsafe with him at home, and the fact that he did not want to go home. He noted that she told him she experienced *"no actual violence but* (he) *comes close aggressively."* She also said she did not believe in divorce, but Mr Horner was threatening her with it.

52. Dr Purandare then saw the couple together. Mrs Horner told her husband she wanted a legal separation and that she was afraid of him. Mr Horner was unable to understand her fear: he said he had no suicidal intentions and felt that their marriage could work if his wife changed. He asked his wife if she was having an affair. Dr Purandare said both of them would need further discussion about the practical arrangements for their separation, and he suggested that Mr Horner would need more support and close observation to accept his marital situation. He advised Mrs Horner to contact her general practitioner if she needed more help to deal with her guilt about divorce and Mr Horner's threat to kill himself. He explained that Mr Horner's suicidal ideas were mainly related to difficulties in their interpersonal relationship, and Mr Horner would have to take responsibility for his actions. He then told Mr Horner that he would be discharged in about two weeks. He noted that Mr Fullalove should be invited to attend a ward round and

that Mr Horner should be referred to the day hospital. Mrs Horner left the ward at about 8.45 pm in tears.

53. At interview, Dr Purandare emphasised that he found no evidence of major mental illness in Mr Horner, although he acknowledged that he was better on medication, and that his illness was perhaps being controlled by it. He reminded us that he had seen Mrs Horner alone and she had denied physical violence between them, complaining only about Mr Horner's threatening manner - but he had never hit her. He knew that he had shaken her and that she was afraid of him when he was in a nasty mood, but he believed that her fears were mainly about feeling guilty if he took an overdose.

54. Mr Horner also told him that he thought about suicide on the ward but did not actually do anything. Dr Purandare thought it likely that in the long term he would make a serious suicide attempt. The nursing notes of *15th March* indicate that *'Mike will be discharged in approx. 1/52,* (one week) *to attend day hospital after discharge.'*

55. Staff told us that the next day another patient was particularly provocative at lunch time. This led to a heated verbal exchange, which Mr Horner later attributed to the stress he was experiencing from his marital situation.

56. The nursing notes of the *18th March* ward round, chaired by Dr Purandare and attended by Mr Fullalove, record that it was decided Mr Horner should have some time on the ward before discharge, after his wife had made the decision that she wished to separate from him. They also note Mr Horner was attending occupational therapy and was feeling, *"like everything was up in the air and they do not know who will be living where."* On the other hand, the medical notes for that day, written by Dr Kodali, record that Mrs Horner had decided to leave him, that Mr Horner wanted to stay on in the marital home, and that he was feeling better.

57. On the same day Mrs Horner met her new GP, Dr Susannah Craig, and had her first and only consultation with her. Dr Craig provided us with a valuable contribution about the pressures felt by Mrs Horner.

58. She noted that they had had *"a long chat"* and in particular that Mrs Horner *"needs to decide soon what to do - husband being discharged, ? end of this week."* She noted that Mrs Horner had been suffering from severe stress; that her husband had been an inpatient at Queen's Park Hospital for three weeks; that he had been suffering from *'depression plus mania'* with *'long-standing personality problems, with jealousy, temper loss, violent mood swings, etc. Physically violent at times, always verbally abusive. Feels can't live with him any more but doesn't want a divorce. Is thinking about trial separation.'* She also noted that she had advised Mrs Horner to see a solicitor and recorded, *'? move out to rent accommodation so not there when discharged - discuss with daughters, one in Oxford, one in Yorkshire.'* She arranged to see Mrs Horner again in four weeks.

59. Dr Craig did not recollect Mrs Horner giving her any details of the physical abuse from her husband, other than that it had happened. Nor did she remember any specific statement from her about being out of the house by the time her husband was discharged, but she did convey the idea that her arrangements should be so well under way by the time he was discharged that he could not stop her moving out. Her impression of Mrs Horner was that she *"was scared of him and his power over her, but not scared for her life."*

60. The following day, Dr Purandare interviewed Mr Horner on the ward. He recorded that Mr Horner had talked to his wife *"about who will live where."* He did not want to leave his house, but his wife was going to see solicitors. She wanted them to be friends, but he was finding it difficult to accept they were going to split up and was still hopeful that it might not happen. He had felt suicidal on one occasion but was taking it well. Dr Purandare noted *'not much worsening in mental state apart from anticipatory grief.'* He advised Mr Horner to contact his wife to take the discussion further, and noted that Mr Horner was aware that he could not be kept on an acute ward for long. He concluded *'? discharge next week.'*

61. During the afternoon, Mr Horner attended the projective art group, where he talked about hanging himself. The occupational therapist told us that she went to the ward that afternoon and informed the staff of this, but she did not know to whom she spoke. The ward staff on duty that afternoon denied any knowledge of the visit, but the nurses on duty the next day recorded the event. Staff Nurse

Dobson told us that the occupational therapist informed an assistant nurse, who passed the message on to her. She then: a) put Mr Horner on 10 minute observations, b) recorded this on the Nobo board, c) asked Nursing Assistant Sange to observe him, d) handed this over to the night staff and e) asked them to inform the medical staff in the morning. **However, she did not alter the care-plan nor did she comply with the Trust's observation policy.** Sister Dewhurst and other staff told us they did not know Mr Horner was on observations. However, in her statement to the Internal Review, Sister Dewhurst wrote *"Mr Horner's name was noticed to be on the observation board for 15 minute observations."* And in the nursing notes (on *25th March*) she wrote *'15 minutes observations discontinued.'*

62. On the same day Mr Fullalove visited Mr Horner, who told him that he had tried to hang himself four or five days earlier. Mr Fullalove told us he informed the staff there and then, and followed it up with a letter to Dr Franks. The nursing notes record, *'Seen by CPN this pm who will make a report as to what was said.'* There was no mention of the suicide attempt, but at interview we were told the nursing staff checked the male dormitory curtain rails but could not find any evidence of an attempt. We have seen the letter Mr Fullalove wrote that day to Dr Franks describing Mr Horner's attempted suicide, and we were told in evidence that Dr Franks referred to the letter at the ward round on *22nd March*. Dr Franks arranged for it to be copied to the ward, but it was not received there until after Mr Horner's death. We also learned that neither Dr Purandare nor Dr Kodali were aware of the letter at that time.

63. **Mr Horner's reported suicide attempt whilst an inpatient was not discussed with him by either ward nursing or medical staff, nor was the Trust's observation policy complied with.**

64. The following day, *(20th March)* Dr Kodali recorded that Dr Purandare had chaired the ward round, at which it was decided that Mr Horner was to be observed but allowed to go out. He was to be discharged home within two weeks to attend the day hospital five days a week.

65. That evening Mrs Horner had an appointment with her solicitors, which resulted in separation papers being delivered to Mr Horner the next day. A staff

nurse sat with him whilst he read them. The following day Mrs Horner telephoned the ward, to tell her husband that she had taken out a separation order and intended to find a flat for herself and move out. She had also told Mr Fullalove this, and he notified the ward of her intention of moving out of the matrimonial home.

66. Dr Franks chaired the Friday (*22nd March*) ward round - Dr Purandare was away for his regular study day. He was informed of the telephone call from the CPN and decided, (according to the nursing notes) *'awaiting for wife to move out of home before Mr Horner will be discharged.'* The medical notes state *'wife is moving away, Mr Horner may be discharged next week ...'* Dr Kodali told us she did not remember Dr Franks suggesting that Mr Horner should not be discharged until his wife had left the marital home. For his part, Dr Franks cannot remember making this decision, but added that he could not imagine the team would have been insistent on Mr Horner being discharged if they had known that Mrs Horner was going to move out on the Friday - only three days after his actual discharge, particularly when there was no great pressure on beds at that time.

67. On Monday *25th March,* the ward round was chaired by Dr Purandare as Dr Franks was on holiday. Mr Horner was seen in the ward round at his own request, and stated that he had been home on Saturday *(23rd March)* and discussed accommodation arrangements with his wife. They had agreed that they would both live in the same house until she moved out in about four weeks time. He also said that his wife knew about his impending discharge and that "*.....it's too much. I cannot go on any longer. We didn't discuss much.*" We can only speculate whether the *'I cannot go any longer'* refers to his stay in hospital, his marriage, or simply living. Dr Kodali explained she had altered the discharge date in the medical notes - from *25th March* to *26th March* - because her assumption during the ward round was that he was to be discharged that day, but when it was realised that Mr Fullalove - who the team thought Mr Horner should see before discharge - was not due to visit the ward until the next day, the discharge was deferred.

68. A programme was arranged of occupational therapy three days a week, attending the day hospital two days a week, and continuing with his Lithium and Prozac, and it was noted that he had an appointment on Wednesday (*27th March*) to see his solicitor.

69. Dr Purandare told us that nobody had informed him of Dr Franks' apparent decision the previous Friday to keep Mr Horner as an inpatient until his wife had moved out. If he had known this, he would have asked him to remain and he was sure Mr Horner would have done so, *"because he was a compliant personality, and he usually did as he was told."* He believed that when Mr Horner told him he had been home at the weekend and discussed his discharge with his wife, he was being truthful. He had never worried that Mr Horner would harm his wife.

70. During the morning of Tuesday, *26th March* Mr Horner met Mr Fullalove. In the afternoon he attended the projective arts group and he was discharged at about 4 pm. On the same day Mrs Horner telephoned her solicitors to tell them she had found rented accommodation.

71. At 10 am the next day, *(27th March)* Mr Horner met his solicitor, to discuss legal separation/divorce matters. In the afternoon he visited another ward to fit a watch strap he had brought for a patient friend. That evening Mrs Wilkins spoke on the telephone to her mother. She later told us that everything seemed to be fine. At about 9.30 pm Mr Horner's patient friend spoke briefly to him on the telephone at his home. That conversation was reported to be cordial. At 10.09 pm Mr Fullalove's telephone answering machine recorded an agitated message from Mr Horner that he wanted to speak to him urgently. The ward staff have recorded that a minute later (although Nursing Assistant Yates told the inquest this conversation occurred at 11 pm), he telephoned the ward and asked which staff were on duty. When he was told, he asked to speak to Nursing Assistant Yates. He told her he had been trying to contact the CPN but had been unable to do so. Then he said he had killed his wife. Nursing Assistant Yates passed the telephone to Staff Nurse Dodds, who found Mr Horner had rung off. He then looked up Mr Horner's telephone number in the admission book and telephoned him back, but all he could get was a recorded message on a telephone answering machine. He completed administering medications, then briefly discussed the telephone call with the duty medical officer before contacting the police. The ward log book indicates the police telephoned the ward at 1055 to ask further questions about the level of threat they were likely to encounter, and at 1105 they telephoned again for details of Mr Horner's mental state. However, the autopsy report stated that the police entered the house at 1045, and the ambulance service logged a request to attend 20 Higher Croft Road at 1101. They arrived at 1108 pm.