NHS
West Midlands

The Report of the Independent Investigation into the Care and Treatment of OS

Commissioned by the West Midlands South Strategic Health Authority
[now part of the West Midlands NHS Strategic Health Authority – 2006]

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FOREWORD

The members of the Investigation Team wish to express their sympathy to the family and friends of Fiona, whose tragic death led to the establishment of this investigation. It was her family's wish that Fiona should be referred to by her first name throughout this report. We recognise that the family of OS have also had a tragic loss in Fiona's death and have to come to terms with the fact that she was killed by her husband, their son, brother, and nephew.

Despite an inquest and subsequent criminal proceedings, the process of an in-depth investigation is often the only way in which the families of both perpetrator and victim can find out the truth concerning a homicide. The outcome of an investigation into one incident may not be sufficient to restore confidence in the mental health service and its constituent professional groups. Sadly, this incident was followed by another with some similar features only four weeks later. The second incident, involving the death of a young woman at the hands of her partner and father of her child, is the subject of another report ("The Care and Treatment of a Patient known as PW") commissioned at the end of 2005 by the then West Midlands South SHA. Both perpetrators were of Afro-Caribbean background. Both Colette and Fiona were from Irish Roman Catholic families. They attended the same church and school, and were part of the same local community.

The subject of this investigation was in his forties and he had been married to Fiona for 14 years when she died. He had been a patient of the mental health services in Rugby, but he was not regarded as suffering from a mental illness. His problems were understood to be due to the interaction of his personality with a variety of emotional stressors. We were told that some members of Fiona's family believed that he had inflicted both physical and emotional abuse on Fiona over a period of years. Although she left OS on one occasion, they believed that she felt 'resigned' to staying with him because of her strong religious convictions and family background.

At his first trial in October 2005, OS pleaded not guilty to murder. The jury could not reach a satisfactory conclusion, and the Judge ordered a retrial. The second trial was held in March 2006. On this occasion OS pleaded guilty to manslaughter due to diminished responsibility. He is currently serving a sentence of life imprisonment.

In contrast, the subject of the PW investigation suffered from a diagnosed mental illness, schizophrenia, for about 18 months before, tragically, he killed Colette, the mother of his daughter. He is currently detained in hospital in a Medium Secure Unit.

These events in January and February 2005 had tragic consequences for both of the families. There were also consequences for the local community, including a loss of confidence in the mental health services for adults in Rugby.

There is no doubt that these two tragedies must have had a significant impact on the staff who work in the mental health services in Rugby. They must learn lessons from the findings and conclusions of the two reports. With appropriate education and training staff should be equipped with a wide range of clinical skills, including the ability to confidently make a risk assessment and deal with challenging behaviour, informed by an understanding of real supervision and effective communication strategies.

Staff are a service's greatest asset and should be valued. We need to acknowledge that the work they do is difficult. Staff can become exhausted and burnt out, which can be avoided through good quality management of resources and staff. The Investigation Team learnt that at the time of these tragic events, there were significant shortcomings in both management and administrative support provided to the clinicians working in Rugby. Despite being brought to the attention of senior managers, little seemed to have done until a further Consultant appointment was made and more permanent secretarial support was provided.

The members of the two Investigation Teams have come to question the quality of leadership in the mental health services in Rugby. We have found that there was a lack of supervision, that communications were poor and that staff did not appear to be able to evaluate events and behaviours with a critical eye.

Investigations of this sort should aim to increase public confidence and to promote professional competence.

The purpose of these Investigations was:

1. To learn any lessons that might help to prevent any further tragedies.

2. To learn any lessons that might help to improve the reporting and investigation of similar serious events.

We ask that the two reports should be read together as many aspects of the mental health services in Rugby were discussed in the previous report. These points are relevant to this report, but we have only repeated them in this document where they have a direct bearing on our findings with regard to the care and treatment of OS.

In October 2006, the mental health services in the North Warwickshire area underwent a substantial re-organisation. The mental health services across Coventry and Warwickshire became part of a specialist mental health trust. North Warwickshire PCT was subsumed into a new all-Warwickshire PCT[1]**.** These organisations have new Boards of Directors. When they decide on changes that need to be made to improve mental health services in Warwickshire, we hope that they will consider the comments, findings, conclusions and recommendations we have made. We hope that they will pay particular attention to the measures that are needed to improve the mental health services for people living in Rugby.

[1] *Since commissioning the investigations Warwickshire and Rugby PCTs have been dissolved and are now part of a new organisation, Warwickshire PCT who are responsible for commissioning mental health services. Mental health services are now provided by the new Coventry and Warwickshire Partnership Trust. Each of these new organisations came into being on 1st October 2006. The new Trusts have taken responsibility for producing and implementing the action plan in response to the recommendations set out in this report.*

ACKNOWLEDGEMENTS

Much has been said about the 'blame culture' resulting from investigations, and there is no doubt that staff are sometimes left feeling bruised and demoralised. We hope that the process we have adopted (set out in Appendix 1) has helped to alleviate any anxieties held by the people we interviewed. We were encouraged by, and grateful for, their frank and open discussion.

We spoke to Fiona's youngest sister, who acted as spokesperson for Fiona's extended family. We also spoke to this sister's husband, who was assaulted by OS in January 2004. Fiona's parents are caring for her children. We hope that they are receiving all the support that they need to help these children to come to terms with what has happened in their family.

We interviewed OS. He freely discussed his view of his marriage and his relationships with Fiona's family. With his permission, we made contact with his family, through one of his sisters. We were mindful that his mother is frail and elderly, and living in a nursing home. We took the decision not to make contact with her.

INTRODUCTION

The West Midlands South Strategic Health Authority (which from July 2006 became part of the West Midlands Strategic Health Authority) commissioned this Investigation under Department of Health Guidance EL (94)27, LASSL(94) 27, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

> "*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved*".

The National Confidential Inquiry into Suicides and Homicides – *Safer Services,* published in 1999 recommended that alternatives to the existing system of external investigations should be considered. To date there have been something in the region of 120 mental health investigatations, but there has been little published evaluation of them. Anecdotally, there have been concerns about variable standards of methodology and rigour, and some doubts over the aptness of recommendations or their subsequent implementation. There have been further concerns about the timescale and cost of some inquiries.

In 2000 the Department of Health published *An Organisation with a Memory,* the report of an expert group on the process of learning from adverse events in the NHS. Their recommendations, *Building a Safer NHS for Patients*, led to the creation of the National Patient Safety Agency, to improve patient safety by establishing a system of adverse event reporting across the NHS.

The guidance was slightly amended the following year and the particular paragraphs in the guidance relating to 'when things go wrong' were further amended in 2005. The criteria for conducting such an inquiry now include:-

i) *Where a homicide has been committed by a person who has been subject to regular or enhanced care under the Care Programme Approach within a specialist mental health service in the previous six months.*

ii) *When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry*

out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

With the introduction of Clinical Governance, Trusts have been required to have robust systems in place which examine services and staff actions when things are deemed to have 'gone wrong'. In line with this approach the North Warwickshire PCT conducted an internal review of the incident, carried out by an Associate Medical Director and the Head of Psychological Services. This report is discussed in Chapter 10 in this report.

It seems important to point out that with hindsight it is easy to pick out all sorts of errors. Professor Tony Madden, in his review of homicides by patients with severe mental illness (March 2006), makes the point that:

"when reviewing Inquiry reports one is confronted by the unfairness of some comments made with the benefit of hindsight, and the consequent damage to morale in general, as well as to the staff directly involved'

Any such investigation should establish the facts, provide an independent perspective on the events, identify areas for development within the service and where possible make recommendations to help to prevent further incidents.

The main outcomes must be to increase public confidence, to promote professional competence and to create a culture of openness in which the quality of care to patients can flourish, and move away from the 'blame culture'.

To enable us to carry out this task we were given the following:

TERMS OF REFERENCE

1. *To examine all the circumstances surrounding the treatment and healthcare of a patient known as OS by North Warwickshire Primary Care Trust, in particular the treatment and healthcare in the period leading up to the death of his wife Fiona.*

2. *To examine the mental healthcare received by OS in the context of his life history, taking into account any issue raised by cultural diversity which appears to be relevant, in order to obtain a better understanding.*

3. *To assess the extent to which the treatment and healthcare of OS complied with the statutory obligations, and relevant guidelines from the Department of Health and local policies.*

4. *To identify any constitutional systemic or professional deficiencies in the treatment and healthcare provided to OS, including any deficiencies in the quality of the assessed risk of potential harm to himself or others by root cause analysis and such other means as appear appropriate, for the purpose of enabling lessons to be learnt rather than the apportionment of blame or liability.*

5. *To consider the effectiveness of inter-agency working, including communication between the mental health services, the police, and other agencies with particular reference to the sharing of information for the purpose of risk assessment.*

6. *To review the Internal Inquiry into the care of OS already undertaken by North Warwickshire Primary Care Trust, any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the Internal Inquiry and assess the effectiveness of their implementation.*

7. *To prepare an independent report for West Midlands Strategic Health Authority (known as NHS West Midlands), North Warwickshire Primary Care Trust and any other relevant bodies.*

EXECUTIVE SUMMARY

Contact with Mental Health Services

OS had two episodes of care from the mental health services in Rugby, from October 2000 until May 2002, and from February 2004 until October 2004.

October 2000 until May 2002

In all OS attended nine appointments with a Consultant Psychiatrist at the Linden Unit. He was diagnosed as suffering from delusions of jealousy. These concerned his wife having an affair with her sister's husband.

OS had fantasies about killing his wife and her brother-in-law. He had had dreams about "standing over Fiona's brother-in-law with a knife and then seeing him with his throat cut". He had apparently assaulted his wife on several occasions, usually when he had been drinking, although Fiona did not consider herself to be at risk at this time.

The Consultant Psychiatrist referred OS to the Reaside Clinic, South Birmingham, for a forensic psychiatric assessment in January 2001. A Consultant Forensic Psychiatrist saw OS and his wife. He recommended that OS continue with anti-psychotic medication and that he should be reviewed regularly. He concluded that:

> *"his symptoms will be very difficult to treat and it is likely that he would discontinue treatment if the dosage of medicine is increased or he experiences side effects such as sedation, which he has already complained of".*

He was given a series of appointments with the Consultant Psychiatrist until November 2001, some of which he did not keep. At the appointment in November he admitted to still having the same feelings about his wife. There was a previous incident when he had apparently tried to smother her. From the correspondence it appears that they were living apart. He was still taking the medication, although this was eventually discontinued in February 2002. Instead of going ahead with divorce proceedings, Fiona moved back into the home. OS was discharged from the out patient clinic in May 2002. Their third child was born later that month.

In January 2004 OS was referred to another Consultant Psychiatrist by his GP. At a family christening he had approached Fiona's brother-in-law in an apparent spirit of

reconciliation. Fiona's brother-in-law wanted OS to accept that there had been no affair between him and Fiona. OS became enraged and attacked Fiona's brother-in-law with a broken glass, severely lacerating his throat. The wound required about 30 stitches. He was arrested and charged with grievous bodily harm. His GP saw him with his wife, who was frightened by his sudden rage leading to such violence.

At his first appointment with the second Consultant Psychiatrist in February 2004 she recommended that OS and his wife attend Relate – a marriage guidance organisation. OS was apparently referred for an EEG (electroencephalogram). It never took place. He was referred for assessment by a psychologist. The Consultant Psychiatrist suggested a small dose of Olanzapine, an anti-psychotic medication, to help him sleep and/or to 'stabilise his mood'.

She wrote to his GP:

> *"he will need continual monitoring for his mental state in order to assess the risk to himself and others".*

OS was given another appointment and the telephone number of the Crisis Team. In all until June 2004, when the Consultant discharged him from her care, OS had eight appointments. He was referred to the psychologists in March 2004 and had eight sessions with the Clinical Psychologist, which finished in October 2004.

Neither clinician was of the opinion that he was suffering from a mental illness. When he was discharged from the mental health services, they both believed that he had made good progress and that the prognosis was good.

Fiona was found dead from stab wounds on the 3rd January 2005. OS had taken a substantial overdose of Paracetamol tablets with a very large amount of whisky. He was admitted to the local hospital for treatment, where he recovered. On 7th January 2005, OS was arrested and then remanded to prison. He was charged with the murder of his wife.

Findings, Conclusions and Recommendations

With the benefit of hindsight, the Investigation Team thought it highly likely that OS's beliefs about the relationship between Fiona and her brother-in-law was not fully resolved in the four and a half years following his first referral to the mental health

services in Rugby. It is likely that, from time to time, it was not immediately obvious to those outside of the immediate family that he remained convinced that his wife was having an affair. During the second contact with the mental health services, it should have been evident that there was a risk of further violence. However, we do not believe that it could have been predicted that OS would kill his wife.

There were some deficiencies in the delivery of care. We cannot exclude the possibility that, if certain actions based upon first principles of mental health practice had been taken, the homicide may not have occurred. We found and concluded the following:

1. In our opinion, the Court Report prepared for OS's court appearance in March 2004 could have been misleading. In particular, it did not mention all the available information that was pertinent to the assessment of the risk of further violence, especially his previous fantasies of cutting the brother-in-law's throat and his previous history of assaults on Fiona. It also referred to a "cut on the chin" rather than a wound requiring sutures.

2. In our opinion, ominous significance of the assault on Fiona's brother-in-law was not recognised by the practitioners treating OS or by the Judge who sentenced him in March 2004.

3. We were surprised that the Judge did not impose a Probation Order. It was implied in his Judgement that he had done so. If this had happened then OS would have had to participate in work to confront his violence and its relationship to his consumption of alcohol.

4. We found OS to be charming and engaging. However, we also found him to be skilful in avoiding uncomfortable truths about himself. We felt that it was highly regrettable that, during his second episode of care, no truly independent collateral account of his behaviour was obtained.

5. The Consultant Psychiatrist should have insisted on interviewing Fiona on her own. This would have allowed her to obtain the necessary account of OS and also would have allowed her to warn Fiona of the possibility of violence against her, especially if she ever said anything that OS would take to confirm

his suspicions. This may not have made any difference to the outcome, but it might have done. The Consultant Psychiatrist told us "*From personal experience with people I have advised, counseled and dealt with, where there has been domestic violence, relationships very seldom improve. I have thought about it carefully, because, again, hindsight is a wonderful thing and one of the things that has upset me most is whether I should have in some way advised Fiona to leave him. That is what my advice as a friend would have been, but as a doctor it is a different situation*".

6. We are concerned that OS's alcohol consumption was not explored sufficiently and with a degree of vigour, given that there was a history of violence whilst drinking, during his second episode of care.

7. An early intention to refer OS for a forensic opinion was never acted on. The reasons given to us for failing to make such a referral or to check whether the referral had actually been made, appear to us to be inadequate. Such an opinion would have made a significant contribution to the assessment of risk.

8. Communication between the two practitioners was poor. They have different recollections as to whether there was any discussion between them about the case. We do believe that the level of communication between them was inadequate. Not all of the correspondence with OS's GP was copied between them. Consequently, the Clinical Psychologist was not involved in the Psychiatrist's decision to discharge OS, and she didn't learn of the decision until after the event.

9. The Internal Inquiry, although timely and quickly completed, failed to recognise significant failures of safe practice. It did not fully explore the adequacy of the interventions of the two practitioners. In our opinion, some of the conclusions were erroneous.

10. The Internal Inquiry process did not allow for any support for the staff concerned, such as bringing a colleague or representative, although we recognise that the Consultant Psychologist was well supported as an individual. The GP felt left 'out in the cold' and had to deal with the family's grief and anger alone.

11. When he was discharged by the Psychiatrist, OS was not given clear information as to how he could access the mental health service in future. Consequently, when he asked for help again he was told to go back to his GP. An opportunity for intervention was lost.

12. The Care Programme Approach (CPA) has been national policy since the early 1990s, but it was so ineffective and confused as applied in Rugby that it was never clear who was OS's care coordinator.

13. The mental health services in Rugby appear to have had difficulties for some years with poor administrative support for doctors, the deaths of some key staff and a reliance on locum doctors. The service does not appear to have been well supported by senior managers in the Trust. In our opinion, this failure to respond to significant and persistent problems in an isolated service contributed to the service's inability to respond appropriately to two patients who, in very different ways, showed clear signs of being at risk of behaving violently, and then went on to kill.

RECOMMENDATIONS

Staff are at the heart of a high quality mental health service and need to be valued, nurtured and supported. It is inevitable that some staff will feel disheartened by this report but none the less there are some recommendations that we feel will help them and their managers to build safer services.

The Independent Investigation recommends that the Trust should:

1. Ensure that, as part of the clinical governance policy, medical staff, within the service in Rugby, have sufficient time to meet with their peer group regularly for managerial and educational activities, and that such attendance should be monitored - (Chapter 7)

2. Ensure that all staff of all disciplines, including Consultant Psychiatrists, participate in an externally provided training with regard to risk assessment and risk management, including evaluation of the impact of such training on individual clinicians competence in these areas - (Chapter 8).

3. Ensure that all telephone calls requesting help should be noted and professionals made aware of clients asking to see them. The decision as to whether someone needs to be re-referred should be made on an individual basis by clinicians who know them and are aware of the risks. It is possible that if either clinician had been aware of his telephone call they would have fast-tracked an appointment - (Chapter 8).

4. Review the rationale for asking people to go back to their GP in order to be re-referred. Where the development of a trusting relationship is seen as a vital protective factor, there should be a more direct route back for certain people - (Chapter 8).

5. Ensure all clinicians are familiar with local Trust policy and procedure regarding record keeping and with documents relating to their own profession e.g. Clinical Psychology and Case Notes: Guidance on Good Practice (Division of Clinical Psychology, British Psychological Society, 2000). Supervision records should be kept and discussions recorded. There should be entries made in the clinical notes when clients have been discussed in supervision - (Chapter 8).

6. Ensures that in its development of integrated multi-disciplinary teams clinicians work with a shared clinical record - (Chapter 8).

7. Ensure that clinical psychologists allocate enough time per client for reflection, note writing, report writing and planning - (Chapter 8).

8. Enable all practitioners to work to an appropriate Domestic Violence Strategy having undertaking a multi-agency training programme taking into consideration the Warwickshire Constabulary policy - (Chapter 9).

9. Review the application of the local CPA policy to ensure that it reflects both the Department of Health (1999) Guidance, and the experience of best practice within mental health services nationally. This should include:

   - ❒ The development of a system which ensures that all information relating to the care and treatment of a person in contact with services is available to all the practitioners involved. It should be accessible across all disciplines and equally applicable to Health & Social Care.

   - ❒ Work to ensure that the CMHTs in Rugby work to a proper multi-disciplinary model, and that all staff involved in a patients care are involved in key decisions, such as discharge and demonstrate their working together through the use of a shared clinical record - (Chapter 10).

10. Reviews the use of the electronic record. EPEX should be used to communicate between professionals rather than simply be used to collect activity data. The Trust should provide training for all staff in the use of EPEX - (Chapter 10).

11. Comprehensively review its Serious Untoward Incident processes to take account of a more open approach to help staff and families. This will ensure that:

    a) a senior person makes contact with families who are the victims of serious incidents;

    b) staff take account of the sensitive nature of support required, seeking guidance from and including the various voluntary agencies such as Victim Support in the preparation of the training programme;

    c) the level of competence and confidence of staff, when dealing with serious untoward incidents is enhanced;

d) a supportive framework is provided - which includes counselling if necessary, adequate time for briefing and the opportunity to receive feedback as well as full discussion about any action plan which has to be implemented - (Chapter 10).

12. Consider all the comments made in this Report and amend Trust practices and processes accordingly.

CHAPTER 1

OS'S HISTORY PRIOR TO THE REFERRALS TO MENTAL HEALTH SERVICES IN RUGBY

BACKGROUND HISTORY

OS was born in Rugby on the 28th May 1958. He has two brothers, two sisters and a half-sister. His parents married in Jamaica and then came to the UK. They worked hard with his mother being the dominant influence in the household.

OS was very fond of his mother, referring to her as "the light of my life". Although she used corporal punishment, he did not consider this to be violence.

His father was described as kind. He had an affair resulting in a child (OS's half-sister) which was unknown to the rest of the family until the child was left with them when she was six years old.

OS described his early life as happy. He was a keen sportsman who particularly enjoyed playing football. He apparently performed well at the school he attended and he was appointed Head Boy. However, he left with mediocre examination results. He went to college, and apparently he achieved seven O' levels and two A' levels whilst working in a Social Security Office. He studied part time and completed a Higher National Diploma. For some time he lived and worked in London, returning to Rugby when he married Fiona.

Fiona and OS met at a party while she was still in a relationship with one of his brothers. She described this brother as '*abusive*' towards her. OS encouraged her to visit him in London. OS said that at this time Fiona was "*bubbly and charming*" and that she made him feel '*special*'.

On his return to Rugby, OS obtained employment with another Housing Association and became a housing manager.

OS and Fiona's first child was a daughter. She was born in 1990. Their first son was born in 1994. He was born with an uncommon congenital condition known as Kabuki Syndrome. (Affected people have learning difficulties and characteristic facial

features with a broad and depressed nasal tip, prominent earlobes and sometimes a cleft or high-arched palate. They have long palpebral fissures (openings for the eyes) with eversion (turning out) of the outer third of the lower eyelids, and arched eyebrows. These features are said to be reminiscent of the make-up of actors of Kabuki, a Japanese traditional theatrical form. They have an abnormality of the inner ear resulting in recurrent otitis media infections. There are approximately 50 babies born with the syndrome each year in the UK).

It is reported that from this time OS was unhappy and felt that there were problems in his marriage. He cited the pressures on him as a result of moving to a bigger house with a larger mortgage, and a growing sense that everything he provided for Fiona was not appreciated. He has said that the birth of this child was very stressful and that Fiona never forgave him for going back to work rather than staying with her after the birth.

Fiona came from a family of four sisters and a brother. Fiona was particularly close to her youngest sister. OS and Fiona's youngest sister's husband shared similar interests, especially football. When the couple moved house, Fiona and OS helped them. They stayed with them on many occasions. During one of these visits OS became convinced that Fiona was being overly friendly with her sister's husband. He felt that they shared lingering, knowing looks and '*stole'* time together. When Fiona visited her sister, OS became sure that she really went to see her brother-in-law.

In July 2000 OS went to see his GP and complained of feeling depressed. He described early morning waking with loss of appetite. His unhappiness was attributed to the stress of coping with his disabled son. He was prescribed Dothiepin 25mgs to be taken at night. He returned the following week and said that he was feeling worse and could not face going to work. He was advised to go off sick and to continue the medication.

OS next saw his GP on 4th August 2000. He was feeling no better, complaining of mood swings, with depression and anxiety. His medication was changed to Citalopram 20mgs once a day. He remained off work and he was given an appointment to be seen in two weeks. He was next seen by his GP on the 18th August 2000. He was still complaining of insomnia and anxiety. He told his GP that his brother-in-law was '*obsessed'* with Fiona, although the brother-in-law denied it.

His GP referred him to the practice liaison Community Psychiatric Nurse (CPN). He was given a further appointment to see the GP in three weeks time.

OS saw the CPN on 4th and 11th September 2000. On the first occasion he told her that he was depressed because Fiona's brother-in-law had made a pass at her and although both had denied it, he was still convinced it had happened.

She found him to be polite, well dressed and easy to talk to, with good social skills. He was distressed by the recent deaths of his father and a close friend. Furthermore OS was anxious because other people had told him that his ideas about the affair between Fiona and her brother-in-law were 'an obsession'.

He told her that he was no longer visiting Fiona's sister and her husband. He had agreed to seek help to please Fiona. He felt that all would be well if she did not mix with her brother-in-law. The CPN's care plan was:

1. *Encourage OS to attend for counselling sessions, where I can monitor mood and effects of medication*

2. *Commence bereavement counselling*

On the second occasion he insisted that he was not ill but obsessed with thoughts about Fiona's brother-in-law. He returned to work in an effort to take his mind off the situation. OS and Fiona planned to take a holiday. He told the CPN that they had considered having a third child.

OS was seen by the GP on the 11th October 2000 and given a further prescription until the 24th October. On the 12th October 2000, Fiona telephoned the GP. She was 'very agitated' and told the GP that OS was getting worse and that he had threatened to kill her brother-in-law. Fiona followed this telephone call with a letter to the GP stating:

> *"the situation with OS seems to be getting worse and I'm worried that things cannot remain as they are until next Wednesday when we are both due to come to see you. He has been very abusive (which is so unlike him normally!) and quite frightening. He rang my brother-in-law last night and told him he has been having recurring nightmares about stabbing him to death and was very threatening. I have left a message for you to ring me but I thought a letter may*

be easier as OS is at home and it will save me having to do too much explaining on the phone as this might set him off again.

I almost feel at the moment that he is like a time bomb ready to explode. Having said that he has woken up today very cheerful but as the day goes by he seems to get worse. I'm still doing my best to keep him calm and be as supportive as I can which seems to help him. But I don't know how long he will be like this. Sorry to bother you again but I feel this is getting worrying"

16th October 2000

Following a discussion with the CPN about this letter, the GP telephoned the Consultant Psychiatrist at the Linden Unit and asked that he assess OS. She also wrote a referral letter to the Consultant Psychiatrist.

COMMENT
As OS has been referred to the Linden Unit, the CPN did not see OS again.

CHAPTER 2

OS'S FIRST CONTACT WITH MENTAL HEALTH SERVICES IN RUGBY

13th October 2000

OS attended the Linden Unit for psychiatric assessment on 13th October. He was seen again on 19th October 2000. He saw the first Consultant Psychiatrist who wrote to the GP after the second interview:

> *"As you know OS has developed what are basically delusions of jealousy about his wife who he believes has had an affair with her brother-in-law. These beliefs seem to have been present for some months and he is of the view that he had been rather unkind to his wife, particularly to her being overweight and calling her 'fattie' even in public and this in a way is some form of revenge. He admitted to the aggressive feelings towards the brother-in-law and had an angry discussion with him. There were recent stresses related to their son and the death of a friend of his from bone cancer. The latter he described as a close friend who he could unburden himself to and discuss any matter whatsoever….*
>
> *….His wife also came in to the interview and made her protestations that none of his beliefs had any substance. These are often difficult situations and there is really no point and indeed may be counter productive to try and argue him out of his beliefs. I simply took the attitude that these must be difficult thoughts and feelings to live with and that he would need some help with them by attending me and also I prescribed Stelazine 2 mgs three times a day…*
>
> *….He has taken the medication and says he does feel rather better having unburdened himself and taken the medication and that his thoughts are no longer aggressive nor so focused. He still, however, does harbour them and I said that the best thing was for to continue with the medication and to see me on a regular basis which he has accepted…. It will be necessary to monitor the situation reasonably closely certainly in these early phases and if there seems little likelihood of improvement it may be value for me to seek a forensic opinion. He has returned to work and says that people there have commented that he seems to be returning to his old self. I think it is important to encourage him to do as many things that can build his self esteem as possible".*

He attended the psychiatric outpatient clinic on 2nd November 2000 and the Consultant wrote to his GP to appraise her of the situation. OS was next seen on 16th November 2000, when things seemed to have deteriorated. There had been a telephone call between Fiona and her sister during which Fiona told her that OS was leaving her after Christmas. OS and Fiona attended to see the Consultant a week later. The Consultant saw Fiona on her own and he discussed her safety with her.

She told him that she was under no threat and felt quite secure. She told him that the situation had improved. She seemed optimistic and the Consultant told her that conditions like this were often *"rather intractable and certainly would not permit of a quick fix".*

OS complained that the medication was making him a little sleepy. The medication was reduced to Stelazine 2mg twice daily.

OS and Fiona attended again on the 23rd December 2000. They saw the Consultant, when he took the opportunity to interview Fiona on her own. He discussed Fiona's safety and she felt that the situation had improved.

16th January 2001

OS telephoned the Consultant as he wished to bring forward his appointment. He had burst out crying at work. His suspicions were as bad as ever. The Consultant also received a phone call from Fiona's sister who expressed her concerns about OS. The Consultant saw OS later that day (the planned next appointment was for 16th February 2001). He decided to change OS's medication to Phentazine 4mgs three times a day. He referred him for a forensic psychiatrist's opinion.

Fiona also telephoned the GP on the 16th January 2001 as she was concerned that OS had stopped taking his medication and that OS was relapsing. OS and Fiona had started to see a marriage guidance counsellor.

6th February 2001

The Consultant Psychiatrist wrote a referral letter dated 6th February 2001 to the Forensic Consultant Psychiatrist based at the Reaside Clinic, who had responsibility for patients in Warwickshire. In the letter (which followed a meeting between the two Consultants), the Consultant outlined the situation to date and listed the medication prescribed for OS, which he did not think that OS took regularly.

In the letter he said:

> *"…He started having jealous beliefs about his wife approximately 10 months ago believing that she had an affair with her brother-in-law. He thought that the development had been because for a few months his wife had been a bit overweight and he had unkindly called her 'fattie' even in public and he felt that this was her way of taking revenge. He holds the beliefs with*

absolute conviction and cannot be brought to look at the situation in any different way. He admitted to having angry aggressive feelings towards his brother-in-law and there have been angry interchanges with him on the telephone. He has never actually done anything physical but there have apparently been dreams where he sees himself standing over his wife's brother-in-law who is lying in a pool of blood. He denies having any aggressive feelings towards his wife. I should mention that his wife's sister and her brother-in-law actually live in Leeds and so contact is kept somewhat at a minimum anyway but he is unwilling now to go and visit in Leeds and if they come to Rugby he will not go round with his wife to see them and is distrustful if his wife goes on her own……."

He ended the letter:

"I did manage to see his wife albeit briefly, on her own, she does not express any fear of him and there do not appear to have been any developments such as looking through her underwear etc. for evidence. I have not actually mentioned to him the possibility of a second opinion at this point in time"

16th February 2001

OS saw his Consultant in the outpatient clinic. He and Fiona had seen a marriage guidance counsellor on two occasions without any definite results, other than a discussion about communication between them. At this appointment the Consultant informed OS of the referral for a second opinion. OS's medication was continued as before, Phentazine 4mgs three time a day.

3rd April 2001

The Forensic Consultant Psychiatrist and a medical student saw OS on his own. The interview lasted approximately one hour. The Consultant spent a further 30 minutes speaking to Fiona alone and then saw the couple together. OS told him that during the previous summer he had had fantasies about killing Fiona's brother-in-law. These involved images of OS with a knife in his hand standing over the brother-in-law whose throat had been cut. OS said that these fantasies had arisen when he was at his "lowest ebb". When Fiona was interviewed on her own she adamantly denied that she was involved in any sort of improper relationship with her brother-in-law. She said that her sister and brother-in-law had been very supportive when their second, disabled, son had been born as they were both nurses and understood the issues concerning a disabled child. She denied that OS had ever been violent toward her but did acknowledge that he had kicked her on one occasion and had hit her on three other occasions. There had been no incidents for over two years.

The Forensic Psychiatrist wrote:

> *…of note is that Fiona described one previous occasion in 1988 before they were married when she described OS as "he was obsessed that I liked his flatmate M", saying that he had said to her for approximately three months that she talked to M too much and that she was too close to him, even though M had a girlfriend at that time and they were going out as a foursome. However she denied that he threatened her at that time……"*

The Forensic Psychiatrist agreed that OS had developed a delusion that Fiona was having a relationship with her brother-in-law. He felt that OS had developed a paranoid outlook due to the pressures of coping with a disabled child, financial difficulties and a deteriorating marital relationship. The Forensic Psychiatrist noted that the previous violence had coincided with episodes of heavy drinking, as did the fantasies about cutting Fiona's brother-in-law's throat. Fortunately, these had not recurred.

He concluded:

> *"I do not believe that he would act on these fantasies and they seem to be more related to putting himself in a position of power or increasing his own feeling of self worth, rather than a determined effort to plan to kill either his wife or brother-in-law.*
>
> *My recommendations are as follows:*
>
> 1. *OS should be encouraged to cut down and stop his consumption of alcohol.*
>
> 2. *They should both be advised attending for marital counseling.*
>
> 3. *I would recommend that you continue with reviewing OS and treating him with anti-psychotic medication although I suspect that firstly his symptoms will be very difficult to treat, secondly, it is likely that he will discontinue treatment if the dosage of medication is increased or he experiences side effects such as sedation which he has already complained of.*
>
> 4. *Although his wife was not very happy that you recommended that her brother-in-law and sister should not visit Rugby, I have reaffirmed this decision with them.*
>
> 5. *I have not arranged to see OS again, but should you have any further concerns about him I would be very grateful if you would refer him again for further assessment."*

9th July 2001

OS and Fiona went to see their GP. OS said that he wanted to 'move on' but he still believed that Fiona was unfaithful. He was no longer taking any medication but he was seeing a private counsellor, who he described as "*not much help*".

16th August 2001

The Consultant's secretary wrote to OS offering him an appointment, as it had been six months since he had last attended the outpatient clinic. The appointment made for the 23rd August 2001 was not kept and the secretary assumed OS might have been on holiday.

He was seen on 13th September 2001.

1st November 2001

OS did not keep an appointment with the Consultant Psychiatrist at the Linden Unit.

5th November 2001

Fiona telephoned her GP and reported that at the weekend OS had tried to suffocate her with a pillow. She had fled to her sister's house. The GP decided that an urgent assessment under the Mental Health Act was necessary.

COMMENT

At this time, one of Fiona's sisters had gone to Cyprus to get married. OS was worried about her attending the wedding on her own, because her brother-in-law would be present. He took Fiona's passport to work and hid it so that she could not go to Cyprus. OS told us that in the event she was unable to obtain a flight. The attempted suffocation had happened whilst Fiona was getting ready to go to a family party for those relatives who had been unable to attend the wedding.

When we interviewed Fiona's sister, she told us that Fiona had told her that on this occasion OS stood over her, making stabbing movements with a clenched hand and hitting her on her chest and saying "I'll get him, kill, kill, kill". There are several different accounts of this incident and it seems as if Fiona told different people different things.

When we interviewed OS, he denied that anything like this had happened. He told us that Fiona later accused him of 'tapping' her on the head, and that all the accusations against him were unfounded.

7th November 2001

The GP, the Consultant Psychiatrist and two Psychiatric Social Workers went to the family home and formally assessed OS under the Mental Health Act 1983. Fiona and the children were still staying with one of her sisters. OS was 'rational but angry' about the break up of his marriage. He saw the assessment as an attempt by his wife to brand him 'mad' so that she could take possession and/or ownership of the house. He was still convinced that Fiona was having an affair with her brother-in-law. He denied ever trying to hurt Fiona and said he had no intention of doing anything to harm her brother-in-law. The professionals agreed that OS did not meet the criteria for detention under the Mental Health Act.

22nd November 2001

OS saw the Consultant at the Linden Unit. There appeared to be no change in his thinking or his feelings about his situation. Fiona was visiting the house to continue her work as a beauty therapist. She asked OS to apologise to her sister and brother-in-law, so that they could all 'move on'. OS had resumed taking his medication. He was given a further appointment to be seen in two weeks.

6th December 2001

OS attended the Linden Unit to see the Consultant. He told him that although she had now filed for divorce, Fiona was visiting him at the house. He interpreted this as a kind of bribe or inducement for him to leave, so that she and the children could have the house. Fiona told him that she would come back if he apologised to her sister and brother-in-law. OS refused to do this. He was still taking his medication. He gave no indication that he had any violent intentions.

The Consultant wrote:

> *"I think there is little further that I can do except monitor the situation and try and persuade him to continue with medication until some sort of outcome or other becomes clear"*

10th January 2002

OS attended the Linden Unit to see the Consultant. Fiona had moved back into the house, although OS had been served with divorce papers. She had told him that if he apologised to her sister's husband then she would discontinue divorce proceedings. This remained unacceptable to OS. He had decided to leave the family

home to live with his mother. He had instructed his own lawyer to deal with the divorce proceedings.

14th February 2002

OS attended the Linden Unit to see the Consultant. He and Fiona seemed to have resolved their differences and they had agreed to a fresh start. Fiona agreed not to see her sister so often. OS was feeling more confident.

The Consultant wrote:

> *"I think one could be forgiven for treating this with a degree of reservation and what I have said is that at the moment I will send him another out patient clinic appointment in approximately two months time with a view to reviewing how matters have gone. He was clearly happy with this, I think at present also the Stelazine may be discontinued and we can only await developments".*

16th May 2002

OS attended the Linden Unit to see the Consultant. He remained well. Fiona was pregnant and was due to have the baby in two weeks. OS no longer took any medication. The Consultant thought that there was little more that he could achieve and he discharged OS from the outpatient clinic.

28th May 2002

OS's third child was born on OS's birthday.

CHAPTER 3

OS'S SECOND CONTACT WITH RUGBY MENTAL HEALTH SERVICES

11th January 2004

OS and Fiona attended a family christening in Rugby. Her sister and brother-in-law were also present. Following the service and reception, OS went to the home of a family member. Fiona's brother-in-law went to another house to watch a particular football game on television, then later went to collect his wife and children, from the house were OS was, and return home that evening.

OS saw Fiona's brother-in-law and they exchanged a few words about the football match. Shortly after this, OS approached the brother-in-law and said he wanted to put their differences behind them. Fiona's brother-in-law said that he wanted this too, but only if OS would accept that there never had been an inappropriate relationship between him and Fiona.

Fiona's brother-in-law and OS had not seen each other for over two years. When OS approached him, the brother-in-law noticed that OS smelt of alcohol, and he felt very uncomfortable. He was surprised when OS spoke to him in a friendly way about the football match. OS went on to mention their children and expressed regret that they were no longer in contact. OS told Fiona's brother-in-law that he had forgiven him. Fiona's brother-in-law repeated that, as nothing had happened, there was nothing to forgive.

When the brother-in-law reiterated his denial of an affair, OS rapidly became enraged. He suddenly said "*Well fuck you*" and jabbed the wine glass that he was holding into the brother-in-law's throat and jaw. The glass smashed on impact, causing severe lacerations and copious bleeding. Fiona's brother-in-law ran from the scene into the road, following which, Fiona's sister took her husband back into the house to see to his wound. An ambulance was called and the brother-in-law was taken to hospital. The laceration required approximately 30 stitches.

OS told us that he had no recollection of having the glass in his hand and had intended to punch Fiona's brother-in-law. We learnt that he had to be restrained as he attempted to throw another punch. OS told us that during this incident he had '*lost*

it' or *'flipped'.* He described his behaviour as *'a nervous reaction'*. OS cut his own finger and went to the local Accident and Emergency Department where he said he'd cut himself whilst cleaning a vase. OS was arrested at home and taken to the Police Station. Whilst in custody he decided that he would move out of the family home. He was bailed and went to stay with a friend.

The following day, Fiona told her sister that she was planning to leave OS but when she saw him, in protective clothing at the Police Station, she felt sorry for him. He returned to their home a day after his release from police custody. However, some members of Fiona's family expressed anger at the reconciliation. As a consequence OS went to stay with his mother for a week.

13th January 2004

OS went to see his GP with Fiona at the suggestion of his solicitor. He explained what had happened at the christening. She telephoned the second Consultant Psychiatrist at the Linden Unit (the first Consultant had recently died) and followed the call with a referral letter. In her letter she wrote:

> *"I would be grateful for your help concerning this patient about whom we spoke briefly this morning. As you can see from his notes back in the summer of 2000 he developed obsessional ideation concerning his wife's sister's husband. He believed very firmly that his wife was having an affair with her brother-in-law and no amount of protestation from her could relieve him of this belief. It came to a head some months later when Fiona thought that he had tried to smother her one evening when he was in a temper, after they were once again discussing this situation. The Consultant and I and the PSW went along to assess OS at home but he behaved very rationally and there were no real grounds to section him. He did see the Consultant a couple of times later but it was felt there was no particular need for any intervention and nothing further was done. Fiona found herself pregnant again by OS and has since had the baby and things seemed to have settled down.*
>
> *However, this last weekend was the christening of the baby of another of Fiona's sisters and OS was making an effort to rebuild bridges within the family. He was having a discussion with his brother-in-law on lines of "well let's draw a line under what's happened and move on but apparently his brother-in-law could not accept this. He wanted acknowledgement from OS that what he believed had happened had not in fact ever done so, and OS was unable to do this, he flew into a rage and attacked his brother-in-law with a broken glass in the face. Needless to say the Police were called and OS was charged with GBH and will appear in Court this Friday.*
>
> *When I saw him in surgery today accompanied by Fiona, his wife, he was again behaving very rationally and normally and very contrite for what had*

happened. He says he does not know why he flipped but quite reasonably is seeking help to prevent it happening again and I think that Fiona is quite frightened with his sudden rage that can lead to such violence as this. He still cannot rid himself of the idea that his wife has been unfaithful with her brother-in-law and may never do so. However it would be very helpful to find someway of him being able to move on otherwise their relationship will fall apart and since it involves four children now including one with learning difficulties it would be a great pity. OS was treated for a short while with anti-depressants but this did not seem to make any difference to his basic ideas. I would be very for any help you can offer."

9th February 2004

OS attended the outpatient department at the Linden Unit. He was assessed by the second Consultant Psychiatrist. She wrote to the GP:

" Thank you for referring OS and many thanks for your helpful letter. He came to clinic on 9th February. He is a 45year old housing manager. He has worked there for 13 years and in housing for 20 years. He is currently off sick since what he describes as the incident which occurred on 11th January. OS said that this was part of what he described as "ongoing situation" with his wife's brother-in-law. Four years ago he accused his wife of having an affair with her brother-in-law. It seems to have occurred following difficulties in their relationship after the birth of their six year old disabled son who has got Kabuki's syndrome. They were told at birth that the prognosis was bad and he thinks that they blamed each other and grew apart…

…... He that in this period she became closer to Fiona's brother-in-law.

Mental State: OS was a pleasant and cooperative man, articulate, intelligent, well presented, who gave a good account of himself and smiled appropriately. Although he was able to talk about his difficulties without any sign of emotion, he went on to describe quite serious anxiety problems, which he tries to control. He is sleeping poorly at the present and his stomach is churning. He went on to say that he tries to keep calm because he does not want to go back to being depressed and he is scared of developing a depressive illness and feeling suicidal. I think he tends to block out emotions because he is a very sensitive, rather insecure man. I could detect no evidence at present of a medically treatable illness. There is a very clear history of a depressive episode with potential for self harm. There is definitely evidence of underlying low self esteem. He is a sensitive man and he is insecure and he tends to block emotions.

There is a lot of stress in his life even before the incident and I understand that he may loose his job if he has a custodial sentence and there is a real possibility of this. I have recommended that they go to RELATE. I think he needs a psychological assessment and I will put a referral in. I have requested an EEG (Electro-encelphalogram). This is particularly in view of the fact that OS definitely seems to tolerate alcohol poorly. He may require PRN (when necessary) Zopiclone if sleep is a problem and should more extensive symptoms of anxiety and/or depression emerge then Venlafaxine would be

appropriate possibly with a small dose of Olanzapine. I suspect his difficulties are more related to personality development and stressful situations than any current psychotic illness. Under stress the situation could easily change. He will need continual monitoring for his mental state in order to assess the risk to himself and others. I would be happy to provide a report but he may be asked to be seen by the Forensic Psychiatrists in addition".

At his next appointment on 19th February I will ask him to bring his wife. I have also given him the number of the Crisis Team".

The Consultant Psychiatrist in requesting the EEG, stated:

" aggressive abusive with memory loss. Episodic and clearly defined, very poor tolerance on alcohol. ? please exclude TLE"

11th February 2004

The Consultant Psychiatrist sent a letter, referring OS to 'the Psychologists' for an assessment. She also wrote to OS, asking him to attend his next appointment a little earlier than planned as she wished to see him with his wife.

13th February 2004

OS gave permission to the Probation Service to contact the Consultant Psychiatrist for details of his mental health problem.

27th February 2004

A trainee Probation Officer prepared a Pre Sentence Report. He interviewed OS, and had telephone conversations with OS's manager, Fiona, OS's GP and the second Consultant.

In the report he wrote, under the heading "Assessment of risk of harm to the public and the likelihood of re-offending":

"*OS has no previous convictions and all indications are that this incident was a one off, being totally out of character. OS describes himself as being non-confrontational and level headed and this is supported by others I have spoken to. Both he and they have difficulty in understanding his actions on this particular occasion. OS's anger management and ability to control his temper was discussed in detail. Whilst OS has shown the capability of committing a serious offence, causing serious injuries, I assess that he presents a low risk of harm to the public.*

There is nothing to suggest that OS poses a risk regarding general offending or property related offences. He indicated no pro-criminal attitudes and any

risk is low. The consequences of this offence for OS lead me to believe that he is unlikely to come to the attention of the Court again.

There is no evidence of a risk of self harm, however it is a factor that I feel would require monitoring by the health professionals to ensure OS's own safety.

Conclusion

Having regard to the comments by the Consultant, I feel that it would be inappropriate to make a proposal for a sentencing option until her assessment is complete and a psychiatric report had been prepared.

I would ask that the Court considers an adjournment in order that a psychiatric report can be completed. The Consultant has stated that she is able to produce a report at short notice, as OS has already been interviewed and therefore a shorter than usual adjournment period may be adequate.

Once I have had view of that report, an Addendum to this Pre Sentence Report can be prepared to address sentencing options".

4th March 2004

OS attended the Linden Unit to see the Consultant Psychiatrist with Fiona. He had been sleeping better and he was much calmer. Fiona told the Consultant that she had never felt that OS posed a risk to herself or the children, although he was often 'broody'. During the interview the Consultant felt that it was apparent that they had communication problems and that they had different expectations of each other. The Consultant's follow up letter to the GP was copied to a second Forensic Psychiatrist. A covering letter told him that this was for his information as it was possible that he might be asked to prepare a Court Report on OS.

5th March 2004

OS appeared in Court. The proceedings were adjourned to allow the preparation of a further Pre-sentence Report. He was charged with section 20 Wounding. According to a letter from the Probation Officer to the Consultant Psychiatrist, OS had an appointment on 11th March at the Reaside Clinic to see a Forensic Psychiatrist.

The letter stated:

"…..we understand that you are in receipt of a letter from the Defence Solicitor, in respect of this request. We also understand that OS has been offered an appointment at Reaside Clinic on 11th March 2004".

COMMENT
The Investigation Team came to the conclusion that this was an error, as in fact OS had an appointment to see the Consultant Psychiatrist and a separate appointment to see the Clinical Psychologist in Rugby on that day.

8th March 2004

The Consultant completed her Court Report. In the Report she said:

> *"….originally he was confident that he could handle the matter because at work he is trained to be non-confrontational and OS tried to make a conversation about football and then went on to ask Fiona's brother-in-law to draw a line under the past. Fiona's brother-in-law replied, according to OS, "I want you to acknowledge nothing happened in the past", when he refused the situation got more tense, with Fiona's brother-in-law repeating the line and then OS admitted that he lashed out with a glass in his hand, which he did not realise and the action was unpremeditated. Fiona's brother-in-law received a cut to his chin, which he required stitches for and OS has subsequently been charged.*
>
> *…he tries to keep calm and in control because he is frightened of becoming depressed. My view is that I could detect no evidence of a medically treatable mental illness, but he comes across as a sensitive rather insecure man and he finds it difficult to discuss emotions. Although there is clear evidence that he has suffered a depressive episode with a potential for self harm in the past and there was evidence of underlying self-esteem. His beliefs regarding Fiona and her brother-in-law appear to be more in the nature of over valued ideas and fixed delusions.*
>
> *….OS was coping with the situation at work and I was also able to interview Fiona and OS together. Fiona was able to give a clear account of the difficulties she and OS had had".*

The report ended:

> *"….Fiona has never believed that he poses a risk to her or the children. This confirms the belief that OS has, presently, no medically treatable mental illness, but his beliefs regarding his wife's infidelity are very much related to insecurity issues and a number of stressful events that occurred to them in the last recent years and the difficulty he has expressing his feelings as he certainly tries to block things out. I think it is most important that he, as an individual and the couple receive psychological therapy and I would also need to monitor his mental state. It is my view that the prison sentence would adversely affect OS's mental state as he is at risk of developing a depressive illness with subsequent self-harm. It will obviously be important to continue to assess OS's risk both to himself and any potential risk to other people. In addition, in view of this I have requested a second opinion from the Forensic Services, to see if there is any other advice they can offer on future management of this case".*

11th March 2004

OS saw the Consultant Psychiatrist. He appeared to her to be coping with his difficulties, she wrote:

> *"extremely well. although he found the Court appearance last Friday, understandably, stressful and had anxiety symptoms and felt panicky, although I gather his legal advisor has been very supportive. It appears that the communication problems between have been picked up. My view is that Fiona probably does not realise quite how sensitive OS is as he tends to present as a very calm and strong man, but underneath he is a lot more insecure".*

OS and his wife had started marital counselling. He denied any thoughts of harming either himself or his family.

In her letter to the GP, the Consultant further wrote:

> *"I will be continuing to monitor his mental state and the risk. He is aware that this is necessary, particularly because of high profile cases in the press, where men kill their children and take their lives.*
>
> *… I have put in a referral to Reaside and he is aware that he can contact the Crisis Team for support at any time.*
>
> *... I will be seeing him again on 1st April, this will be after his Court appearance. I have prepared his Court report, which I hope will be helpful to him."*

This letter was copied to both the psychologists and the Crisis Team.

OS attended for his first appointment with the Clinical Psychologist. A plan of twelve sessions over a year was agreed.

COMMENT

When we interviewed the Consultant, she was fairly certain that OS had sought support from the Crisis Team. The Investigation Team were not so sure about this as there are no notes concerning OS in the Crisis Team records despite the letter from the Consultant being copied to them. This may have been as a result of the poor secretarial support at the time.

The Consultant Psychiatrist appears to have believed that OS was going to be seen at the Reaside Clinic. We were unable to find any referral to the Reaside Clinic, either in the Consultant Psychiatrist's notes or OS's Reaside medical notes.

It is most unlikely that he ever had an appointment with the Forensic Psychiatry Service on this date. It seems that the Probation Officer was wrong about this, which then may have caused the confusion over the Forensic Psychiatry referral.

23rd March 2004

The Probation Officer completed an addendum to his previous Pre-sentence Report. In this he stated that the offence was serious and that the victim had sustained a very unpleasant injury. The offence was expected to carry a custodial sentence but the Probation Officer believed that it was a 'one off' and that it was unlikely that there would be a recurrence.

He agreed with the Consultant Psychiatrist that a custodial sentence would be an alien environment for OS and that imprisonment was likely to affect his mental state. In his view, a Community Service Order would be appropriate for OS. He acknowledged that this was an exceptional recommendation in the light of the seriousness of the offence, and so further recommended that the number of hours should be commensurate with the seriousness of the offence.

26th March 2004

OS appeared at Warwick Crown Court and pleaded guilty to wounding/inflicting grievous bodily harm. He was sentenced to 200 hours of community service under a Community Punishment Order.

The Judge in his sentencing remarks concluded that, as OS had led a decent law abiding life, he would not send him to prison. He seemed to accept that OS had intended to have a reconciliation with the brother-in-law, and that the incident happened on the spur of the moment. He stated that the offence was *"totally out of character"* for OS and that he was satisfied that OS was *"unlikely to re-offend*".

He also took into account the impact that a custodial sentence would have on his family, particularly the effect on his disabled son. He mentioned the possibility that Fiona would not be able to cope without him. He concluded:

> *"So, in those circumstances, I have come to the conclusion (and I have to stress after a certain amount of consideration and concern and worry as to whether this was the right thing to do bearing in mind the seriousness of the offence) that you should not be sent to prison; but I think I must mark the gravity of the offence by a punishment. And the appropriate punishment, it seems to me, would be by way of requiring you to serve 200 hours by way of a community punishment order. That is to say doing unpaid work for the benefit of the community. Now you have to do that work at the direction of the Probation Officer. I have been told in this instance that it would have with it a certain enhanced element, which would be the assistance of the probation*

service to you, which I imagine would be offered to you in conjunction with a Psychiatric Treatment order, which you will receive and continue through your GP and through the specialist involved.

If you fail to comply with the requirements of the Probation Officer as to what work you should be doing, well, that Probation Officer has the power either to take you before a Magistrate's Court when you might be ordered to do additional hours, or alternatively, as this is much more serious, you could be brought back before this Court. This Court has the power to revoke that order and substitute a sentence, which would include a sentence of imprisonment.

That is the sentence, which I propose to pass and it is very exceptional where injuries of this sort are done then very frequently, and almost inevitably, it results in a custodial sentence; but I think there are special circumstances in this case which enable me not to follow that course."

COMMENT
The Judge appears to have believed that a Community Punishment Order would have a similar effect to a Probation Order with respect to the type of supervision provided by the Probation Service with a condition of accepting psychiatric treatment. In fact all OS had to do was to work in a local charity shop every Saturday until his community treatment hours were completed. The Probation Services involvement was confined to ensuring he attended. There were no sessions with a Probation Officer to reflect upon the assault. There was no further opportunity for a multi-agency discussion about his violence.

29th March 2004

OS kept his second appointment with the Clinical Psychologist. She wrote:

"….he narrowly escaped custodial sentence. OS exhausted now and wants to put it all behind him"

1st April 2004

OS attended the Linden Unit and saw the Consultant Psychiatrist. His relationship with Fiona was the subject of the work with the Psychologist. There was no evidence of *"a medically treatable mental illness".* The plan was stated, for the Consultant to see him for "*follow up for six to twelve months".*

8th April 2004

OS kept an appointment with the Clinical Psychologist. He was feeling 'flat'. He and Fiona had attended both RELATE and their Pastor for help with their communication difficulties. OS had considered leaving Fiona if they were unable to resolve their

problems. He felt that he had to give priority to Fiona's family, and that this pushed his own family into the background.

30th April 2004

The Clinical Psychologist cancelled OS's appointment with her.

10th May 2004

OS attended his fourth appointment with the Clinical Psychologist. During this session, she explored OS's experience of his anger. She felt that the triggers were more to do with feelings of inferiority. He acknowledged that alcohol played a part in his response. However, he considered that Fiona was 'crossing the boundary' and that he was in a 'danger zone' when he was not listened to.

19th May 2004

OS attended the psychiatric outpatient department. The Consultant Psychiatrist wrote to the GP:

> *"……he is doing very well indeed, was cheerful and positive and showed no evidence of psychotic symptoms. He and his wife are going for marital counselling and he is also having counselling in his own right, looking at security issues and how he deals with emotions. All this is having a beneficial effect on the way he deals with things. Follow-up end of June and if all is well will discharge him from the clinic"*

8th June 2004

OS attended his fifth appointment with the Clinical Psychologist. They discussed the 'build up' to the incident in January 2004. He felt he was being excluded and dismissed by Fiona. He described telephone calls that he had received when no-one spoke, but there was the sound of someone eating crisps.

28th June 2004

OS attended the Linden Unit and saw the Consultant Psychiatrist for the last time. She felt that no further appointments were necessary. She wrote to the GP:

> *"..OS came to the clinic on 28th June 2004. He was very relaxed and positive and showed no evidence of symptoms of mental illness. He has derived a lot of benefit from seeing the Psychologist and I am sure that this will help him deal with his difficulties in expressing his emotions. In addition, he and Fiona are going for marital counselling and that has strengthened their relationship.*
> *I have not made a further appointment to see him again but if there are any further difficulties please do not hesitate to re- refer him"*

COMMENT
This letter and the previous one were not copied to the Clinical Psychologist who therefore did not know that OS had been discharged by the from the psychiatric outpatient clinic.

6th July 2004

OS left a message cancelling his appointment with the Consultant Psychologist. A letter was sent on the 8th July re-arranging it for the 15th July. OS did not keep this later appointment and did not leave any message or explanation for his absence.

7th July 2004

The Clinical Psychologist wrote to the Consultant Psychiatrist. She copied the letter to OS's GP. In the letter she wrote:

> *"…OS reported feeling overwhelmed by Fiona's family at times. He described them as visiting their home frequently, often advising him how to do things around the house. OS has felt that his views have been ignored by Fiona in favour of the views of her sisters or other relatives. He also described feeling overwhelmed by Fiona at times, saying that she tends to get the upper hand in their relationship, which makes him feel less of a man. He reported that Fiona often wags her finger at him, making him feel like a naughty child – this links with the incident with his brother-in-law who OS reports, wagged his finger at OS whilst denying his involvement with Fiona, immediately prior to OS assaulting him.*
>
> *… OS denied any previous episodes of violence. He believes that the triggers for his anger with his brother-in-law were related to his feelings of jealousy and inferiority, set within the context of ongoing marital difficulties between him and Fiona. OS recognizes that he was experiencing feelings of low esteem and insecurity within his marital relationship for some time, and that this has impacted on his mood.*
>
> *… although OS has shown remorse for his violent behaviour towards his brother-in-law, there are several factors, which in my opinion, may exacerbate the risk for violence. The long-standing nature of his jealous feelings and fixed beliefs; his marital difficulties; his low esteem; and exposure to potential destabilisers, which may include contact with his brother-in-law and the consumption of alcohol. These risks may be buffered to an extent by his remorse for his behaviour. He reported that he is now vigilant to any confrontations as these experiences have made him aware of the impact of his angry feelings. However a further risk assessment by the Forensic Services may be warranted.*
>
> *I shall continue to explore these issues with OS in our sessions and help him to acknowledge the links between thoughts, feelings and behaviour. I shall*

also introduce OS to a cognitive behavioural approach to stress management. I shall of course keep you informed any progress".

COMMENT
This is the second reference to the possibility of a Forensic Psychiatrist's assessment, which never happened. When we interviewed the Consultant Psychiatrist, she said that she came to the conclusion that a forensic assessment was not indicated and that it would add nothing to the overall management of OS's mental health. She feared that it could be counter-productive and might impair the trusting relationships that OS appeared to have developed. It might also discourage OS from seeking help in the future. The Clinical Psychologist informed us that she accessed the psychiatric notes to see whether an assessment had been conducted by the forensic services. On finding no record of an assessment she says she asked OS if he had an appointment with the forensic services on several occasions. On each occasion he said he had not received an appointment. The Clinical Psychologist could have been alerted to the fact that a referral was never made and sought clarification over the referral at any time during her contact with OS.

28th July 2004

OS attended for his sixth psychology appointment. During this meeting it was agreed that only three further sessions were required, one to look again at the incident in January and two to deal with stress management and the possibility of violence in the future.

11th August 2004

OS attended for his seventh psychology session. He discussed some difficulties with his manager at work. He complained that she made him feel inadequate.

21st September 2004

OS did not attend for his appointment with the Clinical Psychologist.

5th October 2004

OS attended for his final psychology session. He was very positive, and said that he had resolved the issues at work with his manager. His relationship with Fiona was going very well. His Community Service at the charity shop was now completed.

6th October 2004

The Consultant Psychologist wrote to the GP informing her that her work with OS had been completed.

She copied her discharge letter to the GP to the Consultant Psychiatrist. She wrote that OS felt that he had a greater understanding of his feelings of insecurity within his marriage, and the way in which this had an impact on his mood. OS and Fiona were attending relationship counselling and they had found it beneficial. As OS had made good progress they had agreed that he required no further sessions. He was now no longer under the care of any mental health professional.

COMMENT

The Clinical Psychologist told us that her letter to the GP was copied to the Consultant Psychiatrist in the belief that the latter was providing ongoing care and monitoring for OS. Under these circumstances it would be normal practice to write to the Consultant Psychiatrist, as the referrer, with a copy to the GP. In fact he had been discharged some months earlier. With respect to her own role, she felt that OS was "disengaging and wanted to get on with his life." In essence "her job was done".

The Consultant Psychiatrist recalled that she had had some informal discussions with the Clinical Psychologist about OS and the progress that he had made during psychological therapy. However, the Clinical Psychologist could not recall any such discussions. She told us that if the Consultant Psychiatrist said that such discussions had occurred, then, she accepted that they must have happened.

The two practitioners were not based in the same building. At the time the Consultants were not based in the Community Mental Health Teams. Specific efforts, such as letter writing or arranging a meeting had to be made to communicate with each other, unless they just happened to bump into each other.

December 2004

OS told the Investigation Team that in December, whilst walking near his office, he saw the Clinical Psychologist but did not speak to her. He had started to feel tense again, and the encounter made his stomach churn. It reminded him that he had been told that he could be seen again if the need arose. As he had been feeling anxious, he telephoned the Linden Unit to make an appointment to see the Consultant Psychiatrist. He was told by a member of administrative staff that he should contact his GP who could refer him. He did not do this.

COMMENT

We asked the Locality Manager at the Linden Unit how telephone calls like this were dealt with. Her recollection was that the content of the telephone call would have been relayed to the Consultant, although this did occur during a time when there was a succession of temporary secretaries so she could not be certain that such a call would have been recorded or passed on at this time.

A few days before Christmas 2004, OS asked his father-in-law to collect him from a Christmas party at work. He did so. OS had had a lot to drink.

COMMENT

Fiona's father had expressed concern about OS's drinking habits in the past. Fiona had asked her father not to give whisky to OS.

During the journey home OS told his father-in-law that he intended to leave Fiona because she no longer loved him. He asked his father-in-law not to tell anyone about this conversation.

CHAPTER 4

EVENTS OF 2ND AND 3RD JANUARY 2005 AND THEIR AFTERMATH

On the evening of 2nd January 2005, Fiona arranged a surprise birthday party at her house for a friend. The guests at the party included children, one of whom stayed the night with Fiona's children. OS described himself as a good host that evening. He told us that he had a number of drinks, but that he was not drunk. He told us that after the party, he and Fiona went to bed. He complimented Fiona on the success of the party. He told us that she was quite intoxicated and that she replied "*new year, new start without you".* There was then an exchange of words, during which Fiona told him she had not loved him for five years. OS told us that his reaction was to feel *'empty',* and then suicidal.

He told us that he went downstairs. He drank some whisky and took a large quantity of Paracetamol tablets. As he waited to die, he came across a kitchen knife in the sink. He later told the police that he felt it was unfair that he was suffering, and that he remembered feeling that he wanted Fiona to suffer. OS has consistently denied having any plan or intention of killing Fiona. He has always denied any recollection of his attack on Fiona.

In the morning, OS's eldest daughter and her friend could not find Fiona and so she telephoned her grandmother. Fiona's father went to the house and met the father of the child staying overnight as he arrived to collect his daughter. When they attempted to go into OS and Fiona's bedroom, they found that the door had been barricaded with a chest of drawers. They called the Police and the Ambulance Service.

On arrival, the emergency services found Fiona dead on the bedroom floor. Forensic reports later stated that she had been stabbed some 57 times with a great force. She had wounds on her face, neck, upper limbs and trunk. She had been lying on the bed when she was attacked, and OS appeared to have moved her onto the floor afterwards. OS was drunk and he admitted he had taken a few paracetamol. He was taken to the Hospital of Cross, Rugby, for treatment.

COMMENT
OS may have taken some paracetamol before he attacked Fiona, but it is very likely that he took some after Fiona was injured as her blood was found on the empty blister packs. The level of paracetamol in his blood indicated that OS had taken 20 or more tablets.

The level of alcohol in OS's blood on arrival in hospital was approximately 497 milligrams per 100 millilitres of blood. This is a level which is associated with unconsciousness and the risk of death in moderate drinkers. It was not possible to determine how much alcohol OS had consumed prior to the attack on Fiona, but the blood level indicated that a large proportion of the alcohol in his system must have been consumed after the killing (to have taken enough alcohol before the killing to have produced the observed blood level in the morning would have cause lethal alcohol poisoning overnight).

4th January 2005

OS had further blood tests to establish whether he had any liver damage and methionine was administered to counter the toxic effects of paracetamol.

7th and 8th January 2005

The forensic CPN saw OS and was assessed as being *"very low in mood and emotionally shut down"*. She arranged for OS to be assessed by the visiting Forensic Psychiatrist.

OS was declared fit to be interviewed under caution. He was charged with murder and remanded in custody to HMP Blakenhurst.

10th January 2005

The Forensic CPN saw OS again and noted that he was very detached and blank surrounding what had happened. His mother was admitted to the local hospital having suffered a stroke.

Fiona's family were caring for OS's three children and he was very emotionless when talking about them.

13th January 2005

The Consultant Forensic Psychiatrist with responsibility for patients in the Rugby area saw OS in prison. He found no evidence of depressive illness. OS denied any thoughts of suicide.

The Consultant wrote back to the Forensic CPN:

> *"thank you for liaising with me about this man who has recently been charged with the murder of his wife. The main concern was that he has taken an overdose of paracetamol prior to the index offence and he be considered at further risk of self-harm.*
>
> *…….his beliefs about her infidelity were clearly overvalued ideas. There was no evidence of psychosis or other severe mental illness. There was some suggestion in his history of a deterioration in his mental health in the months prior to the offence by way of a depression of his mood, presumably secondary to his ongoing marital problems… At present he denied any ongoing thoughts of suicide or self-harm. But, from an objective point of view there is no doubt that he remains significantly emotionally detached from recent events without a true understanding of his current situation and he is tending to minimise or avoid the major consequences for himself and of course for his children. He will need further assessment in due course in relation to the medico-legal issues that will need to be addressed….There is no evidence of a current severe mental illness of the sort which may necessitate transfer to hospital at this stage".*

He concluded:

> *"….there was no doubt that OS remained significantly emotionally detached from the recent events without a true understanding of his current situation and tended to minimize or avoid the consequences for himself and his children."*

He found no evidence of mental illness and therefore did not recommend that OS be transferred to a secure psychiatric unit.

In October 2005 OS went on trial for murder in Warwick. The jury could not reach a verdict, and the Judge ordered a retrial. A second trial was held at Birmingham Crown Court in March 2006. OS pleaded not guilty to murder, guilty to manslaughter due to diminished responsibility. The prosecution did not challenge psychiatric evidence from two expert witnesses that OS was suffering from an "*abnormality of the mind*" at the time of the homicide. It was argued, however, that the Defence had to establish that this abnormality of mind substantially impaired OS's responsibility for his actions in killing Fiona. The prosecution case was that *"the combination of alcohol provoking his violent temper and his consuming hatred towards Fiona were*

the real causes of his conduct in killing her". OS was convicted of manslaughter in March 2006. On the 12th April 2006 he was sentenced to eight years imprisonment.

3rd July 2006

The Attorney General referred the case to the Court of Appeal Criminal Division as it was felt that the sentence was unduly lenient. The sentence of eight years imprisonment was quashed and a sentence of life imprisonment was imposed. The three presiding Judges disagreed with the Crown Court Judge who had said that the risk to any future partner was 'remote'. Their view was that there was a real risk to future partner(s) and that the 'protection of the public required a sentence of life imprisonment'.

CHAPTER 5

DIFFICULTIES IN RISK ASSESSMENT AND RISK MANAGEMENT

OS was fully assessed by four mental health professionals prior to Fiona's death. He was assessed by a Consultant General Adult Psychiatrist and a Forensic Psychiatrist when he was first referred to the mental health services in Rugby in 2000. After the attack on Fiona's brother-in-law in January 2004, he was re-referred to the service. A second Consultant General Adult Psychiatrist assessed him, who continued to see him until June 2004. She referred him to a Clinical Psychologist, who saw him from March 2004 until October 2004.

All of these assessments were carried out by experienced senior clinicians. Each of the professionals came to the conclusion that the risk that OS would commit a serious act of violence was small. Although OS went on to kill Fiona, it does not necessarily follow that the assessments were incompetent or carried out without an adequate level of care. It is quite possible for mental health practitioners to carry out risk assessment carefully and conscientiously and to arrive at a reasonable conclusion, only to be proven wrong by subsequent events. One of our tasks has been to decide whether or not there were shortcomings in the risk assessment and risk management processes in the case of OS, and whether or not the standard of care that he received was within acceptable limits.

In order to explain how we have arrived at our conclusions, it is necessary to make reference to the nature of abnormal jealousy, and to draw attention to some significant difficulties in assessing OS.

Abnormal Jealousy

Normal jealousy is experienced by almost everyone at sometime in their life. It arises in the context of loss of the affection of someone who is important to the individual, or in the face of events that give rise to a reasonable and logical apprehension that this is about to happen. Jealousy is intrinsically an uncomfortable and unpleasant emotion. It is frightening to many people who experience it, because it is commonly accompanied by feelings of anger and vengefulness. It is intrinsically highly salient, which is to say that it constantly intrudes into awareness, and tends to

be at the front of the person's mind. It is difficult for the person to stop dwelling on jealous pre-occupations by an act of will. Because jealousy is uncomfortable it tends to spur the person to action, whether this is to end the relationship, or to have a confrontation. If the relationship cannot be restored, most people would prefer to end it completely rather than continued to be tormented by jealous feelings. As a consequence of this, jealousy is not an emotion that normally persists for long periods. Although one normally thinks of jealousy with respect to perturbations in sexual relationships, it can occur in other types of relationship.

There is no generally accepted operationalised definition of pathological jealousy. Most psychiatrists would regard jealousy as pathological where it causes the individual long term distress because it is persistent or recurrent, and where the objective evidence of imminent loss of affection is minimal or non-existent. However, other psychiatrists might define pathological jealousy as a situation where one partner's jealous concerns become a destabilising factor within the relationship.

Pathological jealousy appears to be more common in men than women. There are invariably understandable psychological antecedents to pathological jealousy. Most commonly the jealous person is insecure, and frequently there is evidence of impaired attachment to parental figures in childhood. The consequence of this is that the jealous person is not confident that they can retain the affections of a loved one. They are therefore abnormally vigilant for signs that their partner is becoming interested in somebody else. A person suffering from pathological jealousy may be enraged by noticing their partner smiling or glancing at another person of the opposite sex, or even if they watch a television programme featuring an attractive actor. They frequently interrogate their partner about suspected liaisons and the meaning of objectively trivial events. Although jealous ideas may focus on a particular suspected lover, there is usually a high degree of sensitivity and vigilance over all the partner's dealings with eligible members of the opposite sex.

There is a strong association between jealousy and excessive alcohol use. Men, in particular, often try to cope with their jealousy by drinking, which then releases aggression. This commonly leads to recurrent episodes of domestic violence. Heavy drinking can exacerbate insecurity and jealousy by causing impotence. Where the jealous person drinks heavily, persuading them to abstain from alcohol can be

sufficient to end violence and to stabilise the relationship, though it rarely has much effect on their underlying jealous feelings. Naturally enough, prolonged exposure to jealous accusations, whether or not accompanied by heavy drinking, can lead to a previously loving partner to start to lose affection. The cycle can be self sustaining.

This form of 'neurotic' abnormal jealousy is relatively common, and it is a frequent cause of domestic violence. In the vast majority of cases a jealous person recognises that their apprehensions are unreasonable, and under these circumstances jealous ideas can be understood as 'over-valued ideas'. These are irrational beliefs that are held without unswerving conviction, but which are highly salient. People with this type of abnormal jealousy almost invariably express convincing remorse when they have been violent. Unfortunately, this quality of insight often does little to prevent them from remaining in a cycle of jealousy, drinking and domestic violence. People with this problem are often referred to mental health services, most commonly in the context of an ultimatum from their partner that they will leave them unless they get help. There is no specific intervention which can be relied upon to permanently resolve abnormal jealousy. It is generally recognised as being very difficult to treat. However, the single intervention that is most likely to make a difference is to assist the jealous person to long term abstinence from alcohol or illicit drugs.

Jealous delusions arise where jealous feelings are not only highly salient, but are also intense fixed beliefs that are not amenable to reason and which arise in the absence of adequate evidence to support them. People suffering from schizophrenia or bipolar affective disorder sometimes develop jealous delusions. Under these circumstances, jealous delusions tend to respond to the standard treatments for the condition. The prognosis for jealous delusions under these circumstances is relatively good.

Jealous delusions most commonly develop in a person who is in any case prone to a pathological level of jealousy. The movement from 'neurotic' abnormal jealousy to delusional jealousy is sometimes regarded as being due to a psychological process called a "paranoid shift". Under these circumstances the *only* symptom of mental illness present is fixed jealous beliefs. There are no other psychotic symptoms or experiences. If there is an abnormality of mood, it arises intermittently as a

consequence of the person's circumstances. It is not an underlying cause of the beliefs (as evidenced by the fact the delusional beliefs are there whether or not the person's mood is depressed). Within modern psychiatric nosology (e.g. ICD 10) delusional jealousy is regarded as a form of persistent delusional disorder.

The syndrome of delusional jealousy has been recognised for a very long time, and it is sometimes known as the Othello syndrome, because Shakespeare's play clearly set out many of the features of the disorder. At the end of the play Othello smothers his wife, Desdemona, to death. The link between delusional jealousy and uxoricide has been recognised since the birth of psychiatry. It has been a prominent part of psychiatric teaching on risk assessment for many years. The link between mental illness and violence is, in general, a rather weak one. However, all forms of jealousy are associated with an increased risk of violence. The link between delusional jealousy and violence is unusually strong. Although most sufferers do not display serious violence, and only a small minority become homicidal, the association is sufficiently well recognised as to demand special care in assessment from professionals attempting to help them.

Amongst the well recognised features of delusional jealousy is the fact that the deluded person will often avoid definite proof of the partner's innocence or guilt. It is believed that people who are suffering from jealous delusions find it unbearable to confront the actuality of losing the loved one, and therefore they avoid taking steps to refute or confirm their ideas (such as employing private detectives) for fear that they will finally get absolute proof of infidelity, and all hope of reconciliation will be lost.

In keeping with this, it is further recognised that the most dangerous thing that can happen between the jealous person and their partner is for the latter, in exasperation, to confirm the deluded person's suspicions. This can happen either in the general mood of "alright, have it your own way, I've been having an affair", or because the strain on the relationship proves unbearable and the partner eventually doesn't love the jealous person any more, and says so. It is exactly at this moment that a homicidal assault is most likely to happen.

Persistent delusional disorder does not generally respond well to anti-psychotic medication or any other specific treatment. In delusional jealousy, the prognosis is poor. All forms of abnormal jealousy tend to recur in subsequent relationships.

Because delusional jealousy is essentially mono-symptomatic, the jealous person often appears entirely normal in settings away from the family home, or when discussing other matters. The distinction between ordinary pathological jealousy and delusional jealousy is not entirely clear cut. The same personality factors are common in both conditions. Some of the alarming features of jealous delusions (especially salience and vengeful thoughts) can arise transiently in non-pathological jealousy. For this reason, when jealous people undergo psychiatric assessment it is important to carefully explore both the person's full history and their current ideas. As jealous people are usually taken to see a psychiatrist in the context of an ultimatum, their superficial description of their beliefs and expressions of regret can be misleading.

Finally, psychiatrists have been taught for a very long time that the only satisfactory solution to delusional jealousy is a geographical one. In other words, psychiatrists should recommend that such couples should separate. Whilst direct and dramatic advice like this is out of keeping with the current climate in mental health services, nonetheless the association between jealousy and violence is such that it is generally recommended that the spouse should invariably be interviewed separately from the jealous person, in order to get a clear history from them, but also in order to warn them of the risks and of the poor prognosis.

OS's Account of Himself

We interviewed OS for almost three hours at HMP Gartree in October 2006. This was not a clinical interview and it would not be appropriate for us to attempt to revise the existing diagnosis or formulation of his condition. We were struck by the similarities between OS's account of himself to us and previous accounts that he had given. We had read the latter in the case notes and Court records, and quite frequently he used identical turns of phrase. OS presented in a manner that was entirely consistent with previous accounts of him. The content of what he says about himself appears to have been consistent over several years.

OS presented to us as relaxed, personable and articulate. He displayed an obvious charm. We were left with the impression that, had we met him under different circumstances, he would in all probability have been good company.

Although OS's manner was unremarkable, we felt that some of the things that he said were unusual. He told us that he had loved Fiona, and despite acknowledging that he had done wrong in killing her, he only ever expressed *regret* over the homicide. At no stage did he express any convincing *remorse*. By this we mean that he seemed unable to acknowledge to us his personal responsibility for what had happened. He appeared to show no concern for the effect of his action on other people, including his children and members of both extended families.

OS told us that he has never been mentally ill. He told us that he did not accept the advice that he has received from different clinicians over the last six years that alcohol releases his aggression. He told us that he did not believe that he has ever had an alcohol problem, and that he rejected the idea that intoxication had any role in the homicide. He told us that he continued to believe that Fiona had had a relationship with her brother-in-law. He told us that he still continued to believe that both Fiona and her brother-in-law had been taunting him and provoking him over several years. He believed that the objective of this was to make it look as if he was mentally ill, so that Fiona could get rid of him and gain possession of their house.

OS described problems in his marriage at length, whereby, by his account, he had to work hard in order to earn the family money, which was spent by Fiona if she had the opportunity. He told us that much of the burden of childcare and housework fell to him. He told us how he felt that Fiona had undermined him in his ambitions and how she made invidious comparisons between him and other men (for example, with regard to the amount he earned). He did make some positive remarks about the relationship during its early years, but he said nothing positive about their relationship in more recent times. He did not appear to acknowledge any responsibility for any of the difficulties.

OS told us that he had never been a violent man. When we asked him how this could be reconciled with the fact that he had made a potentially lethal assault on Fiona's brother-in-law and an actually lethal assault on Fiona, he told us that the

circumstances were unique and beyond his control. His argument seemed to be that he had been provoked beyond endurance until he finally lost control of himself.

OS's understanding of what happened was consistent with continuing unresolved jealousy which appeared during our interview to be delusional. However, some of the ideas had a more distinctively paranoid feel to them (for example, with regard to being taunted by Fiona and his brother-in-law *after* he had assaulted the latter and his fear that they were trying to make him appear mentally ill).

Needless to say that, whilst the content of some of what OS said to us was quite shocking, his manner was entirely plausible and pleasant. We felt that he showed an ability to seamlessly extricate himself from situations where he appeared to have been "*caught out*" making statements in conflict with other accounts. We believe that this was probably relevant in the context of his treatment by the mental health services in Rugby.

In our opinion, OS's pleasant, articulate persona, taken with an ability to 'slide away' from awkward facts, means that he did, and always will, represent a challenge for any clinician trying to make a full psychiatric assessment.

CHAPTER 6

ASSESSMENT AND MANAGEMENT DURING FIRST EPISODE OF MENTAL HEALTH CARE : 13TH OCTOBER 2000 – 16TH MAY 2002

OS initially presented to one of the partners at his General Practice with symptoms of depression. This GP had not previously known him well, but OS saw this same doctor at his General Practice from 2000 until Fiona's death.

COMMENT
In our opinion, the quality of care that OS received from his General Practitioner from 2000 until Fiona's death was entirely satisfactory. At each step she made appropriate assessments, and sought specialist assistance as soon as it was evident that this was necessary. Her communication with other professionals over the case was excellent. We have no criticism of the quality of primary care that OS received.

As soon as it became apparent to his GP that OS was suffering from pathological jealousy, she referred him to the practice liaison CPN. The CPN saw him twice. She established an initial intervention plan.

COMMENT
The CPN's intervention was low key, but his initial presentation was no different to many other jealous men who are seen in primary care. The CPN's assessment and plan was appropriate on the basis of the information that was available to her at the time.

The situation changed when Fiona telephoned the GP and followed this up with a letter. She was now frightened by OS's abusive behaviour and his threats to seriously harm his brother-in-law. At this point there was a discussion between the GP and the CPN, and a referral was immediately made to the first Consultant Psychiatrist at the Linden Unit. This Psychiatrist has since died. From the records it is apparent that he felt from the outset that there was a risk of aggression. He obtained a history from OS of violent fantasies of harming the brother-in-law. He felt that the prognosis was poor. He prescribed medication and monitored the situation. He interviewed Fiona alone and discussed safety issues. When the situation failed to improve, he sought the opinion of a Forensic Psychiatrist, to assist in risk assessment.

The Forensic Psychiatrist saw OS on one occasion. He made a comprehensive assessment. He interviewed Fiona on her own. She gave a different history to OS with regard to domestic violence and his drinking behaviour. She reported that episodes of violence, mainly kicking or punching, had occurred when OS had been drinking, particularly when he drank whisky. The Forensic Psychiatrist asked Fiona about behaviours that commonly accompany delusional jealousy. He questioned OS about fantasies of harming his brother-in-law and his wife. He gained the impression that the fantasies had been short lived and that they arose during a period when OS had been drinking heavily.

The Forensic Psychiatrist reinforced advice that had already been given to the couple by the Consultant Psychiatrist, namely that they should avoid contact with Fiona's sister and brother-in-law and that OS should avoid alcohol. He discussed the risk of violence against Fiona with her, though it is not clear exactly what warnings he gave her.

He concluded that the risk of serious violence was low. He believed that OS had made threats in an attempt to control the situation or exert power over the other parties. He did not arrange to see the couple again, but gave advice to the Consultant Psychiatrist about the future management of OS.

COMMENT
Although this assessment was not supported by subsequent events, in our opinion the conclusions were reasonable on the basis of the information available at the time. They were based upon a careful assessment. At that time there were no clear indicators of a significant risk of serious violence.

At this time Fiona was keen for the relationship to continue, whilst OS was threatening to end it. It seems that Fiona found it difficult to accept the advice that was given with regard to avoiding contact with her sister's family.

COMMENT
It is common under these circumstances for the patient's partner to be reluctant to accept advice with regard to safety, and Fiona was not unusual in this respect.

Fiona had seen both the Consultant Psychiatrist and the Consultant Forensic Psychiatrist on her own. Despite her earlier statements to the GP, she insisted that she was not fearful of OS. During this period the couple had some counselling together from a voluntary agency and OS had some individual counselling.

Following assessment by the Forensic Psychiatrist, OS was seen less frequently. The Consultant Psychiatrist wrote to him through his secretary asking him to attend in August but he missed two appointments without explanation.

On the 5th November, Fiona phoned her GP to tell her that OS had tried to suffocate her with a pillow. She had left the family home with the children and was staying with one of her sisters. On 7th November 2001, OS was seen at home by the GP, the Consultant Psychiatrist and two social workers. This was an assessment under the Mental Health Act.

On assessment OS continued to express delusional beliefs, but denied that any violence had occurred. He claimed that Fiona had invented this story in order to have him "branded as mad" so that she could get the house.

COMMENT

This was still OS's account of this incident when we interviewed him in HMP Gartree.

At this time Fiona appeared to have decided to leave OS, who was prepared to resume seeing the Consultant Psychiatrist. It was decided that there were insufficient grounds to detain him under the Mental Health Act.

COMMENT

We accept that, under the usual interpretation of the Mental Health Act, there were no grounds to detain OS at this time. He was prepared to accept treatment and the risk appeared to be low as Fiona was no longer living with him. In our opinion, a period of detention in hospital with compulsory treatment would not have been helpful. It was very unlikely that such an intervention would resolve the underlying problem. The use of compulsion without therapeutic benefit can reasonably be avoided on the basis that it is likely to destroy all possibility of the patient cooperating with treatment in the future.

OS resumed attendance at appointments and the Consultant Psychiatrist continued to monitor the situation, including the risk of violence.

Despite Fiona commencing divorce proceedings the couple continued to have a sexual relationship and Fiona became pregnant.

COMMENT

Fiona would have been in the early stages of pregnancy at the time of the incident in November 2001, which resulted in the assessment under the Mental Health Act. This incident may have related to the pregnancy as OS said at our interview with him that he was concerned about the paternity of this baby before it was born. There was no record in the clinical notes relating to Fiona's pregnancy.

By February 2002 OS and Fiona had a reconciliation and Fiona moved back into the family home (though there was no alteration in OS's jealous ideas). At this point the situation appeared to be under control. OS discontinued medication. The Consultant Psychiatrist expressed his reservations that the improvement would continue, and arranged to see OS again on 16th May 2002. At that appointment all appeared to be well and OS was discharged from follow up.

COMMENT

In our opinion, although the risk assessments made during this first episode of psychiatric care failed to predict OS's subsequent behaviour, nonetheless, they were conducted carefully. The quality of psychiatric care was within the parameters of good practice

CHAPTER 7

ASSESSMENT AND MANAGEMENT DURING SECOND EPISODE OF MENTAL HEALTH CARE : 9TH FEBRUARY 2004 – 5TH OCTOBER 2004

On 11th January 2004, OS attacked his brother-in-law with a glass in his hand, causing a severe laceration to his throat. He was arrested and charged. He saw his GP with Fiona two days later, in part because his solicitor had asked him to request a note for the Court from his GP explaining that he had a mental disorder. The GP immediately telephoned the second Consultant Psychiatrist, who was now covering the area, following the death of the first Consultant Psychiatrist. The quality of information that she provided on referral was good. For reasons that are not clear there was a three and a half week delay before OS was actually seen by the Consultant Psychiatrist, though the GP felt that this was satisfactory and that an emergency assessment did not appear to be necessary at the time.

OS was interviewed by this Consultant Psychiatrist alone. She took a full history. The assessment letter is long, running to some three pages of A4. This Psychiatrist had access to the complete records from the previous episode of care, including the Forensic Psychiatrist's opinion. She was aware that he had previously described fantasies of slashing his brother-in-law's throat.

COMMENT

In her assessment letter, the psychiatrist reported OS's account that, when he felt provoked by the brother-in-law, he had lashed out and not noticed that he had a glass in his hand. She did not mention other possible explanations for his behaviour. The Psychiatrist told us that she had been aware that the incident was a "glassing" in other words the wine glass had been used as a weapon. She was aware that the injury to the brother-in-law's throat was serious, though the letter stated "OS received a cut to the chin, which he required stitches for".

The Psychiatrist believed that the assault was unpremeditated. In our opinion, this was a reasonable interpretation of the known facts. She told us that because the previous violent fantasies were reportedly transient and the assault was unpremeditated, she believed that the fantasies had no bearing on the assault or on risk assessment. In our opinion, she attached insufficient significance to the potential relationships between violent fantasies and violent acts.

The Psychiatrist's assessment was that the problem was one of a man with insecure personality traits who was struggling with a range of psychological and social

stressors, and who had developed intermittent over valued ideas of jealousy. She felt that he had, in the past, been depressed. She regarded the assault as entirely impulsive. She stated that:

> *"I could detect no evidence at present of a medically treatable mental illness".*

COMMENT

The phrase "no medically treatable mental illness" is used frequently by OS's Psychiatrist, but her usage of the term is idiosyncratic. When we interviewed her she clarified that what she meant by this was that OS did not suffer from bipolar affective disorder, schizophrenia or major depression. This was clearly correct. She believed that he suffered from a problem with jealousy that was intermittent. When we interviewed OS he was initially a little hesitant to discuss his jealous beliefs, but eventually he spoke at length about them. It appeared to us that they had been continuous, although variable in their intensity, and they were unaltered when we saw him.

OS's Psychiatrist did not believe at this time or later that he was deluded.

At the end of the initial assessment she stated that she would be happy to provide a Court report, but added that he might be referred (by implication by his solicitors) to a Forensic Psychiatrist for a report. A low dose of an anti-psychotic was prescribed, a referral was made to the clinical psychologist, he was given the number of the crisis team and he was asked to bring Fiona to see the Psychiatrist at the next appointment a week later. This initial assessment letter mentions the risk that, under stress, the situation could change and that:

> '*he will need continual monitoring of his mental state in order to assess the risk to himself and others'.*

The Psychiatrist has clarified to us that she had meant 'continuing' rather than 'continual' monitoring, as she had not intended that she would follow up OS indefinitely.

COMMENT

At this stage it should have been obvious that the risk assessments from the previous episode of care were no longer relevant. It was previously believed that OS was unlikely to behave in a violent way. In fact, he had now acted very violently, and in a way that lent significance to his earlier violent fantasies of cutting his brother-in-law's throat. A reasonable sense of objectivity should have made it evident to the Psychiatrist that risk assessment had to be approached with a fresh eye and that a degree of scepticism was necessary in order to fully explore the continuing risks.

Risk assessment in mental health practice involves balancing known objective risk factors against contextual, and relatively more subjective, safety factors. The only reliable indicator of risk is previous behaviour, especially with regard to violence. When OS had no history of serious violence, an assessment of low risk was sustainable. The assault upon his brother-in-law was a major escalation from the previous threats and relatively low grade domestic violence that had preceded it. Once he had acted with serious violence on the basis of his jealous ideas, the objective risk of further violence was greatly increased.

The second Consultant Psychiatrist told us that she was mindful of the previous assessments of low risk in coming to her own assessment that the risk was low. Unlike the two Psychiatrists who had previously assessed OS, she didn't feel that he was deluded. She identified contextual factors that she regarded as reducing risk, for example OS's regret over the assault, his apparent willingness to engage in psychological work and his religious faith. These contextual factors were similar to those that had been identified in the previous assessments, but they were being balanced against new, more powerful, objective risk indicators. In our opinion, in assessing risk the Psychiatrist failed to attach sufficient weight to OS's assault on his brother in law against the background of the previous violent fantasies.

There was then a further appointment with OS. He was accompanied by Fiona. The Psychiatrist told us that she gave Fiona the opportunity to be interviewed alone, which she declined. OS and Fiona were interviewed together.

COMMENT

The Psychiatrist told us that she had experience of interviewing victims of domestic violence, and that it was her standard practice to give the couple the option of being interviewed separately. Sometimes, if she felt that one partner was uncomfortable, she would suggest a separate interview.

In our opinion, this is poor practice. If a partner asks to be seen alone, especially where jealousy is an issue, there is obvious risk of later unpleasantness within the relationship. For this reason the professional should take responsibility for insisting on separate interviews, as this act is neutral and less likely to provoke recriminations.

Soon after the interview, OS's solicitors requested that the Psychiatrist should prepare a report for the Court. It is unclear as to whether she had access to the depositions in the case. It seems likely, on balance, that she did not see them. She did have at least one telephone conversation with the Probation Service about OS.

The report is dated 8th March 2004.

COMMENT

In our opinion, the psychiatric report of 8th March 2004 was flawed.

The provision of medical evidence to the courts is an intrinsic part of the work of the consultant general adult psychiatrist. Requests for such reports may be made when patients under the care of the psychiatrist are accused of committing criminal offences, or they may be requested by the family courts. Such reports are provided as the treating clinician. The provision of expert opinion to the criminal courts, on the other hand, is the role of the forensic psychiatrist.

The volume of such work varies considerably from one area to another, and consequently there is considerable variation in the level of expertise held by individual general adult psychiatrists in preparing medico-legal reports. When requests are made with regard to serious offences, general adult psychiatrists have to judge whether they have sufficient expertise to provide a report. If they do not, they should suggest that a forensic psychiatrist should be approached instead.

There are several guidelines regarding standards of medical evidence to Courts, but the main principles are well known amongst senior Psychiatrists. Such reports should be fully comprehensible to an intelligent layperson. Most usually either the Defence or the Judge requests a psychiatric report, but in all cases the Psychiatrist is acting for the Court. Reports should be as objective as possible and they should not be written in order to achieve a particular outcome. Fact, observation and opinion should be clearly separated. Sources of information should be clear. Where witnesses' accounts of events differ from the patient's account, this should be made clear. Reports should be comprehensive and accurate. They should not omit information which might be important to the Court in its deliberations. Where there is mental illness, it is acceptable to make recommendations on sentencing, which may be linked to the person's vulnerabilities and/or to the risk of re-offending.

The main flaws in the report of 8th March 2004 are:

1) It was probably written on the basis of inadequate information. Depositions should always been seen prior to preparation of a psychiatric Court report where the patient is accused of a serious offence.

2) It is generally disorganised. There is no separation of fact, observation and opinion.

COMMENT cont …

3) The use of language is idiosyncratic, for example, "I have given him Olanzapine 2.5mg as a mood stabiliser". The term 'mood stabiliser' has a specific meaning within psychiatry, which is to say a drug that prevents mood swings caused by bipolar affective disorder. Whilst Olanzapine can be used as mood stabiliser, it belongs to the pharmacological class of anti-psychotic drugs. As the Psychiatrist confirmed when we interviewed her, the drug was actually being prescribed for OS as a tranquiliser.

4) There are failures of logic. For example, the final paragraph begins:

"At times OS has been able to say that he listens to other people, puts people before himself. Fiona has never believed that he poses a risk to her or the children. This confirms the belief that OS has, presently, no medically treatable mental illness, but his beliefs regarding his wife's infidelity are very much related to his insecurity issues…"

There is no logical connection in normal psychiatric reasoning between the first two sentences and the conclusions in the third sentence.

5) There are uncorrected typing errors which, in places, reverse meaning. For example, "His beliefs regarding his wife and OS appear to be more in the nature of over-valued ideas and fixed delusions" 'and' should read 'than'.

6) The description of events at the time of the index offence is a simple repetition of what OS had told her : *"he lashed out with a glass in his hand, which he did not realise and the action was unpremeditated. OS received a cut to his chin which he required stitches for".*

There is no reference to witness accounts or to the severity and true site of the laceration, almost certainly because the Psychiatrist had not seen the depositions. In our opinion, in reading the report it would be possible to gain the impression that the Psychiatrist believed that OS had indeed lashed out without realising the glass was in his hand and that he had only intended to punch his brother-in-law. Many individuals charged with assaults that involve using a glass as a weapon claim that they did not know that the glass was in their hand. It is clear that these accounts have to be regarded with a degree of scepticism. The Psychiatrist was not aware that OS had made a second attempt to assault his brother-in-law with the broken stem of the wine glass and had to be restrained by other party goers. However, she told us that she was aware that the glass must have been jabbed into the brother-in-law's throat, and that the assault was not a punch but a 'glassing'. In our opinion, the report was particularly unsatisfactory on this critical point, as it could be taken to substantiate OS's account and hence minimise the seriousness of his actions.

7) Important information is omitted. There is no description of the previous fantasies of cutting the brother-in-law's throat, which had relevance to the offence. There is a statement that, when seen in his first episode of care, OS had "*admitted to having angry and aggressive feelings towards his brother-in-law."* In our opinion, there is a major difference between angry and

COMMENT cont …

aggressive feelings and specific ideas about cutting someone's throat. Following our interview with her, the Psychiatrist has written to us to clarify a number of points, including this one. She has written: *"My report of March 2004 includes a clear statement that when (the first Psychiatrist) saw OS that he had angry and aggressive feelings towards his brother-in-law, and also that OS was referred to (the Forensic Psychiatrist) whose view was that it was unlikely that OS would act on the fantasies about harming his brother-in-law. I felt that this information was relevant to the Court but at the time of composing the report did not consider that the specific details of the fantasies were necessary inclusions because of what appeared to be very different circumstances, their apparently transitory nature, the setting of acute stress, the association with a period of particularly heavy drinking and a time period of over three years."* A report prepared to an adequate standard would have had a passage rather similar to this, thus drawing the Court's attention to the previous fantasies, and explaining why the Psychiatrist did not think they were relevant in her present risk assessment. The Judge would have had the opportunity to assess the logic that dismissed a link between the fantasies, the index offence and the risk of further violence. There was little, if any, comment about domestic violence, which may have influenced the Judge's deliberations.

8) <u>There is a recommendation to avoid imprisonment, but no alternative disposal is suggested.</u> The Psychiatrist made a recommendation that a prison sentence would adversely affect OS's mental state, in that he might become depressed. Many Psychiatrists take the view that where the defendant does not appear to be suffering from a mental illness or personality disorder, no recommendation should be made about sentencing. Others would regard this as an unduly austere understanding of the Psychiatrist's role and would feel that it is reasonable to recommend that imprisonment should be avoided where there is reason to believe that the defendant would not cope well. However, both schools of thought agree that where it is recommended that imprisonment should be avoided, an alternative disposal should be recommended.

The Psychiatrist told us that she believed that imprisonment was likely. Having recommended that a custodial sentence should be avoided, she could have made a recommendation of a more appropriate disposal. In our opinion, an obvious alternative disposal in this case would have been a probation order with a condition of Psychiatric Treatment. The Psychiatrist has told us that she believed that this was inappropriate, as she did not believe that OS was mentally ill, and in any case he was attending his appointments. A forensic psychiatrist would have known that neither factor is an impediment to the imposition of a Probation Order with a condition of psychiatric treatment. Whilst he may not have been regarded as suffering from a mental illness per se, OS could have been regarded as suffering from a mental disorder. Furthermore, so far OS had had only two appointments, for which he had a strong ulterior motive to attend, namely the forthcoming Court appearance. He had not always attended regularly during his previous episode of care. Such a Probation Order would have ensured an extended period of psychiatric monitoring, and the Probation Service could have carried out work with

COMMENT cont …

OS on his aggression and his drinking in a focused and challenging manner.

9) The report does not clearly express the Psychiatrist's intentions. She stated in the report: "It will obviously be important to continue to assess OS's risk both to himself and any potential risk to other people. In addition, in view of this I have requested a second opinion from the Forensic Services, to see if there is any other advice they can offer on future management of this case." We agree with the sentiments in the first sentence. In our opinion, it is not clear from this that she was likely to discharge OS from follow up within three months of sentencing.

The Psychiatrist has explained to us that she might not have expressed herself clearly in the report, and that it was never her intention to continue with longer term follow up if OS made good progress with the Clinical Psychologist. In our opinion, in the light of the severity of the assault, and given the normally extended time scale necessary for significant psychological change, the court could reasonably have concluded that there was an intention for more extended follow up.

10) There is no evidence that a request was ever made for a second opinion from a Forensic Psychiatrist. The Psychiatrist has indicated to us that, although she has experience of providing psychiatric reports for legal proceedings as a treating psychiatrist, the provision of such reports does not feature frequently in the course of her work. In our opinion, in the light of the seriousness of the charges she might reasonably have suggested that OS's solicitor request an assessment and report from a forensic psychiatrist. She did sent a Forensic Psychiatrist a letter on 4th March 2006, just four days before she wrote the report. She enclosed a copy of her clinic letter to the GP dated 4th March 2004. This was not a request for a second opinion. It was for the Forensic Psychiatrist's information, as *"This chap may come your way. I am not sure who will be asked for the report."* OS did not see a Forensic Psychiatrist during the second episode of care. The Psychiatrist has told us that she had the impression from a letter from the probation service dated 5th March 2004 that OS had an appointment at the Reaside Clinic on 11th March 2004. The solicitors acting for the Psychiatrist's defence organisation have stated in a letter to us *"It is (the Psychiatrist's) belief that she had herself triggered the referral and that the referral was in some way frustrated, or the relevant correspondence lost, as a result of the secretarial deficiencies prevalent within the unit at the time."* There is no record that this appointment was ever requested or made. The Psychiatrist has told us that she did not request a forensic opinion later in OS's second episode of care because the previous forensic opinion "*appeared to be consistent with the findings of my assessment*", because OS was making good progress and a forensic opinion would not add to the management of the case. Furthermore she felt that "such a referral could have even been counter-productive, could have impaired the trusting relationships he appeared to develop and perhaps discourage him from seeking help in future". We will comment on this below, but we do not accept that these were adequate reasons for failing to make a referral that the Court believed she had already made.

COMMENT cont …

During her interview the Psychiatrist enquired whether it was being suggested that her report was partisan, and went on to state emphatically that this was not the case.

The flaws in the report are unrelated to the Psychiatrist's diagnosis and risk assessment. Whilst we accept that the Psychiatrist did not intend to mislead the court, it is our opinion that the inadequacies of the report, in combination, may have had this effect.

On 26th March 2004, OS was sentenced to 200 hours of community service. By now he had already started seeing the Clinical Psychologist. He had four further appointments with the Consultant Psychiatrist.

OS was next seen in clinic by the Psychiatrist on 1st April 2004. The letter to his GP reports the favourable outcome of the Court case, and states that OS was *"doing very well".* Approximately half of the letter concerns the fact that OS had reported to the Psychiatrist that his solicitor was critical of her report. The letter ends by stating:

> *"I will need to follow him up over the next 6 months to a year".*

OS's next appointment with the Psychiatrist was on 19th April 2004. There was no letter to the GP. The handwritten note is brief, and mentions that he was no longer on medication.

The next psychiatric appointment was on 17th May 2004. All was still apparently going well, but there had evidently been a major change of plan, as the letter states that the next appointment would occur at the end of June and that if all was well, he would be discharged.

OS's final appointment with the Psychiatrist was on 28th June 2004. The letter to the GP states that he continued to do well, that he was benefiting from seeing the Clinical Psychologist, and that he and Fiona were attending marital counselling. He was discharged from the clinic, but the GP was told *"please do not hesitate to re-refer him".*

COMMENT

It has been difficult to ascertain the extent to which there was meaningful communication between the Psychiatrist and the Psychologist over OS's care. The Psychiatrist was relying upon her letters to the GP being copied to the psychologist by her secretary. In the context of chronic difficulties with secretarial support, this did not happen. The Psychiatrist was unaware of this, though the relevant letters do not have "*cc Clinical Psychologist*" at the bottom. In our opinion, there was little communication of any description between them, as, when the Psychologist wrote to the Psychiatrist on 7th July 2004, she was unaware that the Psychiatrist had discharged OS a week earlier and that she had abandoned the plan of obtaining a Forensic Psychiatrist's opinion. At that time there was no proper CPA process in place in Rugby, and CMHT working had yet to be put in place. Nonetheless, given the seriousness of the index offence, and given that at times they worked in the same building, we are surprised that the Psychiatrist did not consult with the Psychologist prior to making the decision to discharge OS.

COMMENT

From reading the contemporaneous records, it is possible to gain the impression that the Psychiatrist changed her treatment plan sometime between the appointment on 1st April 2004 and the appointment on 17th May 2004. Three components of the plan seemed to change:

1. From her comments in her GP letter of 1st April 2004, quoted above, the Psychiatrist seems to have intended to continue follow up until sometime between October 2004 and April 2005. In our opinion, this was appropriate as there was a need for regular monitoring of the overall situation and of OS's mental state. This should have continued until it was clear whether any apparent improvements in the situation were likely to endure. OS was discharged twenty weeks after initial assessment, which was not compatible with the stated plan. In our opinion, this was not an adequate length of follow up.

2. In her initial assessment letter, and in the Court report, the Psychiatrist stated that she was going to arrange an EEG. This never occurred, almost certainly as a consequence of staffing difficulties in the service at the time. We doubt if an EEG would have contributed to OS's psychiatric management, but the repeated mention of an EEG followed by the failure to ensure that one was carried out gives an impression of a disorganised and poorly considered approach to treatment planning in OS's case. This may have been in part reflective of the organisational problems prevalent in the unit

3) In her assessment letter the Psychiatrist stated that she might ask for a Forensic Psychiatrist's opinion, and in her Court report stated that she had already done so. A Forensic Psychiatrist, with greater expertise in assessing mentally disordered offenders, would have formed an independent opinion with regard to risk. In our opinion, once it was apparent that no appointment for OS to see a forensic psychiatrist had been made, the Psychiatrist should have made a referral.. In a letter following our interview with her the Psychiatrist explain why she came to the view that a referral was superfluous

COMMENT cont …

> at that stage: "My opinion at the time was that psychological management focusing on his underlying issues and feelings of insecurity, his problems with anger, his coping strategies and his relationship with his wife would lead to the most benefit. I would also like to stress the importance of encouraging trusting therapeutic relationships with a user-friendly approach, facilitating future contact and engagement with the services should the need arise at a later stage. I believed that these two aspects of care would have the best chance of decreasing the possibility of further marital difficulties and domestic violence and harm."

When we interviewed her, the Psychiatrist told us that she had come to the opinion that a referral to a Forensic Psychiatrist would undermine the trusting therapeutic relationship that she had formed with OS. We reject this argument. It is very important that Psychiatrists should form good quality and 'user-friendly' relationships with their patients. It is widely believed that this is a critical factor in achieving a good outcome of treatment, and we agree with this. However, therapeutic relationships are undermined if the Psychiatrist feels constrained by the patient's reaction to appropriate measures and the practitioner feels unable to confront difficult issues.

The Psychiatrist discharged OS when she did on the basis that she had formed a good rapport with him and she was confident that he would readily see her again if the need arose. When we saw OS, he told us that he did start to feel worse sometime after he stopped seeing the Clinical Psychologist. One day he saw the Clinical Psychologist in the street, and he decided that it would be helpful to be seen again. The Psychiatrist's judgement on his readiness to return to see her was therefore correct. He phoned her secretary but was told that he could only come back via a referral from his GP. The moment passed, and he never got round to doing this.

Many services across the country have a mechanism to ensure that discharged patients can be seen again at their own request, without delay. This often means that they have a system whereby named patients can refer themselves. No such mechanism existed in Rugby. Without such a mechanism, many patients who need to be seen again will be deterred in exactly the way that OS described to us. If the Psychiatrist was relying upon OS asking for help when he needed it, it would have been prudent to ensure that the service would respond to his request for help. In the absence of such a mechanism, it would have been more sensible to have kept him in follow up.

In conclusion, in our opinion the second Psychiatrist's management and risk assessment of OS were flawed. This has to be understood against the background of serious problems within the service, including inconsistent secretarial support, the general problems associated with assessing and treating abnormal jealousy and the particular problems in assessing and understanding OS.

The Consultant Psychiatrist put considerable effort into her initial assessment of OS and organised psychological assessment promptly. However, irrespective of whether her diagnosis and risk assessment were accurate, there was a failure to observe some first principles of clinical practice. In our opinion, she should have:

1) Prepared a Court report of an adequate standard. If she lacked the expertise to do this, she should have recommended that a Forensic Psychiatrist should prepare a report instead.

2) Followed through her initial intention to obtain a Forensic Psychiatrist's opinion

3) Communicated appropriately with the Clinical Psychologist. Irrespective of the fact that she was unaware that her letters were not being copied to the Psychologist, she should have consulted with her prior to OS's discharge.

4) Followed up OS for longer to assess whether his initial improvement would persist or ensured an effective route back into the service.

RECOMMENDATION

The Independent Investigation recommends that the Trust:

- ❒ **Ensures that, as part of the clinical governance policy, medical staff within the service in Rugby have sufficient time to meet with their peer group regularly for managerial and educational activities, and that such attendance should be monitored.**

CHAPTER 8

PSYCHOLOGICAL INTERVENTIONS

From the interview given and statement provided by the Clinical Psychologist it was apparent that she had reflected and learned from this incident. Credit should be given to the individual Psychologist involved, who has identified various deficits in her practice and has acted on them already.

The main points of learning for the Clinical Psychologist were:

- to improve clinical record keeping
- to improve communication with colleagues
- to use formal risk assessment
- to use psychometrics and handouts to reinforce material covered during sessions
- to keep supervision notes
- to establish clear routes back to therapy
- to improve risk assessment
- to ensure adherence to the CPA process.

Referral to Psychology

The Consultant Psychiatrist referred OS for psychological therapy in February 2004. This referral seems entirely appropriate and consisted of a brief covering letter enclosing the Consultant Psychiatrist's assessment report.

The assault leading up to this episode of psychiatric contact is outlined in some detail although the extent of the injury caused was not detailed fully. The first period of psychiatric care and forensic involvement was noted. Mention is also made of domestic violence following alcohol, the need for monitoring of his mental state to assess the risk to himself and others, and that he was given the Crisis Team contact information. The information in the letter from the GP indicating that Fiona was frightened by the sudden rage which lead to the assault on Fiona's brother-in-law,

the level of assault (which the GP recorded as GBH) and the incident where Fiona thought OS had tried to smother her were not included.

The referral was discussed at the regular referral allocation meeting held by the clinicians within the psychology department. A letter was sent dated the 3rd March 2004 offering OS an appointment on the 11th March 2004. It is unclear why he was given an appointment so quickly but two factors were given as potential reasons for this. The first was that referrals from psychiatrists tended to be fast-tracked over those from other referrers. The second was that the clinical psychology manager recalled the waiting list was minimal for psychiatric referrals. Neither the manager nor the Clinical Psychologist who took on the referral could remember the discussion that took place regarding OS's referral, and so could not comment on whether he was prioritised because of the risks outlined in the referral itself.

COMMENT
Not much notice was given for an employed person to arrange time off from work for the initial appointment.

The referral was allocated to an experienced Clinical Psychologist with over seven years of experience of working in this field as a qualified practitioner.

Number of sessions, cancellations and DNA's

OS was seen eight times by the Clinical Psychologist between 11th March 2004 and 5th October 2004. In addition to these sessions, four were made but not kept. Of these four, one was cancelled by the clinician, one was cancelled by OS and the remaining two were not attended. There is a telephone call on record apologising for one of these missed appointments and asking for another to be made.

COMMENT
OS cancelled an appointment on the 6th July 2004. There is no record of how or why this cancellation occurred, except in the letter sent offering him another appointment. This letter, dated 8th July, was sent offering him another appointment on the 15th July. It was this latter appointment that was not kept and there is no record of any explanation as to why. Again it is very short notice for someone with a job.

Therapeutic aims, process and outcomes

The aims of therapy were outlined in the Clinical Psychologist's statement given to the Independent Investigation. From this they appear to have been:

1. Developing a formulation
2. Risk assessment
3. Exploratory therapy
4. Marital therapy
5. Cognitive therapy
6. Stress management
7. Anger management

COMMENT
Although not wholly independent of each other the Investigation Panel felt that whilst all the aims were appropriate, they had been covered in too few sessions to have been addressed fully.

Development of a Formulation

The formulation outlined in the statement given to the independent inquiry is around OS's feelings of inferiority, jealousy, low self esteem, stress and depression. It provides a cognitive-behavioural explanation for depression, hypervigilance and potential misinterpretation of the behaviour of others. It is outlined in the clinical notes how these factors, combined with situational factors such as alcohol, stress and contact with Fiona's brother-in-law, could have led to the assault on Fiona's brother-in-law.

The formulation does not attempt to explain why OS had developed the feelings of inferiority and low self-esteem. It tends to focus on the present, rather than provide a hypothesis of the potentially deep-rooted beliefs which may have been triggered when the assault on Fiona's brother-in-law occurred. Issues of racial identity were discussed with OS but OS felt this was not a factor in his problems with Fiona's brother-in-law.

COMMENT

Providing OS with a theory incorporating how his thinking patterns could potentially interact with environmental factors is a valid therapeutic aim. However, helping him understand how these thinking patterns had developed and why his self esteem was low may have helped him make more permanent improvement. In one session it is recorded in the clinical notes that:

'OS reported finding the sessions valuable and wants to understand his insecurities'.

To do this would have required an increased number of therapeutic sessions and a more in-depth assessment of his childhood, early relationships and feelings around major life events *(for example: the arrival of his step-sister into the family, the death of his friend and his involvement in his friend finding out his diagnosis, the birth of his disabled son).*

Assessment, including Risk Assessment

Assessment was by means of self-report interview only. No formal psychometric measures were made of symptoms, personality characteristics, self esteem or risk. Previous psychiatric records were not accessed as part of the assessment process. OS denied any violent outbursts prior to the assault on Fiona's brother-in-law. This claim does not appear to have been challenged despite reference to previous violence in the referral letter. It was also considered to be a safety factor in the Clinical Psychologist's risk assessment as outlined in the statement given to the independent Investigation:

> *Safety factors included:*
>
> *- No previous history of violent behaviour in provocative situations (marital conflicts, racial intimidation).*

COMMENT

Previous episodes of violence were in evidence and should have been considered as factors indicating increased risk.

Links were not made between the thoughts he had expressed during his first period of psychiatric care about harming Fiona's brother-in-law and the fact that he had subsequently harmed him. Links might have been made had the previous notes been accessed as part of the assessment. Such links may have altered the risk assessment process and enhanced the perceived risk.

Despite being trained in the use of a well-respected clinical risk assessment tool, the HCR-20, this was not used. Risk factors were missed, in particular the previous episodes of domestic violence and the fact that he had acted on his thoughts since the initial risk assessment on 2001. It is not feasible to conclude that a structured clinical risk assessment would have made a difference to the tragic outcome of this case. However, it may have made professionals more cautious in their management of OS.

It is also possible that had an HCR-20 assessment been completed, increased risk factors might have been identified as arising over the Christmas period, such as increased contact with family, increased alcohol intake and being off work with no distractions from the domestic situation. Over previous years January had been a stressful time for OS.

In January 2001 he needed an earlier appointment and was *'reviewed as emergency*'; in January 2002 he was planning to move out of the home having had divorce papers served on him; in January 2004 he assaulted Fiona's brother-in-law.

COMMENT

The quality of the HCR-20 training should be investigated to ensure clinicians are aware of when to use it.

Having failed to use an HCR-20 risk assessment it would be reasonable to have expected a good risk assessment to include information from personal interview, review of case records, where possible other informants and often psychological and medical tests. In this case risk assessment has been made using unaided clinical judgment by individuals in isolation from each other. This seems to have been unstructured which, in the field of risk assessment and management particularly, is generally considered to be unreliable, of questionable validity with no/low accountability. Structured professional judgment offers a much better method of risk assessment. This involves an individual risk formulation around prevention, not prediction. The risks are clearly stated, missing information is identified and sought out, and core risk factors are clearly communicated. Transparency of decision making is improved and this is clearly lacking in both the psychiatrist's and the psychologist's input. All the relevant information was not collated nor discussed as a team.

Personal, social and forensic history should generally be collected using multiple methods and sources, and considering multiple domains of functioning. The adequacy of the information should always be questioned. Relying only on the person considered to be a risk would generally lead to any conclusions being made with caution.

COMMENT cont …

Risk formulation should be shared and ideally developed in a team of more than two knowledgeable practitioners. risk formulation should include a comprehensive analysis of offending and other linked behaviour leading to identification of relevant risk factors, highlighting critical and signature risk factors and protective factors. Judgments about interactions between risk factors over time (including short-term triggers) should be included, taking into account possible future circumstances. The risk formulation should be reviewed in light of effective/ineffective risk management. If possible the effectiveness of the risk management should be measured.

In this case, the risk management appears to have been psychological intervention for anger and stress. However, the intervention was limited due to the small number of clinical sessions allocated and the fact that effectiveness was based on the subjective opinion of one person. Longer term management of risk involving on-going monitoring and supervision was not considered.

Risk assessment interviewing should include questioning the client about their own perceptions of risk, identifying early warning signs for the future, making judgments about insight and self report should be confirmed with file and collateral information. In this case OS's own perceptions of risk were poor and any apparent insight should have been viewed with caution. It is unclear from the clinical notes how much OS was challenged about his perception and recollection of the events surrounding the assault on Fiona's brother-in-law. When assessing risk, clients must be challenged in a timely way using gentle challenges mostly, but more directly if necessary. This can be done successfully and in a collaborative way with clients such that the therapeutic relationship is maintained.

When communicating the findings of a good clinical risk assessment and management plan there should be a traceable route from assessment to management and back again. If events do not go according to plan, decisions are likely to be regarded as acceptable if clinicians can demonstrate that they have done the following:

- ❑ Conformed to the relevant Trust/locality policies and procedures and national guidelines.
- ❑ Used the best information available, tried to obtain information held by others and used empirically-based methods of evaluating the information available.
- ❑ Accounted for their decisions and chosen courses of action, and documented their decision-making appropriately.
- ❑ Informed the most appropriate people of their concerns.
- ❑ Took all reasonable steps to try and manage risk.

Unfortunately several of these points were missing when the input of both professionals involved was reviewed which would have altered the risk assessment process and enhanced the perceived risk.

COMMENT cont …

With hindsight it is clear that in this case, objective ratings of risk factors might have provided additional information. It is also clear that other informants might have given a different picture as did the notes from the previous psychiatric episode. By all accounts, and indeed when we met OS, he presented as a pleasant man who wants to be liked and this may well have coloured the information he provided and may have led to risks being perceived as lower than they actually were.

RECOMMENDATION

The Independent Investigation recommends that the Trust ensures that:

- ❒ **All staff of all disciplines, including Consultant Psychiatrists, participate in an externally provided training with regard to risk assessment and risk management, including evaluation of the impact of such training on individual clinicians competence in these areas.**

Exploratory Therapy

The Clinical Psychologist's statement to the external Investigation records:

> *"This aimed at enhancing OS's insight into the links between his early life experiences, racial experiences and his marital and family relationships and their impact on his psychological state and mood and the consequent assault on his brother-in-law. In addition, OS was able to explore his feelings regarding the assault and the impact of this on the wider family. OS commented that he had found this work to be valuable."*

This is a particularly important part of the intervention and seems to have been that part most valued by OS. However, it is likely that only part of this work was carried out and further development of the formulation as indicated above might have made a greater impact on his subsequent behaviour.

Marital Therapy

This was not begun because OS said Fiona had declined to come to a joint session as they were receiving marital support from RELATE and their church. It has not been in the remit of the investigation to involve either RELATE counsellors or the Pastor. Contact with these services does not seem to have been something that any of the mental health professionals considered an option.

Cognitive Therapy

As indicated above in the formulation section, the cognitive explanation linking feelings with behaviour and the environment is useful and valid. However, the conclusion outlined in the statement to the independent Investigation is over-confident. That is:

> *"From this work OS demonstrated a shift in his belief that his wife had engaged in a sexual relationship with her brother-in-law, to a belief that she shared an emotional bond with him to the exclusion of her husband."*

The clinical notes from the first appointment with the Clinical Psychologist on the 11th March 2004 record

> *'Now views rel(*ationship) *bet*(ween) *Fiona and her brother-in-law as an "emotional entanglement" and doubts they had a physical rel*(ationship)*. OS admitted feeling envious of him as he believed S was getting the love and affection from Fiona that he wanted'*

Stress Management

The Consultant Psychologist indicated in her written statement for the Independent Investigation that stress management was addressed. It is unclear from either this statement or the clinical notes how much time was devoted to this or in what form the information was given.

Anger Management

There is more information provided about the form of anger management that was provided during clinical psychology sessions. However, it is unclear whether information was given in any way other than verbally within the sessions.

Retention of Information Given

OS stated that he felt he had benefited from the sessions, both with the Psychiatrist and the Psychologist. However, he described them as times when he could talk about his worries and concerns and get things off his chest. He could not recall any formal strategies and denied knowing about the link between thoughts, feelings and behaviour.

OS was asked if he was given advice, or any information or handouts. He replied:

> *'No. I thought the Clinical Psychologist's job there was to explore why I was*

feeling these things. I got no handouts or advice. Obviously, it wasn't the Clinical Psychologist's job to offer advice but she could suggest certain things. 'Why not do - ?', or 'You could have a go at doing this.' There are certain aspects which I cannot remember, which I may have taken on board, or tried to take on board. When I got back to the environment with me and Fiona, then it was like it washed over anyway. It was as though it did not matter what professionals say …Therefore, when I was going back to see the Clinical Psychologist, it was as though I was going back in time. I hadn't achieved anything.

COMMENT
It is possible that he would have recalled more if there had been more sessions and/or things had been repeated more. There is much evidence to indicate how little patients do retain following clinical appointments. Also, the Psychologist could not recall whether OS had been given information such as handouts or homework to try and put suggestions into practice. The Psychologist did recall using visual information in the form of writing and diagrams on a board in the office. OS also recalled this but could not give any detail about the content of the information.

OS said that he did try to explain the psychology sessions to Fiona but that he felt *"she did not listen".*

He said:

"*However, whenever I went back from any meeting with one of the professional people, and said what they had suggested, she would just throw it out of the window and say that, at the end of the day, I just needed to sort myself out, because everyone was just losing patience with me, and everyone was just ignoring us now. People were not ignoring us……..'*

OS said that he did go back and tell the professionals that he had been unable to put into practice what they had said, but there was no further evidence to indicate that he did report this back.

Discharge from Psychology

OS was discharged from psychology and therefore the mental health service on the 5th October 2004. This was after eight attended sessions, although initially 12 were planned. It is clear from the clinical notes that discharge planning occurred. However, only two of the three planned sessions took place, the middle appointment was not kept by OS. He rang after the missed appointment to apologise and ask for another appointment. The Clinical Psychologist used her clinical judgement in the decision to discharge OS at this time. It seems that this decision included a review

of the risks, as discussed in the statement she provided to the Independent Investigation and there was evidence in the clinical notes that this was discussed in the penultimate session. However, it is possible that the improvements noted in the documentation would have been maintained for longer if further consolidation sessions had been planned.

Also, the benefit that OS reported to have had from these sessions was probably an important protective factor and this was not recognised at the time. OS was very clear when we interviewed him that the sessions with both professionals were cathartic and helped him give vent to his feelings.

When asked about how he felt about the end of the therapy sessions OS said:

> *'I remember feeling a little disappointed because I can only emphasise that I felt really positive from those chats…*

He described an incident when he felt disappointed by something Fiona did.

> *… It was all those things that I could let off to the* Clinical Psychologist*, and let the* Clinical Psychologist *know how I was feeling, and how I felt rejected'.*

He also said:

> *'I was a little shocked. Because I kept everything inside … I found that there were very few opportunities … .when I could express myself and talk about what was beefing me. That was one of the few places. I do not know whether I just kept going over and over the same things, but there were still different things happening in my life'.*

No formal measures were used in the sessions and progress was judged in more subjective terms. As noted earlier, some of the documented 'changes' in his thoughts may have been in evidence at the start of psychological work. However, there is no doubt that he had benefited from the therapeutic input and it was felt by both clinicians involved that he would seek further help again should he need to.

The Clinical Psychologist stated that she were unaware that she was the only person from the mental health services who was in contact with OS. The Clinical Psychologist was not copied into the discharge letter written by the Consultant Psychiatrist. It was not clear whether this information was available on the EPEX system, but as the administrative staff made the entries onto EPEX, this detail might not have been forwarded to the Clinical Psychologist even if it were available. The

Clinical Psychologist stated that she believed that the Consultant Psychiatrist was still in contact with OS. It is unclear what would have occurred if the Clinical Psychologist had been aware that this was not the case, but it may have meant that a better plan at discharge would have been developed.

It was interesting to note that the Clinical Psychologist's discharge letter, dated October 6th 2004 was addressed to the GP with a copy to the Consultant Psychiatrist. This suggested that the Clinical Psychologist may have been less sure at the time about whether OS was still being seen by the Consultant Psychiatrist, than they reported in the annotated interview notes.

COMMENT

It would be usual practice to write the discharge letter to the person who had referred the patient unless they were no longer seeing the patient.

It has been impossible to resolve whether the Clinical Psychologist was informed that OS had been discharged by the Consultant Psychiatrist or when she first became aware of this.

Route back to Mental Health Services

The Clinical Psychologist, in her statement to us, outlined that a route back into therapy was discussed with OS:

> *We discussed how he might resume psychological sessions again if the marriage became problematic, or if he felt the need, by seeking re-referral from his GP or Consultant Psychiatrist. OS was reminded of the number to contact the crisis team if he should feel the need.'*

OS recalled some of this information but did not recall having the number of the Crisis Team. He recounted an incident just before Christmas when he saw the Clinical Psychologist walking through town. He did not feel it was appropriate to approach the Clinical Psychologist directly but seeing her prompted him to try to make contact with the services again. He told us:

> *'During December… I was walking up the parade and I saw someone walking towards me who I thought I recognised, and I realised it was Clinical Psychologist. But I didn't walk straight in front …but I kept to the side and then just kept walking on. After Clinical Psychologist had passed me, however, I could feel my stomach churning. I felt totally unnerved by seeing Clinical Psychologist. It was either the same afternoon, or the following day, I*

rang consultant psychiatrist's office, down at St. Cross, Linden Ward, and I asked whether I could see the Consultant Psychiatrist. However, the woman said, 'Are you seeing her?', and I said no, and that I had not seen her since June or whatever. She told me that I would have to go through my GP. However, I didn't ring my GP because I thought that, since I had been a client, I could go and see her. I didn't really want to go through. The other thing was that I wanted to see Consultant Psychiatrist without Fiona knowing.

There was no available record of this telephone conversation, possibly as a result of the lack of secretarial support at this time. OS also thought that the way to see the Clinical Psychologist again was through the Consultant Psychiatrist.

Later in the interview OS said:

'The reason I rang around Christmas was because I felt my stomach tightening. The Consultant *Psychiatrist said that when I felt like that, and if I needed to talk to someone, I should contact her. But that was during the course of treatment with her. I just felt that that meant that at any time after that, I could contact her.*

RECOMMENDATION

The Independent Investigation recommends that the Trust ensures that:

- ❑ **All telephone calls requesting help should be noted and professionals made aware of clients asking to see them. The decision as to whether someone needs to be re-referred should be made on an individual basis by clinicians who know them and are aware of the risks. It is possible that if either clinician had been aware of this telephone call they would have fast-tracked an appointment.**

RECOMMENDATION

The Independent Investigation recommends that the Trust ensures that:

- ❑ **A review is undertaken of the process to inform patients how to re-access the service rather than to go back to their GP in order to be re-referred. Where the development of a trusting relationship is seen as a vital protective factor, there should be a more direct route back for certain people.**

Record keeping

The clinical notes made by the professionals involved were kept separately as there was no shared record. Had there been a shared record, it would have been much easier to see who was involved in the care at any time. Also, all the old notes would have been readily accessible to all clinicians making any risk assessment much

more thorough. The lack of an integrated community mental health team including all professionals also made communication and record keeping more likely to be flawed.

The Clinical Psychologist reported that supervision was utilised appropriately and as recommended by professional guidelines. However, there was no record of whether OS was discussed in supervision.

The Clinical Psychologist has obviously reflected a lot on the input she provided and the processes involved in this. More could have been recorded in the notes about the content of each session, details of therapy administered and recommendations made. More time may be required at the end of sessions to make accurate records and to allow time for reflection and planning of the next session.

The Clinical Psychologist also recognised that the discharge letter sent included minimal information only and should have provided more detail about any outcome and progress that OS made.

Given that the Clinical Psychologist did not make entries in a shared patient record, letters and reports assume greater significance. The interim report written on the 7th July 2004 was a record of the assessment completed up to that date, with a brief formulation, an outline risk assessment, and a plan of intended work. Although there were only three further sessions over the next three months the Clinical Psychologist did not highlight risk in the discharge letter and at interview said:

> *'I felt that at the time as well that the risk factors had decreased significantly in terms of any risks that he may pose to himself or others. At that time I felt that his mood was improved. He was more aware of the factors that had been involved in his violent behaviour and he had shown some shifts in his thinking.'*

RECOMMENDATION

The Independent Investigation recommends that the Trust:

- ❑ **Ensures that all clinicians are familiar with local Trust policy and procedure regarding record keeping and with documents relating to their own profession e.g. Clinical Psychology and Case Notes: Guidance on Good Practice (Division of Clinical Psychology, British Psychological Society, 2000). Supervision records should be kept and discussions recorded. There should be entries made in the clinical notes when clients have been discussed in supervision.**

- ❑ **Ensure enough time is allocated per client for reflection, note writing, report writing and planning.**

Communication

The Internal Inquiry recognised that communication was flawed in this case. Several factors were put forward as contributing to this, including lack of permanent secretarial support.

Letters appear to have been lost or perhaps not typed with the Consultant Psychiatrist suggesting that administrative support was poor at this time. She told us:

> *'There were over this period serious and well documented difficulties with administrative support, it appears likely that a tape may not have been transcribed or I may not have dictated a letter'.*

> *'What should have happened then is that discharge letter should have been sent to the Clinical Psychologist. I assumed it had been, but I do not think the Clinical Psychologist got that'.*

Forensic Involvement

A letter written by his senior Probation Officer on the 5th March 2004 recorded:

> *'We also understand that OS has been offered an appointment at Reaside Clinic on 11th March 2004'.*

This was an error and both the Psychiatrist and the Psychologist appeared to have assumed that OS had been offered an appointment by the Forensic service at the Reaside Clinic. The Consultant Psychiatrist came to realise that this had not happened but the Clinical Psychologist was not aware that this appointment had not made.

The Consultant Psychiatrist wrote in her statement:

> *'I understood that OS had been given an appointment at Raeside* (sic) *on 11th March 2004, before his court appearance (referred to in a letter from the Probation Officer 5th March 2004)…. Following discharge from my clinic when* Clinical Psychologist *wrote to me on 7th July, suggesting that a further risk assessment from the forensic services "may be warranted" I felt at that specific time a referral was not indicated and would probably not add to the overall management. … At that stage I also believed that such a referral could have been counterproductive, could have impaired the trusting relationships he had appeared to develop and perhaps discourage him from seeking help in the future. I believe that I had some informal discussions with* Clinical Psychologist *at this time regarding OS progress and the appropriateness of a referral but this is not documented in the medical notes.*

The Clinical Psychologist did not recall this informal discussion. The Clinical Psychologist accessed the psychiatric notes to see whether there was a report from the forensic services at this time. However, the Clinical Psychologist did not actively chase up the referral despite indicating in the interim report that a forensic risk assessment may be warranted. The Clinical Psychologist recorded:

> *'I do not have recollections of such a discussion. I doubt that I would have agreed that a forensic assessment was not necessary, as I am certain that I would err on the side of caution and proceed with the assessment to gain a specialist forensic view of the case. Indeed, I had believed that the assessment was still pending at the time I discharged OS.'*

COMMENT
Given this belief it might have been appropriate to have copied the interim report and discharge letter to the forensic services with a covering letter that explained why they were being sent. This action would have alerted the forensic service and perhaps prompted further discussions about the case and whether a forensic appointment was warranted at that time. However, given the view of both the Psychiatrist and Psychologist that risk was low it is probable that a referral would not have been considered necessary at the time of discharge from psychology.

System Issues

At the time it appears that the community mental health teams were in their infancy and individuals were not coming together routinely to discuss referrals or particular clients. Also there appeared to be several sets of notes based in different places. Had the team been more developed, it is possible that some of the errors in procedure outlined above would not have occurred, including those around CPA, copying correspondence, route back into service and informal discussions.

A Clinical Psychology Manager stated that:

> *"We were fairly peripheral part-time members of the CMHTs, but we were part of the CMHT meetings. But there were not at that time an allocated psychiatrists; the psychiatrists were a separate service and they did not have clear CMHT allocation themselves."*

There were discrepancies in the history taken by the various professionals involved in OS's care, mainly in that there are omissions in the accounts he gave. It may have be that had the notes been kept together these discrepancies would have been spotted.

For example, the Clinical Psychologist recorded that:

> *"OS reported that his best friend had died of cancer in November 2003. He reported that his friend was the only person he could talk to and who he felt listened to him".*

However, the first Consultant Psychiatrist who saw OS in 2000 – 2001 wrote in a letter dated 20th October 2000:

> *'As you there* (sic) *were recent stresses related to the health of their son and the death of a friend of his three years from* (sic) *bone cancer'.*
>
> There are also discrepancies around the effect of alcohol (in particular whisky) and the extent of previous domestic violence.

RECOMMENDATION

The Independent Investigation recommends that the Trust:

- ❒ **Ensures that in its development of integrated multi-disciplinary teams clinicians work with a shared clinical record.**

COMMENT
Throughout her interview with the panel it was apparent that the Clinical Psychologist had recognised most of the issues picked up by the panel and has since sought to address them. There appeared to be some time pressure on the Clinical Psychologist and this may have had an impact on the number of sessions given to OS. Time needs to be built in to support planning, documentation, discussion, scrutinising old notes and indirect clinical work. If there is a waiting list for psychology this needs to be addressed in different ways, other than increasing turnover of patients seen. This pressure does not seem to have been part of the clinical decision made to discharge OS from psychology but it may have impacted indirectly by influencing the time spent looking at old notes. Had more time been allocated to this it is possible that additional risk factors would have been noted and the risk assessment carried out might have indicated higher risk.

CHAPTER 9

OS AND DOMESTIC VIOLENCE

BACKGROUND

Over the last thirty years social attitudes to domestic violence in the UK have changed. The issue was once regarded as a private matter, where by a 'domestic' was rarely seen as requiring a response from the criminal justice system. There are now police Domestic Violence Units in most areas across the UK. The first woman's refuge was opened in Chiswick in 1971. There are now over 400.

Domestic violence is not restricted to physical violence, it may include psychological, emotional, sexual and economic abuse and these may occur together or separately within the same relationship. It can be defined as "*any incident of threatening behaviour, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality*" (Tackling Domestic Violence: The Role of Health Professional 2nd edition Home Office Practice Report 32).

Whatever form it takes, domestic violence is rarely an isolated incident. More usually there is a pattern of abusive and controlling behaviour whereby the abuser seeks to exert power over their victim. Domestic violence occurs across the whole of society, regardless of age, gender, race, sexuality, wealth and geography. However it consists mainly of violence by men against women, although there is a rising number of men who are attacked by their female partners.

Domestic violence has more recurrent victims than any other crime. It is sad to say that on average the victim will suffer 35 assaults before they report violence to the police. One hundred women, and thirty men, die each year in the UK as a result of domestic violence. It is reported that domestic violence affects 1 in 4 women and 1 in 6 men. (British Crime Survey 1998).

It is ten years (1996) since the Chief Medical Officer highlighted the problems associated with domestic violence in his annual report. The following year a joint letter by Sir Herbert (now Lord) Laming, the Chief Inspector of the Social Services Inspectorate and Dr. Graham Winyard, Director of Health Services (NHS Executive)

was sent to all health authorities and local authorities, with a strategic framework for helping staff identify domestic violence. The Home Office published multi-agency guidance for addressing domestic violence in 2000. (*Domestic Violence: Break the Chain. Multi Agency Guidance for Addressing Domestic Violence).* The Domestic Violence, Crime and Victims Act received Royal Assent in November 2004.

Worldwide, domestic violence is the commonest cause of death in women aged 19-44, greater than war, cancer or road traffic accidents. Research has also shown that children who either witness or overhear incidents of domestic violence can be deeply affected. Children are in the same or the next room in 90% of incidents occurring within families.

In this case, there were children present when the assault on Fiona's brother-in-law took place in January 2004. OS's children were in the house on the 3rd January 2005 together with another child who stayed the night that Fiona was killed.

There is an association between excessive drinking and domestic abuse. Alcohol causes disinhibition and intoxicated people display behaviours ranging from 'being a fool' to becoming aggressive or violent. OS drank alcohol regularly. He told us that his intake was no more or less than anyone else he knew, and that many of his friends could drink him under the table. Fiona did not like him drinking whisky and she had asked her father not to give it to him. OS had been drinking steadily on the day when he assaulted Fiona's brother-in-law. His blood alcohol level was more than three times over the legal limit for driving on the morning after he killed Fiona. He had been advised not to drink alcohol. He told us that, as he did not believe that he drank to excess, he took little or no notice of this advice. As early as 2001 OS and Fiona gave differing accounts of his drinking habits. She did concede that he had drunk more heavily in the past and that part of the family folklore was of her husband getting drunk and doing silly things.

OS tended to minimise his drinking when talking to professionals. He also minimised the extent to which he had been violent towards Fiona. When interviewed by the Consultant Forensic Psychiatrist in April 2001, he initially denied assaults on Fiona but subsequently admitted to hitting her on two occasions after he had been drinking. When the Consultant Forensic Psychiatrist later asked Fiona about the same issues, she said that he had been violent towards her on four occasions, usually when he

had been drinking whisky. She said that he had kicked her on one occasion and that there had been three instances when he had hit her.

In late 2001 Fiona ran away from the house claiming that OS had tried to smother her. The police were involved but Fiona would not press charges. The police apparently could find no signs of injury. OS has continued to deny that he ever smothered Fiona.

In addition to physical abuse, OS taunted Fiona about her weight. She dieted and before she died had lost three stone in weight in the previous year. OS also made 'passes' at two of Fiona's sisters some years prior to her death and apparently showed a lot of interest in her best friend even after he went to prison. What effect his attention to her sisters may have had on Fiona or whether she knew about this is unknown.

The links between domestic violence and alcohol consumption are well known. Following OS's conviction for assaulting Fiona's brother-in-law, insufficient time was spent in dealing with his anger and then his ability to cope with aggression. His treating Consultant, Consultant Psychologist and the Probation Service appeared to assume this was a 'one off' event without exploring his anger in any great detail.

Staff working in mental health services need to have a good understanding of what constitutes a 'domestic' issue and how that impacts on mental wellbeing, if they are to deliver safer mental health services. There was no specific training in domestic violence for the services in Rugby nor did it appear to us that staff were familiar with Warwickshire Police's Policy and Procedures in cases of domestic violence. Staff also need training in risk assessment of the abuser and victim where there is reported domestic violence and they come to the attention of the mental health services.

RECOMMENDATION

The Independent Investigation recommends that the Trust should:

- ❒ **Enable all practitioners to work to an appropriate Domestic Violence Strategy having undertaking a multi-agency training programme taking into consideration the Warwickshire Constabulary policy.**

CHAPTER 10

THE TRUST'S INTERNAL INQUIRY

A 1994 Department of Health Circular, *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community* HSG(94)27, stated that, in the event of a violent incident, '*an immediate investigation should be carried out to "identify and rectify possible shortcomings in operational procedures, with particular reference to the Care Programme Approach*"'.

In 2000, further guidance, *An Organisation with a Memory,* was issued to encourage NHS organisations to take an open and transparent approach to such investigations. This was followed by guidance which set out the principles for clinical governance, *Building a safer NHS for Patients*. Clinical Governance has been defined as *"a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."* (*A First Class Service: Quality in the new NHS Department of Health 1998)*. Trusts are obliged to investigate all serious adverse incidents and to publish their findings. This should include recommendations to improve the service for future patients and to strengthen staff confidence.

This Investigation Team was asked to review the Internal Inquiry regarding OS's mental health care with the following terms of reference:

"To review the Internal Inquiry into the care of OS already undertaken by North Warwickshire Primary Care Trust any action plans that may have been formulated, including the immediate remedial action taken at the time of the incident, or action taken as a result of the Internal Inquiry and assess the effectiveness of their implementation"

An Associate Medical Director, who was a Consultant Psychiatrist, and the Head of Psychological Services, who was a Consultant Clinical Psychologist, were asked to undertake this task under the terms of the Serious Untoward Incident policy of North Warwickshire PCT. They told us that clinical governance arrangements were embryonic in January 2005 and that there had been no previous significant serious

incident since they had been in their managerial positions. They had had no formal training in investigation procedures, for example Root Cause Analysis. Having now received such training, they feel it would have been helpful in completing their investigation. Because there were only two clinicians involved (the psychiatrist and psychologist), it was decided that the investigation should be carried out by the leaders of those professional groups. They were also their line managers.

A managerial decision was taken to act promptly. The Inquiry was therefore completed very quickly.

COMMENT
It is considered good practice to conduct an immediate management review of any serious untoward incident by recalling the records to make sure that the service concerned is safe for both patients and staff. This should not be confused with an Internal Inquiry/Investigation which should be conducted in an objective manner to encompass any external issues such as involvement of general practice. It is not good practice for line managers to investigate their own staff. The task should have been given to other senior professionals in the Trust who had the necessary skills.

Internal Inquiry Process

Interviews with OS's Psychiatrist and his Psychologist were carried out. The Forensic CPN who saw OS in the police cells was also interviewed. No formal notes were kept, but each investigator kept rough notes. The interviewees were not asked for statements prior to their interview. The Investigating Team reviewed the written clinical notes, the EPEX electronic patient record, the CPN notes and all correspondence, including the court report, a referral for a forensic opinion made after Fiona's death and the subsequent letter from a Consultant at the Reaside Clinic.

Interviews with the three members of staff were conducted on 20th January 2005. The content of the report was discussed with the two main clinicians before it was completed. As the Internal Inquiry was completed before OS went to trial, its contents were regarded by the Trust as being sub-judice. The Trust therefore took the decision not to share the contents with either of the clinicians, and regarded the

document as confidential. This was unfortunate as there were errors of fact in the report which could not be challenged by the clinicians involved. For example, there were errors with regard to the number of appointments attended or cancelled by OS.

COMMENT
None of the practitioners were given the opportunity to read the report and therefore properly comment on its contents. The report had some inaccuracies such as the number of appointments with each of the clinicians

Conclusions, Recommendations and Outcome of the Internal Inquiry

The Internal Inquiry regarded some aspects of OS's care to have represented good practice:

1) Clinical Management

In terms of clinical care OS appears to have received good assessment and intervention during this contact. Issues of risk were overtly on the agenda in his contacts and the second Consultant Psychiatrist was also able to include his wife in these discussions. He received a comprehensive assessment, a plan was devised and implemented and he was discharged by mutual agreement.

COMMENT
We accept that care was taken over assessment and treatment. However, whilst the Internal Inquiry had access to much less information than we have, the shortcomings in risk assessment and in the court report should have been apparent to them. The short period of follow up by the Consultant Psychiatrist (in contrast to the earlier plan set out in letters to the GP and the court report) and the failure to obtain a forensic opinion were further issues that could and should have been identified in the Internal Inquiry. The Psychologist failed to include previous psychiatric records in her assessment and relied totally on self reporting. The planned number of sessions was reduced by a third. The second Consultant never saw Fiona without her husband. It was the Consultant's practice to give the spouse/ partner the choice. Our view was that the Consultant should have been more proactive in seeking to see Fiona on her own and discuss any risk issues with her. The Psychologist never met Fiona, leaving it to OS as to whether she attended an appointment.

2) Diagnosis and Treatment

There is significant consensus about the formulation/diagnosis and treatment plan in this case. The view that OS was not mentally ill but that he and his wife were experiencing serious strains in their marital relationship combined with other stresses such as looking after their son seems to be shared by all professionals. There is also consensus that OS often felt inadequate and struggled to maintain his status and self-esteem. There also seems to be agreement that his wife was a strong personality who was felt by OS to be dismissive and disrespectful of his needs and feelings.

COMMENT
The statement that OS was not mentally ill echoes the psychiatrist's use of the phrase 'no medically treatable mental illness'. Trained investigators would have recognised the risk of over-reliance on the clinicians' assessment of the case. The issue of whether OS was mentally ill or not seems to us to be a semantic nicety. Even if one accepts that he was not mentally ill, it would make very little difference to our opinion regarding short comings in the care that he received.

3) Risk

Risk was fully assessed by both the Consultant and Psychologist in 2004 and by the forensic Consultant previously. The professionals involved do (with good evidence) conclude there was not a high risk to Fiona or to others. Those risk factors that were in place such as the poor quality of the marital relationship, poor insight and lack of self management techniques were addressed in the treatment plan. OS was also advised about his use of alcohol. There are in fact several references to the role that alcohol played in disinhibiting potential outbursts of aggression. There is also evidence that this concern was shared with OS. There was no evidence at the point of discharge or during psychological therapy that OS posed a serious risk to his wife.

COMMENT
We have fully set out the deficiencies in risk assessment in Chapters 7 and 8. The Internal Inquiry had access to information with regard to the assault on the brother-in-law and the previous fantasies of violence. The Inquiry should have clearly identified the fact the judgement that OS was at low risk of committing violence was erroneous, and that the significance of some major risk factors had been overlooked. This repetition of risk assessment errors has left us with the clear impression that there is a poor understanding of risk assessment and risk management throughout the service.

4) Psychological Therapy

Psychological therapy in the form of helping Mr 05/01/OS1(R) to gain an insight into the sources of the stress and strains that he was experiencing and improve the management of these symptoms by CBT, was both appropriate and well implemented. Self management approaches based on OS developing insight are also fully described in the notes (28.07.04 and 11.08.04)

COMMENT
There are several specific points made in the Internal Inquiry which are disputable. In particular, the Independent Investigation Panel would conclude that: a) Insufficient sessions were carried out to allow for a thorough course of CBT. The planned number of sessions were reduced by one third. b) The efficacy of the intervention may have been improved if literature and homework had been utilized, and information repeated c) The discharge report was inadequate and poorly communicated to other colleagues and he was unaware how to access the service again. d) Despite the Psychologist having completing the training for HCR-20 assessments, the principles of this were not adhered to. In particular the need to access previous notes and to work with other team members to compile a thorough assessment, formulation and management plan. Risk factors were missed, including previous episodes of domestic violence and the fact that he had acted on his previous thoughts. Too much emphasis was placed on self reporting. e) Risk assessment was inadequate and not appropriately managed. f) The clinical notes did not clearly document the interventions described during the external process.

5) The Service provided by Psychiatry and Psychology Services

The service provided by Psychiatry and Psychology Services was based on good clinical assessment, good formulation/diagnosis, good treatment plan, good implementation of treatment plan, was well communicated with the patient and was delivered in a timely and efficient manner. OS was also given advice about how to access help in an emergency out of hours and how to get back into the service post discharge.

COMMENT
There was conflicting evidence around the route back into the service that was given to OS. It was possible that he was given the impression that he could telephone the Consultant Psychiatrist but when he tried to do this he found that the existing system required him to be re-referred by his GP. In our opinion, the assertion that the service received by OS was good was unsustainable on the basis of the evidence available at the time. Whilst a good deal of effort had been made to help him (albeit over a short period), and whilst the clinicians were, in our opinion, well intentioned and hard working, there were major and obvious deficiencies in the standard of service offered to OS. We recognise that it would have been difficult for the Internal Inquiry team to pass harsh judgments on close colleagues in the aftermath of a traumatic clinical disaster. However, in our opinion, there were deficiencies in the standard of care that should have been identified by the Internal Inquiry.

The Internal Inquiry identified some areas of concern:

1) Care Programme Approach

The documentation did not comply with the standard CPA requirements of the Trust and no formal care co-ordinator was agreed. It was the opinion of the review team however that this lack of compliance did not adversely affect the care he received. This conclusion was based on the thorough analysis of the case record. It was clear that assessment, diagnosis, formulation, intervention plan, risk management plan and risk assessment was all addressed. However, due in part to the lack of a good CPA structure, the record was not well structured. This would have been particularly problematic if a wider multi-disciplinary team had been involved in OS's care at any time as the lack of CPA structure made the identification of key pieces of information or conclusions much more difficult.

There was no clear understanding in practice or in the record as to who was the care coordinator in this case. Since the launch of CPA there had not been any update training sessions on the role and use of CPA targeted specifically at medical staff. A lack of clarity about who takes care co-ordinating roles for standard CPA clients in contact only with psychology and medical staff was apparent.

COMMENT
We agreed that the lack of a functional CPA process made good communication difficult. We also accept that this was one of several systems failures that have been highlighted by the two independent inquiries into the service. However, we do not accept that the failure to communicate had no effect on the quality of OS's care, for example, it is highly likely that improved communication would have prompted a forensic assessment of risk The Care Programme Approach (CPA) was first introduced in the UK by the Department of Health in 1991. It is the framework for providing care for all service users accepted by the specialist mental health services in England. It includes care management - the care planning process of the Local Authority - with whom mental health services are often delivered through partnership arrangements. Despite CPA being introduced in April 1991, with a view to improving the delivery of care to individuals with severe mental health problems, many services around the United Kingdom are still striving to achieve more effective processes in this respect. Indeed we heard that the Community Psychiatric Nurses were still using their own nursing model. CPA was introduced as an effective way of communicating between practitioners and involving patients in their care planning. CPA should be the underpinning structure for providing care that runs through every clinical team, whether they are based within the Community or Inpatient Services. To this end the four key elements that make up the CPA process are: 1. The assessment of an individual's health and social care needs. 2. The development of a Care Plan which meets those needs. 3. The need to identify a professional within the mental health service who is responsible for co-ordinating the Care Plan. 4. A regular review of progress and the effectiveness of the Care Plan. Following referral and initial assessment, each service user, in need of a service, is allocated to a level of CPA. In 2001, Dept of Health revised guidance was issued requiring that there should be two levels of CPA, which are intended to meet the different levels of need.

COMMENT cont …

The following indicate some of the differences between the needs of people on either level.

The characteristics of people on Standard CPA are:

- ❑ They require the support and intervention of one agency or discipline or low key support from more than one agency or discipline.
- ❑ They are more able to self-manage their mental health problems.
- ❑ They have an active informal support network.
- ❑ They pose little danger to themselves or others.
- ❑ They are more likely to maintain appropriate contact with services.

The characteristics of people on Enhanced CPA are:

- ❑ They have multiple care needs that require inter-agency co-ordination.
- ❑ They may be in contact with a number of different agencies and have multiple care needs.
- ❑ They are likely to require more frequent and intensive interventions.
- ❑ They are more likely to have mental health problems co-existing with other problems such as substance misuse.
- ❑ They are more likely to present a significant risk to themselves or others because of their mental health problems.
- ❑ They are more likely to disengage from services in an unplanned way.

OS would have been considered to be on Standard CPA and the Consultant Psychiatrist would have been the Care Co-ordinator and therefore responsible for OS's care plan. We know that there were administrative difficulties at the time OS was being seen by the Consultant Psychiatrist and Consultant Psychologist. This may have led to the Consultant Psychologist being unaware that OS had been discharged back to the GP as the discharge letter was not copied to her.

We also heard that the current CPA policy is 26 pages long and until this incident the doctors had had no training.

RECOMMENDATION

The Independent Investigation recommends that the Trust:

- ❑ **Reviews its CPA policy in light of best practice and introduces mandatory multi-disciplinary training.**

2) Communication

Contact between the two practitioners involved following the first referral letter was informal and therefore not well documented. There was a discrepancy between the two practitioners accounts of how much discussion there had been between them. The usual practice of copying all letters sent to the GP to other professionals involved in the care did not occur. In a small unit a lot of communication takes place on an ad hoc basis and informally. Whilst this undoubtedly helps team working at one level it does mean that at times accurate records of agreed plans are not always kept and may lead to discrepancies between practitioners. There was lack of consistent administrative support.

COMMENT

The Internal Inquiry used the EPEX system to count how many times OS was seen by the professionals involved in his care. This has led to inaccurate numbers of sessions being recorded for both Consultant Psychiatrist and Clinical Psychologist. It was not possible to ascertain why this inaccuracy occurred but it might be that cancellations and/or DNA's have been recorded on EPEX as episodes when the patient was seen. It is also not clear whether EPEX entries should have informed the Clinical Psychologist that OS had been discharged from the care of the Consultant Psychiatrist. In general it was not clear from the Inquiry how the electronic system is used in the Trust. It seemed to us that it was used as an administrative tool rather than in a clinical capacity. EPEX should be used to communicate risk, although this would require clinicians to make entries onto the system rather than delegate to the administrative staff.

We would agree that communications were not as they should have been. There was also some discrepancy between the two clinicians as to how much informal discussion there was - being based in separate buildings should not be a barrier to good communication. No doubt the introduction of community mental health teams with associated psychology support or perhaps psychologists being integrated into teams rather than being based separately will help this process.

There are several different models available throughout the country regarding how professional groups come together as a community mental health team. The Trust should review these and consider the pros and cons of full integration of services into teams versus partial integration of an association between professional groups.

Good administrative support is almost as important to the delivery of high quality patient and good clinical input.

COMMENT cont …
Better communication may have resulted in a forensic assessment being sought. A multi-disciplinary discussion may have alerted clinicians to the potential of future violence.

RECOMMENDATION
The Independent Investigation recommends that the Trust: ❑ **Reviews the use of the electronic record. EPEX should be used to communicate risk between professionals rather than being used as a numeric exercise and provides training for all staff.**

INTERNAL INQUIRY CONCLUSIONS

1. *The Internal Inquiry concluded that OS received good and appropriate intervention which was based on a thorough assessment, skilled formulation and good intervention delivered with the active engagement of OS to a point when discharge was both appropriate and agreed.*

COMMENT
We do not agree with these conclusions. We have set out in previous chapters the flaws in assessment and intervention in the case, many of which should have been evident at the time of the Internal Inquiry.

2. *There is no evidence to support the view that the client was suffering from underlying mental illness. There were however clear emotional, psychological and relationship problems.*

COMMENT
Even if one believes that OS was not mentally ill, there was some evidence to the contrary. This statement was therefore inaccurate.

3. *The CPA process in terms of review, care co-ordination, communication and recording fell short of necessary standards, although it is not felt that this negatively effected the care the client received.*

COMMENT
We agree with this finding. However, our view is that this may have had a negative effect on the care OS received as outlined in our previous findings under both communication and the care programme approach.

Internal Inquiry Recommendations

1. *Clarification of procedures for the operation of standard CPA when clients are open only to psychiatry and psychology.*

2. *Refresher training for staff relating to standard CPA requirements.*

3. *Administrative support for medical staff at the Linden unit needs to be reviewed as a matter of priority. Procedures for handling patient information need to be agreed and written down so they can be followed by temporary staff if the situation arises.*

Outcome of Internal Inquiry

The Service Director reviewed the report. It was than submitted to the Directorate Governance Board for scrutiny and approval (see Appendix 5). The report was further submitted for final scrutiny to the PCT Serious Untoward incident Committee who endorsed the report and recommendations. The Director of Integrated Governance assessed whether a second investigation by the PCT using root cause analysis methodology, involving the GP and Relate would add any more value.

In the end it was decided not to go ahead with this process as the interviews were deemed to be "thorough" and the authors of the report had completed a "detailed review of the notes". The senior clinical team concluded that to conduct a second Internal Inquiry was likely to add significant additional distress to the two staff involved and unlikely to yield any further information. The Trust's Chief Executive also reviewed the report before it was sent to the Strategic Health Authority in June 2005. She also confirmed that she was satisfied that all the necessary actions had been undertaken. The Service Director sent an accompanying memorandum, outlining the content of the report.

COMMENT

It was unfortunate in this memorandum that the assault or "glassing" on Fiona's brother-in-law, which resulted in approximately 30 sutures required to deal with the wound to his throat and jaw, was described as an "altercation".

The Director of Public Health wrote back, saying that it appeared to him that the incident had been well investigated, although he had a concern that as OS had been referred to the forensic service in 2001, perhaps he should have been re-referred in 2004 after he assaulted Fiona's brother-in-law. He proposed that an Independent Investigation would have to be completed following the Court verdict.

The Investigation Team's Conclusions of the Internal Inquiry

We considered this review to be more of a management review rather than an Internal Inquiry. We accept that the two senior members of staff had no previous experience of completing such an inquiry and may well have found it difficult to be critical of their colleagues, who they also line managed. Of course the Trust was quite correct to ensure that there were no serious failures and identify any shortcomings that required immediate attention. However, there is enough evidence from other mental health Trusts of how to conduct the process so that practitioners feel that they have had an opportunity to explain their position. Managers from another service should be asked to take part in any investigation so that issues of line management do not cloud the situation. More frequently a non executive directive is asked to chair the investigation.

It is good practice to provide interviewees with:

a) the terms of reference
b) an outline of areas for discussion
c) the possibility of providing a written statement
d) the ability to bring a supporter
e) a copy of their written notes

All interviews should be noted and a copy sent to individuals for correcting and agreed as the record of the discussion. The draft report should also be sent to all interviewees for checking as to the accuracy of the factual content. If this had

happened in this instance, then the errors in the number of appointments could have been corrected.

One of the senior officers tasked with the Internal Inquiry referred to their effort as naïve but this view was not shared by the other person. It would appear to us that they lacked support in this task or did not request it.

Support for Families and Staff

Recent research has demonstrated that the current homicide rate is approximately 800 per year with about 50 homicides being committed by people who have been in contact with mental health services (Maden 2006).

Families involved in this kind of tragedy are often left to support each other. Families often have to rely on the Family Support Officer, a police officer appointed at the time of the criminal investigation.

Domestic homicide often causes surviving members of the family to feel confusion and guilt. They sometimes feel that they should have been able to prevent the tragedy. They often feel belittled and stripped of their self respect when the media expose their family life and private grief to public gaze.

For this reason both families and carers need help with dealing with the crisis they find themselves in and reassurance about future action to be taken. The Investigation Team do consider that early contact with, and offers of support to a victim's family in the aftermath of an incident such as this, is very important and should be documented. A senior member of the management team should be tasked to carry this out,

Family members were not contacted by the Trust or involved in the Internal Inquiry. The process of making contact with victims' families has, in the past, been seen as difficult, through fear of admission of liability or breach of medical confidentiality. There has also been concern that such contact could be seen as intrusive by some families.

Whilst recognising that the health services may not have all the details of families concerned in these matters, we consider that more effort should be made to contact and to keep families informed of the inquiry process. There should also be the offer

of appropriate counselling and support services, if required, to anyone caught up in the incident.

We do know that the Social Services did contact the PCT to provide support to the grandparents who are now caring for the children. We can only hope that the grandparent's task has been made a little easier.

This investigation has also brought to light a similar lack of support for general practitioners. The victims of the two homicides in January and February 2005 were patients of the same general practice. During the previous investigation and this one, we interviewed two doctors from the GP Practice and both told us that the PCT had not been in touch with them. The only way that they gleaned any information was from the victim's family member or the media. The primary care contribution to the management of mental health patients in the community should not be underestimated. They should be asked for their contribution to any Internal Inquiry. They often hold vital information for example regarding families or the use of medication. It would appear that the GP was left out of all formal communications, whether these involved the health services or the Police.

RECOMMENDATION

The Independent Investigation recommends that the Trust:

- **Comprehensively reviews its Serious Untoward Incident processes to take account of a more open approach to help staff and families. A new approach will ensure that:**
  - **a senior person makes contact with families who are the victims of serious incidents;**
  - **staff are able to take account of the sensitive nature of support required, seeking guidance from and including the various voluntary agencies such as Victim Support in the preparation of the training programme;**
  - **staff are both competent and confident when dealing with serious untoward incidents is enhanced;**
  - **a supportive framework is available – to include counselling if necessary, adequate time for briefing and the opportunity to receive feedback as well as full discussion about any action plan which has to be implemented.**

RECOMMENDATIONS cont …

- **the internal processes must take account of the contribution other practitioners have played in the care of patients such as general practitioners Probation Services and other Statutory or non statutory agencies.**

CHAPTER 11

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

With the benefit of hindsight, the Investigation Team thought it highly likely that OS's beliefs about the relationship between Fiona and her brother-in-law were not fully resolved in the four and a half years following his first referral to the mental health services in Rugby. It is likely that, from time to time, it was not immediately obvious to those outside of the immediate family that he remained convinced that his wife was having an affair. During the second contact with the mental health services, it should have been evident that there was a risk of further violence. However, we do not believe that it could have been predicted that OS would kill his wife.

There were some deficiencies in the delivery of care. We cannot exclude the possibility that, if certain actions based upon first principles of mental health practice had been taken, the homicide may not have occurred. We found and concluded the following:

1. In our opinion, the Court Report prepared for OS's court appearance in March 2004 could have been misleading. In particular, it did not mention all the available information that was pertinent to the assessment of the risk of further violence, especially his previous fantasies of cutting the brother-in-law's throat and his previous history of assaults on Fiona. It also referred to a "cut on the chin" rather than a wound requiring many sutures.

2. In our opinion, the ominous significance of the assault on Fiona's brother-in-law was not recognised by the practitioners treating OS or by the Judge who sentenced him in March 2004.

3. We were surprised that the Judge did not impose a Probation Order. It was implied in his Judgement that he had done so. If this had happened then OS would have had to participate in work to confront his violence and its relationship to his consumption of alcohol.

4. We found OS to be charming and engaging. However, we also found him to be skilful in avoiding uncomfortable truths about himself. We felt that it was

highly regrettable that, during his second episode of care, no truly independent collateral account of his behaviour was obtained.

5. The Consultant Psychiatrist should have insisted on interviewing Fiona on her own. This would have allowed her to obtain the necessary account of OS and also would have allowed her to warn Fiona of the possibility of violence against her, especially if she ever said anything that OS would take to confirm his suspicions. It is impossible to know if this would have made any difference to the outcome. The Consultant Psychiatrist told us "*From personal experience with people I have advised, counselled and dealt with, where there has been domestic violence, relationships very seldom improve. I have thought about it carefully, because, again, hindsight is a wonderful thing and one of the things that has upset me most is whether I should have in some way advised Fiona to leave him. That is what my advice as a friend would have been, but as a doctor it is a different situation*".

6. We are concerned that OS's alcohol consumption was not explored sufficiently and with a degree of vigour, during his second episode of care, given that there was a history of violence whilst intoxicated.

7. An early decision to refer OS for a forensic opinion was never acted on. The reasons given to us for failing to make such a referral or to check whether the referral had actually been made, appear to us to be inadequate. Such an opinion would have made a significant contribution to the assessment of risk.

8. Communication between the two practitioners was poor. They have different recollections as to whether there was any discussion between them about the case. We believe that the level of communication between them was inadequate. Not all of the correspondence with OS's GP was copied between them. Consequently, the Clinical Psychologist was not involved in the Psychiatrist's decision to discharge OS, and she didn't learn of the decision until after the event.

9. The Internal Inquiry, although timely and quickly completed, failed to recognise significant failures of safe practice. It did not fully explore the

adequacy of the assessment and interventions of the two practitioners. In our opinion, some of the conclusions were erroneous.

10. The Internal Inquiry process did not allow for any support for the staff concerned, such as bringing a colleague or representative, although we recognise that the Consultant Psychologist was well supported as an individual. The GP felt left 'out in the cold' and had to deal with the family's grief and anger alone.

11. When he was discharged by the Psychiatrist, OS was not given clear information as to how he could access the mental health service in future. Consequently, when he asked for help again he was told to go back to his GP. An opportunity for intervention was lost.

12. The Care Programme Approach (CPA) has been national policy since the early 1990s, but it was so ineffective and confused as applied in Rugby that it was never clear who was OS's care coordinator.

13. The mental health services in Rugby appear to have had difficulties for some years with poor administrative support for doctors, the deaths of some key staff and a reliance on locum doctors. The service does not appear to have been well supported by senior managers in the Trust. In our opinion, this failure to respond to significant and persistent problems in an isolated service contributed to the service's inability to respond appropriately to two patients who, in very different ways, showed clear signs of being at high risk of behaving violently, and then went on to kill.

RECOMMENDATIONS

Staff are at the heart of a high quality mental health service and need to be valued, nurtured and supported. It is inevitable that some staff will feel disheartened by this report but none the less there are some recommendations that we feel will help them and their managers to build safer services.

The Independent Investigation recommends that the Trust should:

1. Ensure that, as part of the clinical governance policy, medical staff, within the service in Rugby, have sufficient time to meet with their peer group regularly for managerial and educational activities, and that such attendance should be monitored - (Chapter 7).

2. Ensure that all staff of all disciplines, including Consultant Psychiatrists, participate in an externally provided training with regard to risk assessment and risk management, including evaluation of the impact of such training on individual clinicians competence in these areas - (Chapter 8).

3. Ensure that all telephone calls requesting help should be noted and professionals made aware of clients asking to see them. The decision as to whether someone needs to be re-referred should be made on an individual basis by clinicians who know them and are aware of the risks. It is possible that if either clinician had been aware of his telephone call they would have fast-tracked an appointment - (Chapter 8).

4. Review the rationale for asking people to go back to their GP in order to be re-referred. Where the development of a trusting relationship is seen as a vital protective factor, there should be a more direct route back for certain people - (Chapter 8).

5. Ensure that all clinicians are familiar with local Trust policy and procedure regarding record keeping and with documents relating to their own profession e.g. Clinical Psychology and Case Notes: Guidance on Good Practice (Division of Clinical Psychology, British Psychological Society, 2000). Supervision records should be kept and discussions recorded. There should be entries made in the clinical notes when clients have been discussed in supervision - (Chapter 8).

6. Ensure that in its development of integrated multi-disciplinary teams clinicians work with a shared clinical record - (Chapter 8).

7. Ensure that clinical psychologists are able to allocate enough time per client for reflection, note writing, report writing and planning - (Chapter 8).

8. Enable all practitioners to work to an appropriate Domestic Violence Strategy, having undertaking a multi-agency training programme taking into consideration the Warwickshire Constabulary policy - (Chapter 9).

9. Review the application of the local CPA policy to ensure that it reflects both the Department of Health (1999) Guidance, and the experience of best practice within mental health services nationally. This should include:

   a) The development of a system which ensures that all information relating to the care and treatment of a person in contact with services is available to all the practitioners involved. It should be accessible across all disciplines and equally applicable to Health & Social Care.

   b) Work to ensure that the CMHTs in Rugby work to a proper multidisciplinary model, and that all staff involved in a patients care are involved in key decisions, such as discharge and demonstrate their working together through the use of a shared clinical record - (Chapter 10).

10. Review the use of the electronic record. EPEX should be used to communicate between professionals rather than simply be used to collect activity data. The Trust should provide training for all staff in the use of EPEX - (Chapter 10).

11. Comprehensively review its Serious Untoward Incident processes to take account of a more open approach to help staff and families. This will ensure that:

   a) a senior person makes contact with families who are the victims of serious incidents;

   b) staff take account of the sensitive nature of support required, seeking guidance from and including the various voluntary agencies such as Victim Support in the preparation of the training programme;

   c) the level of competence and confidence of staff, when dealing with serious untoward incidents is enhanced;

d) a supportive framework is provided - which includes counselling if necessary, adequate time for briefing and the opportunity to receive feedback as well as full discussion about any action plan which has to be implemented - (Chapter 10).

12. Consider all the comments made in this Report and amend Trust practices and processes accordingly.

APPENDIX 1 : PROCEDURE TO BE ADOPTED BY THE INDEPENDENT INVESTIGATION TEAM

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing them:

   (a) of the terms of reference and the procedure adopted by the investigation; and

   (b) of the areas and matters to be covered with them; and

   (c) requesting them to provide written statements to form the basis of their evidence to the investigation; and

   (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the investigation; and

   (e) that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another investigation witness; and

   (f) that it is the witness who will be asked questions and who will be expected to answer; and

   (g) that their evidence will be recorded and a copy sent to them afterwards to sign;

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the investigation's consideration.

5. All sittings of the investigation will be held in private.

6. The findings of the investigation and any recommendations will be made public.

7. The evidence which is submitted to the investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the investigation.

9. Comments, which appear within the narrative of the Report and any recommendations, will be based on those findings.

APPENDIX 2 : PROPOSED ELEMENTS OF A DOMESTIC VIOLENCE POLICY

1. Establishment of a multi-agency steering group to ensure co-operation of all agencies working within and with mental health services

2. Set up of a 'Standing Together' group in health centres to include mental health practitioners

3. Produce training in DV Awareness for all community practitioners and produce a Guidance and Good Practice pack.

4. Train key staff to 'ask questions' of how to respond to likely victims; to make appropriate referrals; to record and monitor incidents and any previous visits to A&E.

5. Develop a procedure for Health staff re. Domestic Violence similar to the one they have found helpful for Children at Risk.

6. Identify problems in supplying prompt medical evidence for prosecutions & test solutions.

7. Secure services of a Health Professional to provide expert reports for victim impact statements to Court.

8. Offer wide range of Advocacy services re. Housing, Welfare, Child safety, Immigration.

9. Offer Group work in rolling programme of workshops & group support to help women come to terms with their experience, extending current service to a workshop per week.

10. Monitor cases from first contact with Health Authority, to identify ongoing good practice.

11. Consult women on their perceptions of increase in their safety.

Principles of Good Practice

1. Ensuring safety for users
2. Maintain confidentiality
3. Ensure appropriateness of procedures to clients and their needs
4. Ensure elements of policy are appropriate to all health care settings
5. Recognise links between domestic violence and child protection

6. Develop protocols based on known good practice which will encourage early disclosure and ensure appropriate responses.

7. Strengthen relationships and information exchange between existing Agencies.

8. Ability to monitor and evaluate protocols using existing audit tools within a Clinical Governance framework in any agency.

9. Establish referral routes to the voluntary sector.

10. Improve the quality of evidence collected by the voluntary sector.

11. Increase the number of referrals to the police and subsequent prosecutions so reducing repeat offending.

APPENDIX 3 : DOCUMENTATION RECEIVED PERTAINING TO OS

- ❒ Court Transcripts
- ❒ GP Records
- ❒ HMP Blakenhurst Records
- ❒ Reaside Medium Secure Clinic Records
- ❒ Police Records
- ❒ Social Services Records
- ❒ Trust Documentation/Records
- ❒ Trust Policies and Procedures

APPENDIX 4 : NATIONAL POLICY DOCUMENTATION AND OTHER DOCUMENTS CONSIDERED

A National Service Framework for Mental Health – Dept of Health1999

An Organisation with a Memory – Report of an Expert Group on Learning from Adverse Events in the NHS – 2000

Breaking the Circles of Fear : A Review of the Relationship between Mental Health Services and African Caribbean Communities – Sainsbury Centre for Mental Health 2002

Building a Safer NHS for Patients – Implementing an Organisation with a Memory - 2001

Building Bridges – A Guide to Arrangements for Inter-Agency working for the Care and Protection of Severely Mentally Ill People – 1995

Code of Practice Mental Health Act 1983

Code of Practice Mental Health Act 1999

Delivering Race Equality – A Framework for Action : Mental Health Service Consultation Document

Domestic Violence A National Report Delivering Services for Survivors of Domestic Violence: the Government's Progress and further action 2005

Domestic Violence – A National Report (March 2005)

Effective Care Co-ordination in Mental Health Services – A Policy Booklet

From Values to Action: The CNO's Review of Mental Health Nursing (DoH – April 2006)

Guidance – "Independent Investigation of Adverse Events in Mental Health Services" – an amendment to paragraphs 33-36 (pages 10-11) of HSG(94)27

Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community – HSG(94)27 Dept of Health

Inside Outside – Improving Mental Health Services for Black and Minority Ethnic Communities in England – NIMHE 2003

Mental Health Act (1983) Section 136 Policy

Mental Health Policy Implementation Guide – Adult Acute Inpatient Care Provision – 2002

Mental Health Policy Implementation Guide – Dual Diagnosis Good Practice Guide – 2002

Psychiatric Interviewing and Assessment R Poole and R Higgo Cambridge 2006

Review of Homicides by Patients with Severe Mental illness T Madden, Professor of Forensic Psychiatry, Imperial College London - 2006

Safety First - 5-year Report of the National Confidential Inquiry into Homicides and Suicides by people with Mental Illness – 2001

Standards for Better Health Care – Department of Health, - July 2004

Still Building Bridges – The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach into Care Management

Tackling Domestic Violence: Exploring the Health Service Contribution - (Home Office 2004)

Warwickshire Sharing of Information Protocol

APPENDIX 5 : INTERNAL INQUIRY

Report following the Inquiry into serious untoward incident reference number 05/01/OS1(R)

1. Introduction

1.1. This report has been jointly prepared by the, Assistant Medical Director, and the Head of Psychological Services, under the terms of the Serious Untoward Incident policy of North Warwickshire PCT. Given the seriousness of the matter under investigation, the service provided to Mr 05/01/OS1(R) is reviewed in this report to ensure that appropriately high standards of clinical and operational practice were met. The report also identifies areas where improvements in practice might be made in future.

1.2. The authors of the report acknowledge and appreciate the full, open and professional cooperation shown by all staff in this investigation and review process.

2. Description of incident

2.1. On 3 January 2005, Mr was 05/01/OS1(R) arrested on suspicion of murder. The victim was his wife, Mrs FS. The police are currently investigating this matter and Mr 05/01/OS1(R) is remanded at Blakenhurst Prison. It is understood that the incident took place at the family home and that Mrs FS died of stab wounds inflicted in the early hours of the 3 January. Mr 05/01/OS1(R) was not in receipt of services from North Warwickshire PCT at this time.

3. Inquiry process

3.1. the Associate Medical Director and the Head of Psychology Services have had the opportunity to view all the notes describing the mental health service provided to Mr 05/01/OS1(R). This includes the psychiatric medical notes describing the services provided by the two Consultant Psychiatrists, the psychological service record describing the service provided by the Clinical Psychologist and ASW records of a Mental Health Act assessment, which took place in November 2001. In addition, they have had sight of the EPEX electronic patient record system relating to Mr 05/01/OS1(R) care; the notes kept by the Community Psychiatric/Forensic Nurse, who has seen Mr 05/01/OS1(R) whilst he has been in prison; the letter Consultant Forensic Psychiatrist following his assessment after Mr 05/01/OS1(R) detention at Blakenhurst and the statement made to the police by the second Consultant Psychiatrist on 13 January 2005.

3.2. On the 20 January 2005, the Associate Medical Director and the Head of Psychology Services jointly held separate interviews with the second Consultant Psychiatrist, the Consultant Psychologist and the forensic CPN to review their work with Mr 05/01/OS1(R).

3.3. The contents of this report has been discussed with both lead professionals before its final submission.

4. Background information: Summary of Referral and Patient Pathway

4.1. Mr 05/01/OS1(R) was referred to the Consultant Psychiatrist in October 2000 by Mr 05/01/OS1(R)'s GP. It is understood that the reason for this referral was concerns that Mr 05/01/OS1(R) apparently fixed belief about his wife's infidelity with his brother-in-law (his wife's sister's husband) was verging on the paranoid, and apart from the stress that this was causing the couple and their family, there was also concern that there might be an underlying mental illness (Note: the review panel could find no record of the referral letter to the first Consultant Psychiatrist on the medical psychiatric notes.)

4.2. A Mental Health Act assessment took place in 2001 involving the first Consultant Psychiatrist, the General Practitioner and an ASW. He was not deemed to need in patient care and was managed on an out patient basis until May 2002.

4.3. He was re-referred by his GP, to Mental Health Services in January 2004 following his committing an assault on his brother- in-law. He was seen in Outpatients by the second Consultant Psychiatrist and referred onto the Consultant Psychologist at Psychology.

4.4. The second Consultant Psychiatrist closed the case on 27.06.04 and the Consultant Psychologist closed her contact on 05.10.04.

5. Family, personal background and summary of intervention

5.1. From the records and from the information received, the following summary of presenting problem and background issues has been prepared.

5.2. Mr 05/01/OS1(R) was born in Rugby, has three sisters and one brother and comes from a family with an afro-caribbean background. He reports that his childhood was both secure and happy.

5.3. After underachieving at school, he obtained good "O" and "A" levels at college and went to London to work in housing for 10 years. He subsequently returned to Rugby where he continued to work in housing and worked his way up to a managerial position.

5.4. He married his wife approximately 14 years ago and they have three children aged approximately 10, 8 and 3. Their middle son suffers from Kibuki Syndrome, a condition that causes developmental delay and that requires intermittent and repeated surgical intervention. Mr 05/01/OS1(R) elderly, frail and widowed mother also lives in Rugby and relied heavily on Mr 05/01/OS1(R) support.

5.5. The PCT records report that Mr and Mrs 05/01/OS1(R) had had a stressful marital relationship with difficulties in communication and Mr 05/01/OS1(R) reporting that he felt inadequate, not listened to or respected in the relationship.

5.6. The first Consultant Psychiatrist was concerned about statements made by 05/01/OS1(R) that he fantasised about killing his brother-in-law and made a referral to the forensic Consultant Psychiatrist at the Reaside Clinic, for full assessment. The Forensic Consultant Psychiatrist conducted the assessment in April 2001. This report, consistent with the first Consultant Psychiatrist's own opinion reflected in his notes, concluded that there was no underlying mental illness and nor was there a high risk of Mr 05/01/OS1(R) acting out his fantasises about harming his brother-in-law.

5.7. It was concluded at this time that Mr 05/01/OS1(R) problems were more to do with intense feelings of inferiority connected to a number of family and interpersonal strains including the quality of the marital relationship and the pressure of caring for his disabled son. He also had a problem with alcohol in that it appeared to exacerbate his feelings and this was mentioned by both the first Consultant Psychiatrist and the Forensic Psychiatrist as a contributory factor to these feelings.

5.8. The first Consultant Psychiatrist followed Mr 05/01/OS1(R) up in Outpatients. Treatment consisted of the opportunity for Mr 05/01/OS1(R), together with his wife, to ventilate their concerns and pharmacological treatment for Mr 05/01/OS1(R) with Stelazine. He was discharged from Outpatients in May 2002.

5.9. Mr 05/01/OS1(R) was re-referred to the second Consultant Psychiatrist, in January 2004, by hisGP, following an assault made by Mr 05/01/OS1(R) on his brother-in-law at a family christening. There had been no contact with mental health services in the intervening two years.

5.10. The second Consultant Psychiatrist saw Mr 05/01/OS1(R) in her Outpatients clinic between February and June 2004 on 9 occasions and prepared a detailed report prior to his Court appearance when Mr 05/01/OS1(R) was facing charges associated with his assault on his brother-in-law.

5.11. Of importance at this stage were background factors relating to his upbringing and his lack of self esteem; longstanding difficulties in his

marriage and the birth some years previously of his disabled child; his fixed and constant belief that his wife had a relationship with his brother-in-law and finally the disinhibiting effects of alcohol consumption at the time of the incident with his brother-in-law. Again there was no underlying mental illness.

5.12. The second Consultant Psychiatrist referred Mr 05/01/OS1(R) to Psychological Services for individual therapy in February 2004. He was subsequently seen by the Clinical Psychologist, on 10 occasions for individual therapy between March and October 2004.

5.13 During this episode of care risk factors were identified and discussed with Mr. 05/01/OS1(R) and his wife, work was aimed at addressing these factors and included:

- ❒ Medication: low dose antipsychotic medication for its calming effects. This dose is not effective for psychosis and no underlying psychosis had been identified.

- ❒ Psychological work: Focussed on his low self esteem, how he controlled his feelings of anger on an individual basis and he received marital therapy in the independent sector.

5.14 He was discharged from Psychology in October 2004 when he reported feeling much better and having gained from the interventions. Both The second Consultant Psychiatrist and the Consultant Psychologist worked with Mr. 05/01/OS1(R) on likely trigger factors for relapse and how to contact the services for help in the future should he need it.

6. Overview

6.1 Mr. 05/01/OS1(R) had two periods of involvement with Mental Health services, between October 2000 and May 2002 when he was under the care of the first Consultant Psychiatrist; and February 2004 and October 2004 when he was seen initially by the second Consultant Psychiatrist and subsequently by the Clinical Psychologist.

6.2 On both of these occasions he received interventions designed to help him to manage his feelings of depression and low self esteem in general and more specifically focusing on his fixed belief that his wife and brother-in-law were having a relationship. On the first occasion he was also seen for assessment by the Forensic Psychiatrist at Reaside clinic. He was managed both times on an out patient basis.

6.3 There is no evidence from the investigation that Mr. 05/01/OS1(R) was given a diagnosis of a Formal Mental Illness at any point and in particular he did not receive a diagnosis of a Psychotic illness.

6.4 His personal difficulties were multi factorial and covered a range of historical and background factors and acute exacerbating factors such as alcohol.

6.5 More information is available about his second period of contact as the review team have been able to talk directly to the practitioners involved.

7. Good Practice identified

7.1 In terms of clinical management Mr. 05/01/OS1(R) appears to have received good assessment and intervention during this contact time. Issues of risk were overtly on the agenda in contacts with him and The second Consultant Psychiatrist was also able to include his wife in these discussions. He received a comprehensive assessment, a plan was devised and implemented and he was discharged by mutual agreement.

7.2 There is significant consensus about the formulation/diagnosis and treatment plan in this case. The view that Mr 05/01/OS1(R) was not mentally ill but that he and his wife were experiencing serious strains in their marital relationship combined with other stresses such as looking after their son, seems to be shared by all professionals. There is also consensus that Mr 05/01/OS1(R) often felt inadequate and struggled to maintain his status and self-esteem. There also seems to be agreement that his wife was a strong personality who was felt by Mr 05/01/OS1(R) to be dismissive and disrespectful of his needs and feelings.

For example, the Consultant Psychologist's record of her assessment process extends over three sessions (11.03.04, 29.03.04 and 08.04.04) and is summarised in her letter to the second Consultant Psychiatrist on 07.07.04. Similarly the second Consultant assessment record of 09.02.04, 19.02.04 and the meeting involving Mrs S on 26.02.04 identifies a similar range of concerns and is reflected in her letters to the GP, on 10.03.04, 04.03.04 and 16.03.04. Both of the lead mental health professionals describe communication and marital difficulties between Mr and Mrs 05/01/OS1(R). Mr 05/01/OS1(R) is said to feel himself to be without power in the relationship and often felt inadequate and not listened to. Consistent with the Forensic Psychiatrist's report (04.04.01), both professionals conclude that it is the interpersonal issues associated with questions of self-esteem and stress, that are important in this case. The record and the letters describe no evidence to support a mental illness or psychotic state – see in particular the second Consultant summary of mental state in her letter to OS's GP (10.02.04). It should also be noted that when Mr 05/01/OS1(R) was seen by the Consultant from Reaside, whilst on remand on 13.01.05, he could find no evidence of psychosis or other severe mental illness at that time.

7.3 Risk was fully assessed by the second Consultant Psychiatrist and the Consultant Psychologist in 2004 and by the Forensic Psychiatrist previously. The professionals involved do (with good evidence) conclude there was not a high risk to Mrs S or to others. Those risk factors that were in place such as the poor quality of the marital relationship, Mr 05/01/OS1(R) poor insight and lack of self management techniques were addressed in the treatment plan. Mr 05/01/OS1(R) was also advised about his use of alcohol.

The issue of risk is attended to in a number of key pieces of correspondence including the second Consultant's letters to the GP (10.02.04, 04.03.04, 16.03.04), the Consultant Psychologist's letter to The second Consultant Psychiatrist (07.07.04) and the Forensic Psychiatrist's letter to the first Consultant, based on his meeting with Mr and Mrs 05/01/OS1(R) (04.04.01). In addition, issues of risk are noted in the patient contact record including second Consultant's record of her initial contact with Mr 05/01/OS1(R) (09.02.04) and her meeting with Mr and Mrs 05/01/OS1(R) (26.02.04). Similarly, the Consultant Psychologist's notes of 10.05.04 discuss various triggers to Mr 05/01/OS1(R) aggressive outbursts including the role of alcohol and his feeling ignored or not listened to. The Consultant Psychologist's sessions of 08.06.04 and 28.07.04 go on to expand on the above and place further emphasis on CBT approaches to the self management of aggression.

Throughout the above record and correspondence, there are in fact several references to the role that alcohol played in disinhibiting potential outbursts of aggression. There is also evidence that this concern was shared with Mr 05/01/OS1(R).

7.4 The motivation for Mr 05/01/OS1® fatal attack on his wife is not yet clear. But there is some evidence that suggests from the CPFN's report on her contact with Mr 05/01/OS1® whilst he was on remand) that Mrs S's declaration that she intended to end the marriage might have been a precipitating factor. There is no clear recorded evidence that during the most recent episode of mental health care, Mr 05/01/OS1® potential emotional reaction to any breakdown in the marital relationship was explored in any depth with the professionals involved. However this is not felt to be a significant omission as Mr and Mrs 05/01/OS1® actively gave the impression (supported by their engagement with the local pastor and Relate) that they both wished to stay together. Moreover it is noted in Mr 05/01/OS1® previous contact with mental health services in 2001 (see the psychologist's report and the first Psychiatrist's notes) that it was Mr 05/01/OS1® who was actively planning to leave his wife rather than the other way round.

7.5 Psychological therapy, in the form of helping Mr 05/01/OS1® to gain an insight into the sources of the stress and strains that he was experiencing and improve the management of these symptoms by CBT, was both appropriate and well implemented.

For example, there was a lengthy period of assessment carried out by the psychologist over 3 sessions (11.03.04, 29.03.04 and 08.04.04) followed by the development of a psychological formulation that was shared with the client (10.05.04, 08.06.04). Self management approaches based on Mr 05/01/OS1® developing insight are also fully described in the notes (28.07.04 and 11.08.04).

7.6 This work was complemented by the counselling the couple were understood to be receiving from Relate and their church. See the second Consultant's account of her contact with Mr and Mrs 05/01/OS1® (26.02.04) and subsequent records (17.05.04 and 27.06.04).

7.7 Mr. 05/01/OS1(R) experience as a black man was also addressed in therapy. See The Consultant Psychologist's notes for her session on 07.05.04.

7.8 The service provided by Psychiatry and Psychology Services was based on good clinical assessment, good formulation/diagnosis, good treatment plan, good implementation of treatment plan, was well communicated with the patient and was delivered in a timely and efficient manner. There was good follow up and Mr 05/01/OS1(R) was reported to be positive and engaged in the intervention process (see The Consultant Psychologist's notes 28.07.04 and 05.10.04 together with the Consultant Psychiatrist's notes 17.05.04, 27.06.04 and associated correspondence). Mr 05/01/OS1(R) was also given advice about how to access help in an emergency out of hours and how to get back into the service post discharge.

7.9 There was no evidence at the point of discharge or during psychological therapy that Mr 05/01/OS1(R) posed a serious risk to his wife.

8. Areas of concern

8.1 Although comprehensive clinical notes were kept by both practitioners during this episode of contact with services the documentation does not comply with the standard CPA requirements of the Trust and no formal care co-ordinator was agreed. It is the opinion of the review team however that this lack of compliance did not adversely affect the care he received. This conclusion is based on the thorough analysis of the case record described in section 7. It is clear that assessment, diagnosis, formulation, intervention plan, risk management plan and risk assessment was all addressed. However, due in part to the lack of a good CPA structure, the record is not well structured. This would have been particularly problematic if a wider multi-disciplinary team had been involved in Mr 05/01/OS1® care at any time as the lack of CPA structure makes the identification of key pieces of information or conclusions much more difficult.

8.2 Contact between the two practitioners involved following the first referral letter between The second Consultant Psychiatrist and The Consultant Psychologist was informal and therefore not well documented. There is a discrepancy between the two practitioners accounts of how much discussion there had been between them.

8.3 There is no clear understanding in practice or in the record as to who was the care coordinator in this case. Again, there is no evidence that this impeded the quality of Mr 05/01/OS1(R) care but the lack of identified formal responsibility means that good clinical planning and care coordination is less clearly reflected in the record.

8.4 This problem was compounded by the fact that the usual practice of copying all letters sent to the GP to other professionals involved in the care did not occur (see below for possible contributory factors)

8.5 Mrs S was seen by the second Consultant Psychiatrist (26.02.04) as part of the initial assessment process. This contact with Mrs S was valuable and confirmatory of the picture presented by Mr 05/01/OS1(R). The review team feel that it would have been good practice to see Mrs S at the end of the Psychiatrist's intervention prior to discharge, to ensure the account of improvement given by Mr 05/01/OS1(R) was again confirmed by his wife.

9. Contributory factors

9.1.1. Patient factors:

9.1.2. There is some evidence that after his first Court case, when he realised that he was not going to Prison, Mr 05/01/OS1(R) mood lifted considerably and he was keen to put the whole episode behind him and move on. This included moving away from services. It is possible that Mr 05/01/OS1(R) was therefore inclined to ignore or not articulate in therapy, any doubts or uncertainties that might have challenged the positive picture he was giving at the time.

9.1.3. With the benefit of hindsight, it seems likely that Mr 05/01/OS1(R) core beliefs about his wife did not change over the last four and a half years, although the intensity with which he expressed them almost certainly did. However given the information that was available to clinical staff at the time, it is unlikely that this apparent lack of change in his belief system could have been more clearly identified and addressed.

9.2. Communication:

In a small unit a lot of communication takes place on an ad hoc basis and informally. Whilst this undoubtedly helps team working at one level it does mean that at time accurate records of agreed plans are not always kept and may lead to discrepancies between practitioners.

9.3. Working environment:

In 2004 there was a very difficult period for medical staff due to a lack of any permanent administrative support because of long term absences. This meant that established ways of working that would normally take place automatically (e.g. copying of letters between professionals) was not taking place but the medical staff were not necessarily aware of this breakdown in procedure.

9.4. Strategic management:

Since its launch there has not been any update training sessions on the role and use of CPA targeted specifically at medical staff. A lack of clarity about who takes care co-ordinating roles for standard CPA clients in contact only with psychology and medical staff is apparent.

10. Conclusions

10.1 This review's conclusion can be summarised as follows.

10.2 The client received good and appropriate intervention that was based on a thorough assessment, skilled formulation and good intervention delivered with the active engagement of the client to a point when discharge was both appropriate and agreed.

10.3 There is no evidence to support the view that the client was suffering from underlying mental illness. There were however clear emotional, psychological and relationship problems.

10.4 The CPA process in terms of review, care co-ordination, communication and recording fell short of necessary standards, although it is not felt that this negatively effected the care the client received.

10.5 Arising from the above, there is a need for clarification of CPA policy and associated staff training.

11. Recommendations

11.1 A clarification of procedures for the operation of standard CPA when clients are open only to psychiatry and psychology.

11.2 There needs to be refresher training for staff relating to standard CPA requirements.

11.3 Administrative support for medical staff at the Linden unit needs to be reviewed as a matter of priority. Procedures for handling patient information need to be agreed and written down so they can be followed by temporary staff if the situation arises.

Sum Time line of intervention - 05/01/OS1(R)

▪ Summer 2000	Contact between pt/pt's wife and GP,.
▪ October 2000	Assessment by consultant. Stelazine prescribed. O.P. F.U.
▪ Seen in O.P. (sometimes with wife or wife alone) Nov 00 to May 02	02.11.00, 16.11.00, 23.11.00, 16.01.01, 16.02.01, 23.08.01 (DNA), 1.11.01 (DNA), 10.01.02, 14.02.02, 16.05.02
▪ 6th Feb 2001	Referred for forensic opinion, Reaside Clinic.
▪ 4th April 2001	Full report completed by Forensic Psychiatrist following assessment on 3.04.01
▪ 15th January 2004	Re-referral by GP, to consultant following assault on brother-in-law in previous week.
▪ 9th February 2004	Assessed by Consultant Psychiatrist.
▪ Seen in OP Feb 04 to June 04	09.02.04, 19.02.04, 26.02.04, 11.03.04, 01.04.04, 19.04.04, 17.05.04, 27.06.04
▪ 11th February 2004	Referral to Psychology Court case leading to community service and suspended sentence took place late March 04.
▪ 2nd March Legal report requested by solicitors	11.03.04, 29.03.04, 08.04.04, 10.05.04, 08.06.04, 06.07.04, 15.07.04, 28.07.04, 11.08.04, 21.09.04 (DNA), 05.10.04.
▪ Seen for therapy March 04 - Oct 04	

Total contacts

Oct 00 - May 02	-	Dr Ashby's O.P. – 9 should have been 10 contacts + 2 DNA
April 02	-	Assessment by Dr (Reaside)
Feb 04 - June 04	-	Psychiatrist's OP – 9 should have been 8 contacts
March 04 - Oct 04	-	Psychologist's OP – 10 should have been 8 contacts + 2 DNA's +1 appointment cancelled by OS and +1 cancelled by the psychologist

APPENDIX 6

RISK MANAGEMENT STRUCTURE