REPORT OF THE INDEPENDENT HOMICIDE INQUIRY

REFERENCE 1999/336

MARCH 2003

COMMISSIONED BY THE FORMER LEEDS HEALTH AUTHORITY

CONTENTS

INTRODUCTION

On 3 November 2000, having pleaded guilty to the murder of his second wife, GE was sentenced to life imprisonment. The murder had taken place on 11 October 1999.

The case had some notoriety and received wide media coverage, firstly because of the manner in which GE disposed of his second wife's body, and secondly because, over the following month, he engaged in an extensive subterfuge, acting the role of a deserted husband who feared for his wife's safety. In the event, he was arrested when trying to leave the country. There seemed no doubt about the criminality of his act. No plea of diminished responsibility was submitted and the Court was content to deal with the matter as it did.

GE was known to Psychiatric Services in Leeds, as he had attended outpatient clinics at St Mary's Hospital, Armley, Leeds (which formed part of Leeds Community and Mental Health Services NHS Trust, as it then was). Owing to staffing changes GE was seen by three Consultant Psychiatrists there between February 1998 and September 1999. He had been initially diagnosed as suffering from a depressive episode of moderate severity with somatic syndrome, and medication was recommended for him by the psychiatrists, and prescribed by them and by his General Practitioner. GE was monitored and reviewed by his Consultant Psychiatrist and his General Practitioner regularly. When last seen by his Psychiatrist on 17.09.99, at that stage, although there was still some depression, GE was more cheerful and optimistic and it was thought that he was continuing to improve. He was given an appointment to be seen three months later, but did not attend Psychiatric Services again.

In August 2001 Leeds Health Authority decided to establish an independent external inquiry into these events. In September 2001, the Community Trust conducted an internal review and prepared its own report. That followed the Trust's own "serious untoward incident report" to the Regional Director of Public Health on 26.11.99 and its own "management review" in January 2000.

When this Inquiry first convened, it was apparent that there had been substantial delay in external investigation of this matter under the provisions of HSC(94)27. There were then considerable delays when the patient, GE would not give consent to his treating clinicians, to give evidence to the Inquiry. GE's reluctance is a factor in the timescale here. It should have been the only delaying factor.

Some form of immediate internal review would be expected that would report as soon as possible, hopefully well before the conclusion of legal proceedings. The Trust may liaise with Police investigating the case and take its own legal advice upon how internal review should be conducted, to avoid any risk of prejudice to criminal procedures. If that leads to difficulties or omissions, the internal review may say so in its report. The priority is for the Trust to ensure that there is not some obvious remediable problem which the Trust can address, to avoid any risk of repetition.

The Trust now indicates that its own delay in internal review would not recur, particularly as the Chief Executive is armed with a discretion to direct internal review, even where formal legal procedures have not been exhausted. The Inquiry welcomes this. The delay in this case has been bad.

There is also an inevitable feeling that the Trust formed a view, at an early stage, that there was nothing to be learned from this particular case, which required accelerated action or the immediate, direct input of the clinicians involved. The case went "off the boil" and even now the Inquiry is unsure what stimulated its own establishment in August 2001, after such delay. The apparent existence of one or more other external inquiries with which this particular Trust had to deal at the same time was mentioned as a reason to explain the lapse of time in the production of documents. This also encouraged the view that the Trust considered that there was nothing to be gained by external review and that this was "going through the motions". That is denied by the Trust, but it should at all costs avoid giving that impression, should another tragic case of homicide arise.

In the broadest terms, the Inquiry agrees with all who have investigated and assessed this matter before (whether the Trust, the Police, Consultant Forensic Psychiatrists or the Court) that this was a case of murder, with no "psychiatric mitigation" that would justify a plea of diminished responsibility.

That being the case, and as this murder is explained, if it can be explained, on its own particular facts attributable to a man in full possession of his faculties, it has to be recognised from the outset that there are few, if any, lessons to be learned from this matter. The patient was "sane" and did not suffer, as the law requires, from any abnormality of mind so as to substantially diminish his responsibility for his actions.

Because this reflects the careful conclusion of the Court, there is grave doubt that an Inquiry under HSC(94)27 is strictly appropriate in these circumstances. Accordingly, this report has been prepared on a largely anonymous basis. In particular, the Inquiry sees no necessity to name individual clinicians or managers, particularly where no criticism is identified of the clinical care given to GE, or the resources made available for the provision of such care. Furthermore, the Inquiry has no wish to identify family members or friends. The impersonality of the report is at times awkward, but it is hoped that those who read this will not seek to identify individuals, which may cause unnecessary distress.

The following witnesses were interviewed by the Inquiry:

28.11.01	Police Officers
14.12.01	Psychiatrist A Psychiatrist C
10.04.02	Psychiatrist C A representative from RELATE Psychiatrist A
11.04.02	GE's General Practitioner The Trust's former Medical Director
07.06.02	The Trust's Director of Nursing
11.09.02	GE

The Chairman, John Taylor first attended an inquiry into psychiatric homicide (in fact attempted homicide) in September 1985 and, in May 1987 he represented the Consultant Psychiatrist involved in the Sharon Campbell Inquiry, a public inquiry into the killing of a social worker by a psychiatric outpatient. He represented individual doctors, principally Consultant Psychiatrists, occasionally General Practitioners, at over a dozen homicide inquiries convened under HSC(94)27 and had therefore seen inquiries conducted in many different ways. These ranged from public inquiries conducted on an adversarial basis (with all relevant parties represented) through to low-key, private inquiries conducted on an inquisitorial basis. In March 1999 John Taylor was asked to Chair another homicide inquiry for Cambridgeshire Health Authority, which report was published in April 2000.

Based upon this experience, it was the Chairman's considered view that the best way in which to conduct an inquiry such as this was:

(a) to hold it in private.

(b) to ensure the attendance of a shorthand writer so that a transcript of evidence could be prepared and sent to each individual witness, for correction and amendment.

(c) not to request statements in advance of hearing a witness.

(d) for the Chairman to take the lead in taking each witness through their evidence with questions from the Panel at appropriate points.

(e) to encourage each witness to feel free to alter or add to the record of evidence so that, at the end of that process, the witness was happy that all ground had been covered.

Although no witness attended with a legal representative, that would have presented no difficulty in the taking of evidence.

This framework arose naturally out of the fact that the Inquiry Panel convened with no preconceived ideas about the case. It was explained to each witness that the Panel approached their evidence with an open mind. Hindsight was not applied by the Panel in conducting a fact-finding exercise. The Panel sought to establish the facts and, in particular, the information that was available to the clinicians at the relevant time.

As soon as it was possible it was made clear to the clinicians involved that GE had given his full consent for them to discuss details with the appointed Panel.

It was the Panel's impression that witnesses found it helpful to know that neither they nor the Panel would or should apply hindsight at the fact finding stage. Hence, those giving evidence were frank and open and it is hoped that all witnesses feel that they were given a full opportunity to give an account of their own involvement.

A chronology has been included in this report because, from the clinical point of view, it tells the full story of what occurred up to the time that GE was last seen by his Psychiatrist about three weeks before the killing (and last seen by his General Practitioner about six weeks before the killing).

No-one has established with certainty what took place between GE and his second wife on the late evening of 11 October 1999, leading to her death. However, having looked at all the information made available to the Inquiry, it is satisfied that GE's diagnosed and treated depression played no significant part in the killing.

For the avoidance of doubt, the Inquiry has not identified any issue where there has been an absence of appropriate resources for dealing with GE's care.

With the justifiable exception of one unavoidably cancelled appointment, the Trust afforded GE proper assessment and review, in conjunction with his General Practitioner. The resources matched the need.

ACKNOWLEDGEMENTS

The Chairman must record, on behalf of the Panel of Inquiry, a huge debt of gratitude to its Co-ordinator, Brian Morden, who has great experience in homicide inquiries of this nature. He followed up every request and requirement raised by the Panel, in particular persisting doggedly in the pursuit of documentation from various sources. The arrangements for the interviewing of witnesses, whether in Leeds or HM Prison Wormwood Scrubs were smoothly efficient, notwithstanding considerable frustrations and difficulties that were encountered along the way. The Panel know that he is involved in other homicide inquiries in a similar capacity - they are fortunate to have his assistance.

Thanks are also due to the Chairman's two secretaries, Lisa Moloney and Avril Jennison, who both worked closely with Brian Morden and shared the task of collating and copying documentation and, of course, the hard task of preparing the drafts of this report and bringing it to its final form.

The Panel would also record its thanks to Stuart Brown QC, who looked very promptly at the legal background to GE's trial and helped the Panel with the brief clarity of his advice.

GE's solicitor also gave freely of his advice to GE and his assistance to the Panel, primarily in securing GE's consent to his treating clinicians giving evidence to the Inquiry. GE also helped in providing the Inquiry with the forensic psychiatric evidence that was made available, on GE's behalf to the Court. Also, GE made himself available to the Inquiry when the Panel visited him in prison. Although he indicated that he would have preferred his solicitor to be present, he resolved to speak with the Panel and was helpful.

It was not considered necessary to press members of GE's family or of his deceased wife's family for evidence. The Panel would, however, wish to take the opportunity in this report, to express condolences to the victim's family in their tragic loss.

COMPOSITION OF INQUIRY PANEL

John Taylor - Chairman

LLB (King's College, London) 1973. Admitted as a solicitor 1977. Joined Hempsons in 1978, specialising in medico-legal practice since that time. Has represented doctors at other homicide inquiries and has chaired a previous homicide inquiry (Cambridgeshire Health Authority, April 2000).

Dr Roger Freeman

Qualified MA, BM BCh (Oxford) 1959. DPM 1965. MRCPsych 1973. Elected FRCPsych 1988. Formerly Consultant Psychiatrist Hillingdon Hospital.

Peter Oldridge

RMN 1967. RGN 1969. MBA 1990. Director of Nursing, Doncaster Priority Care Unit 1984-1991. Deputy General Manager/Nursing Director, Doncaster Priority and Community NHS Trust 1991-1992. Deputy Chief Executive and Nursing Director/Professional Adviser, Doncaster Healthcare Trust 1992-1997.

JURISDICTION

In the Department of Health's Circular HSC(94)27 "Guidance on the discharge of mentally disordered people and their continuing care in the Community", paragraph 35 makes clear:

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

As a result of NHS reorganisations, the responsibility for convening such an inquiry therefore fell initially upon Leeds Health Authority. The establishment of such an inquiry was not proposed by Leeds HA until August 2001 and, upon the making of initial arrangements, the Inquiry was confirmed and its terms of reference approved by the Board on 24 September 2001. Responsibility then passed to Leeds North West Primary Care Trust in April 2002, then ultimately to West Yorkshire Strategic Health Authority, to whom the Inquiry has been asked to address its report.

A copy of the terms of reference is attached to this Report as Appendix A.

At the outset, when it became known that GE had pleaded guilty to a charge of murder, it was appreciated that the case was unusual in the context of such inquiries, as the psychiatric history of the perpetrator, and his mental state at the time of the killing, were not to be raised by the Defence and were not to be taken into account by the Court. Thus, no defence of diminished responsibility was to be raised.

These issues were very carefully investigated. In particular, reports were prepared for the Defence by two Consultant Psychiatrists in August 2000, and the report of a Consultant Forensic Psychologist was obtained in July 2000. These reports were made available to the Inquiry by GE's solicitor. All of the reports demonstrated full awareness of GE's psychiatric history.

It is helpful to quote certain conclusions in these various reports. The first Consultant Forensic Psychiatrist reported on 12.08.00:

"GE maintained that the homicide was a purely impulsive act, committed during a brief period when he had lost his self control. GE expressed remorse for what he had done ... He was upset, however, by the suggestion that he might have in any way planned the killing of his wife ... GE presents the relationship between himself and his second wife as one with which he was unable to cope, but from which he was unable to extricate himself. In my view, GE's homicide was a response to him being trapped in an unhappy and difficult relationship, from which he could not escape ... GE has a history of depression, which largely presents as a response to the difficulties in the relationship between himself and his second wife, ongoing from 1997 up to the time of the homicide. During this period of time, GE was under psychiatric care.

"I understand that a key question to be addressed in this case is whether GE's depression at the time of the offence was sufficient in its degree and nature so as to substantially diminish his responsibility for his actions (Homicide Act 1957). My opinion here is as follows:

(a) I do consider that GE was suffering from an "abnormality of mind" in terms of the Homicide Act 1957 at the time of the homicide. His "abnormality of mind" was depression, which in terms of the Homicide Act 1957 would be classified as a disease.

(b) GE's depression had been ongoing for some time before the homicide. However, there does appear to be reasonable evidence from GE's psychiatric files that in the period before the homicide, his depression had undergone some improvement.

(c) It is my opinion that GE's depression, at the time of the homicide was not of a sufficient degree so as to substantially diminish his responsibility for his action (Homicide Act 1957)".

Also, the second Consultant Forensic Psychiatrist reported on 18.08.00:

"1. GE is charged with the murder of his wife. In relation to the charge he is fit to plead and stand trial.

2. GE has a previous psychiatric history of depression ... However, at the time of writing this report, GE currently shows no evidence of suffering mental disorder within the meaning of the Mental Health Act. He is in remission of depressive symptoms ...

3. GE's history of depressive illness pre-dated the alleged offence. It is clear from both his account and documented information that he developed a depressive illness of moderate severity for which he underwent sustained outpatient psychiatric treatment, between February 1998 and the time of the alleged offence. This depressive illness was attributed to a combination of pressure of work and marital difficulties. It led to GE's early retirement on grounds of ill-health. However, it is apparent that assessments of his mental state in the months prior to the alleged offence from January 1999 onwards described a significant improvement in his depressive symptoms which was maintained at the time of his last assessment in September 1999. This improvement was not total but was significant compared to his initial presentation. From the account given by GE, it is apparent that in the time between his last outpatient attendance in September 1999, and the alleged offence in October 1999, he had continued his anti-depressant medication. In addition, his reported mental state in the days prior to the alleged offence is indicative of maintained improvement of his mental state.

4. At the time of the alleged offence, therefore, it is evident that GE's depressive illness had undergone significant improvement and was in partial, if not substantial remission. At no time during his psychiatric contact is it recorded that he exhibited psychotic symptoms or features of morbid jealousy towards the Deceased. Therefore, in my opinion, there are insufficient grounds for a psychiatric defence in this case. I do not consider that at the material time, GE was suffering from an abnormality of mind as would substantially diminish his mental responsibility. Neither was he suffering from such a defect of reason as a result of a disease of the mind, that either he did not know the nature or quality of his acts or that what he was doing was wrong. Finally, GE's account of the alleged offence indicates that he was capable of forming a specific intent."

The Inquiry has been assisted also by transcripts of the entirety of the trial in this matter conducted at Leeds Crown Court on 23.10.00 and 2 and 3.11.00. To the extent that matters were raised at trial, in submissions made by both prosecuting and defending leading Counsel, the Inquiry referred these same transcripts to another leading Counsel, Stuart Brown QC whose observations, brief but very helpful, are attached to this report as Appendix B.

It is important to set out the learned Judge's sentencing remarks in full:

"You have pleaded guilty to murdering your wife. The fact that you have pleaded guilty is to your credit and I take that into account, although in the final result you have really little alternative.

I have no doubt that what you did that night involved some forethought upon your part, as is evident from what you said in one of your interviews with the Police, that you had previously thought of killing your wife and disposing of her body in the way in which you ultimately did. Furthermore, the prompt and efficient way in which you disposed of her body shows, in my view, that there must have been at least a degree of pre-planning involved. The dismembering of your wife's body and its subsequent incineration can only be viewed with abhorrence and revulsion by right-minded members of society.

Those are significantly aggravating features of this case.

Thereafter, you spun a web of deceit by an elaborate charade in order to cover up what you have done. That involved forging letters and withdrawing money using your wife's credit account from various locations in order to make it look as if she was still alive.

You also left some property at the locations within Cleethorpes in order to try and make it look as if she had committed suicide. That web of deceit is a further aggravating feature of this case.

When you were arrested at the airport, you were plainly trying to flee the country.

I accept that your wife may have said or done something that night which prompted you to do what you had previously contemplated doing, that is to say to kill her, although I very much doubt whether that resulted from what you said in your interviews with the Police passed between you and her.

Whatever it was that did happen, it certainly was not such as to provide you with the legal defence of provocation, which would have resulted in manslaughter rather than murder, and that is particularly so bearing in mind the degree of self-control which you obviously displayed immediately after the killing.

I accept that there were difficulties and tensions in the relationship between you and your wife, and I will bear in mind the nature of your personality as revealed by the documents to which your learned Counsel has referred.

I also accept that you have been suffering from clinical depression of moderate severity for some time for which you had been receiving treatment, but there had been a significant improvement in your condition by the time of the commission of this offence and the result of

that is your mental condition was not such so as to provide you with any defence of any kind to discharge.

All of those matters that I have mentioned, and others, both the aggravating features that I have mentioned and such mitigating features as there are, I will bear in mind when I make my recommendation to the Secretary of State as to the period of imprisonment that you should serve for the purposes of retribution and deterrence before you can be considered for parole. But for the purposes of today, there is only one sentence that by law I can pass, which is a sentence of life imprisonment.

The sentence, therefore, which I pass on you today, is one of life imprisonment."

While the true nature and extent of GE's contacts with Psychiatric Services (and his General Practitioner) are set out in the Chronology and are evaluated to some extent elsewhere, that psychiatric history was ultimately determined to be of no significance in the murder, or in the manner in which the Court dealt with the matter. The Inquiry has looked for examples of similar cases investigated in accordance with HSC(94)27, but no other such case has been identified. However rare an Inquiry in such cases may be, it is appropriate to suggest the adoption of a rule that would render such an Inquiry, in any future case of murder, unnecessary.

It is understood that there has long been discussion whether such an inquiry should be mandatory in all cases of homicide. These inquiries are expensive and can cause considerable stress and anxiety to the clinicians (and others) whose acts and omissions are investigated. It has been suggested that there is nothing new to be learned from such inquiries and that, at the very least, there should be some screening process whereby, at an early stage, the Department of Health should take a preliminary view of a case, whether there is likely to be any new issue that would emerge as a result of such an inquiry and, if it is thought not, no inquiry needs to be convened.

A Minister at the Department of Health, Jacqui Smith MP addressed the Royal College of Psychiatrists Annual General Meeting in July 2001 on a number of issues. In the notes of her speech, she touched upon "local homicide inquiries" and said:

"The NHS as a whole has been criticised recently because of highly publicised incidents in which care has been inadequate and patients have been harmed. We have responded to public demand for a more transparent system throughout the NHS for monitoring adverse incidents and learning lessons that can be used to improve clinical practice. The new National Patient Safety Agency will carry out this work across all clinical specialties including mental health. This means that we shall bring to an end the local homicide inquiries that have been a requirement since 1994."

There seems no doubt that, while these inquiries may be perceived by Ministers as having served their purpose, there is a desire that investigations should continue to be carried out in mental health cases. However, at least for the foreseeable future, the responsibility (and the financial cost) will rest upon the old Health Authorities or the supervening Primary Care Trusts or, now, the Strategic Health Authorities.

However, the question remains, whether an inquiry needs to be established in a case of this nature.

It may be safely assumed that, where the Crown Court deals with a charge of murder on the basis of accepting a plea of guilty, the mental state and fitness to practice of the accused (particularly one who is known to Psychiatric Services) will be forensically investigated exhaustively (as happened in this case). There are known cases where an individual may plead guilty to a charge of murder where, for example, he is mentally ill and has no comprehension or a deluded comprehension of the implications and consequences. There are known cases where an individual may be a diagnosed paranoid schizophrenic who chooses to dismiss his legal representatives and to present his own case at trial and to plead guilty, yet where the Court has accepted that plea. A Court should strive to avoid such a miscarriage of justice. Where the checks and balances are in place, and there is no reason to suppose that the rules have not been properly observed and that justice has not been done, there may be no good purpose served by an inquiry.

There still has to be an exercise of caution. An individual who kills may suffer from mental illness or personality disorder, yet have the clear perception that it may be more in his interests to receive a life sentence upon a plea of guilty to murder (with the certainty of release at some point) rather than to become subject to a hospital order which would compel detention for an indeterminate and possibly far longer time. Such a consideration has had to be addressed in this Inquiry. The Panel feels that GE did not enter a plea of guilty to the charge of murder, for that purpose.

Similarly where, as in this case, a perpetrator has had some contact with Psychiatric Services, but only to a limited extent, it has to be considered whether he was concocting symptoms of a mental illness (in this case, depression) with a view to establishing some form of "psychological alibi" in advance of the crime, so that, after the killing, a conviction for manslaughter on the grounds of diminished responsibility may be the more likely and preferred outcome. Again, the Panel is sure that this did not occur in this case.

Subject to those considerations, there would seem to be no justification for re-visiting the criminal trial or the process by which the Court disposed of the matter and an Inquiry under HSC(94)27 is not strictly appropriate.

WITNESSES AND DOCUMENTS

It is a feature of inquiries under HSC(94)27 that there is no power either to compel the attendance of a witness or to compel the production of documents, particularly medical records. This is illustrated by difficulties that arose in this current case.

Following the establishment of the Inquiry in September 2001, contact was made with GE's solicitor who then indicated that GE had stated that he would not assist the Inquiry by giving any statement, nor would he authorise the disclosure of any medical records to the Inquiry. That view was confirmed by the solicitor after he went to visit GE in prison in November 2001.

At the same time, arrangements were being put in hand to conduct interviews with GE's General Practitioner and treating Psychiatrists who were, of course, made aware of the position and the fact that GE did not authorise them to divulge confidential information to the Inquiry. While the Inquiry was able to meet with the two Consultant Psychiatrists involved, this was only by way of preliminary interview, to look at very general issues that arose out of the case, and without reference to the specific details of GE's case at all.

At the same time, a request to the General Practitioner for the production of the practice records was met, very promptly, with a request for the patient's authority. It was explained that this could not be produced. It was, however, suggested that the position was covered by the provisions of the Data Protection Act 1998. A copy of the letter sent to GE's solicitors, copied to the General Practitioner is attached as Appendix C. Upon that assertion, the General Practitioner again very properly consulted her medical defence organisation who made contact with the Inquiry, to say that they were constrained to advise the General Practitioner that the provisions of the Data Protection Act 1998 did not release her from her duty of confidentiality, and nothing else but the patient's authority would suffice.

At this stage, consideration was given to the possibility of an application to the High Court, for an order to compel the individual clinicians to give evidence to the Inquiry, and to produce records. Fortunately, before that step was undertaken, GE's solicitor informed the Inquiry that GE had reconsidered the matter and now authorised the disclosure of his records, although at that stage he did not indicate a willingness to give a statement or to assist any further. Formal consents, signed by GE, were made available in March 2002.

This at least enabled the two Consultant Psychiatrists and the General Practitioner to attend to give evidence of GE's medical and psychiatric history. GE's solicitor was also authorised to arm the Inquiry with the reports of two forensic psychiatrists and a forensic psychologist, which had been prepared for Court purposes.

It is not known if inquiries will continue long under HSC(94)27. Generally, as new organisations, Primary Care Trusts and Strategic Health Authorities may not yet fully know their obligations to bear the financial cost of such inquiries, and to receive and act upon reports and recommendations. There may be moves to end such inquiries but to conduct inquiries in different form, through other Government/NHS bodies. Whether under HSC(94)27 or under any other authority, it is to be hoped that the provisions of the Data Protection Act will be addressed, but that those who establish such inquiries will guarantee that a Panel of Inquiry receives all necessary medical records and other documents, and can

compel the attendance of significant witnesses, to ensure that such inquiries take off and land satisfactorily.

CLINICAL CHRONOLOGY

DATE	EVENT
13.05.48	GE born in Humberside.
1952	GE's second wife born in Leeds.
1969	GE and family move to Leeds.
03.03.69	GE begins work at X Ltd.
04.10.69	GE marries first wife.
1969	GE convicted of shoplifting and fined.
1976	GE convicted of theft from motor vehicle and obtaining property by deception and fined.
1993	GE's first wife dies of natural causes.
Aug 1995 - Oct 1995	GE address in Meanwood, Leeds.
28.09.95	GE's new address in Armley is identified and GE registers with a local general practice.
04.11.95	GE marries his second wife, herself also widowed and previously twice divorced.
17.11.95	GE requests reversal of vasectomy.
27.02.96	GE referred to Eye Clinic.
June 1996	GE experiences difficulties in working as a forklift truck driver.
22.07.96	GE reports frequency of micturition and nocturia (urinary problems).
24.07.96	Report from Eye Department, Leeds General Infirmary - GE diagnosed with mild anterior cortical cataract in left eye and myopic refractive error - to see optician.
16.08.96	GE seen by General Practitioner with 24 hour history of chest pain. Advised to attend Casualty Department. GE admitted via Casualty to Gastroenterology Department, one day history of epigastric pain, no associated gastrointestinal symptoms - no abnormality found.
17.08.96	GE's pain settled and allowed home as due to go on holiday. Upper GI endoscopy to be arranged. No medication.
27.08.96	GE reports to General Practitioner that, when seen at Casualty 16.08.96, he was told pain was cardiac and he was to rest, for further investigation in one week's time, given medical certificate to 06.09.96 for "angina".
06.09.96	GE seen by General Practitioner - "well, no problems" under investigation,

	medical certificate for "cardiac investigation".
19.09.96	Gastroenterology Department summary re admission 16/17.08.96 sent to General Practitioner.
26.09.96	GE seen by General Practitioner, and reports he was told by hospital may return to work, but paperwork only for the first four weeks or so - medical certificate, to return to work.
09.09.97	GE seen by General Practitioner. GE reports under stress at work, mood low. New technology, wishes to retire next year aged 50 and move around. Managing Director has suggested he retires on ill health grounds. Waking during night ++. General Practitioner describes Dothiepin 25mg one at night to begin with, then to try two at night after two weeks and see again in three weeks.
30.09.97	GE seen by General Practitioner. GE reports not helped by Dothiepin and still not sleeping, due to go on short holiday. General Practitioner provides medical certificate for four weeks "stress/depression" and additionally prescribes Temazepam 10mg one at night if required. 20 tablets prescribed with warning re addiction.
28.10.97	GE seen by General Practitioner. GE reports slowly feeling things are improving, only used two Temazepam. Still reports early morning wakening. Wishes to try and return to work. Medical certificate to 03.11.97.
18.11.97	GE seen by General Practitioner. GE reports "no good" and sleeping very badly, and that threw Temazepam away. Advised to try Dothiepin again, to start with 2 x 25mg at night and increase to 3 x 25mg. Also prescribed Temazepam (10mg) (20) to use sparingly. Medical certificate for four weeks "depression".
17.12.97	GE seen by General Practitioner. GE reports really quite low today and felt like walking out and disappearing the other day, but not actively suicidal. Took dog for walk instead. General Practitioner advises increased Dothiepin to 75mg at night (56). Medical certificate for four weeks "depression". To review in two weeks, earlier if necessary.
06.01.98	GE seen by General Practitioner. GE reports still low and walked along canal all day for miles and ended up near Skipton without realising how far he had gone and how he had got there, and was staring. No active suicidal intent expressed. GE reports wakes in night and feels tablets are knocking him out. General Practitioner advises reduce Dothiepin from 75mg at night to 25mg at night for two weeks and then increase again gradually. GE says not keen on referral to Psychiatric Services, going away for a week with a friend. To see General Practitioner again in two weeks.
20.01.98	GE seen by General Practitioner. GE reports much the same with early morning wakening. It is agreed that General Practitioner will refer him to Psychiatric Services. Dothiepin increased to 75mg at night and 2 x 25mg at night. GE to see General Practitioner again in two weeks. Medical certificate for four weeks "depression".

30.01.98	General Practitioner refers GE to Consultant Psychiatrist A, at St Mary's Hospital. Referral letter states: "Many thanks for seeing this 49 year old man who we have been treating for depression for the last four months. He came initially with problems at work due to the new technology and it soon became clear that he had depressive symptoms. He has been suffering from early morning wakening and anhedonia. On a number of occasions he tells me he has felt like "walking out and disappearing" but denies frank suicidal thoughts. He has once or twice taken the dog out for a walk and found himself wandering some hours later with little recollection of where he has been. He was started on Dothiepin initially in September but stopped taking these after about a month as he did not feel they were helping. We re-started him towards the end of November and have gradually been increasing the dose although when he reached 150mg a night he found that he was feeling too knocked out during the day and I have re-adjusted the dose and gradually trying to build him up again. We seem to have reached a stage where he is not really getting any better, and I find his thoughts about disappearing coupled with the fact that he has wandered off, rather worrying. I would appreciate your expert opinion and advice here."
03.02.98	GE seen by General Practitioner. GE reports still low, listless and not sleeping. Walks +++. General Practitioner advised increase Dothiepin to 2 x 75mg at night (28) and to see again in two weeks.
12.02.98	Consultant Psychiatrist A writes to GE offering outpatient appointment on 23.02.98.
23.02.98	GE seen by Consultant Psychiatrist A, who reports by letter to General Practitioner: "GE clearly had an unhappy childhood ... GE ran away from home at the age of 12 and only returned two years later. He describes himself as a loner in school and left at the age of 15. Although he has had a number of jobs, for the last 27 years he has worked for the same engineering company. Approximately 15 years ago he was appointed as warehouse manager and has done this job ever since. In his relationship history GE's first significant relationship was with his first wife, whom he met at the age of 20. They were together 26 years, she died five years ago…. They had two sons, both in their twenties. Approximately a year and a half after losing his first wife, GE met his second wife. He currently lives with her and her daughter who is 15 years of age. GE does not smoke and is only an occasional drinker. There is no history of illegal drug misuse or forensic history. The only past medical history of note is that GE suffered from some carcinoma of the leg ten years ago and was treated with radical incision. He is currently taking Dothiepin but was not sure of the dose today. He is not

	allergic to any medication. He has no past psychiatric history of note. Today GE gave a four month history of low mood which was associated with early morning wakening, poor concentration, irritability, low concentration, low libido and reduction in his interests. However his appetite is good and he has actually put on some weight. With regard to the future he says "I don't know". However he has no current plans of self harm. He does however say that sometimes he "feels like packing my bags and going". It appears that GE's low mood is related to both problems at work and also in his relationship with his second wife. Today GE gave me a long drawn out history regarding difficulties at work that stretch back for the last three years. It is quite clear that GE feels under-valued by his employers and at the present time could not care less if he returns to his job or not. During the last year, whilst there have been ongoing difficulties with his employers, he has had problems in his relationship with his second wife. It is quite clear that GE's previous partner fitted in with his character traits of being prudent in financial matters and strict with dependents. However, with GE's agreement, his second wife has helped to spend a significant proportion of his savings. GE clearly today was frustrated by one recent situation when he found that one of his cheques had been written for a significant sum of money by his second wife to pay off a debt. I do feel that the above differences between GE and his wife have only served to make him feel less in control of his life. Today he did express the idea that perhaps he should not have settled down with his second wife, but added that he was not one to walk away from a commitment. Today GE presented as a casually dressed man who showed no evidence of self-neglect. He appeared very nervous at the start of the interview and quite suspicious when I asked him details of his past life. He was clearly loathe to discuss details of his childhood. By the end of the interview I noted a fair eye contact and a good rapport was established. His speech was normal in rate and form and objectively and subjectively his mood appeared depressed. With regard to the content of his thoughts he was clearly pre-occupied with his recent difficulties at work and also with difficulties in his relationship with his second wife. There were no psychotic phenomena or suicidal ideation. His attention and concentration appeared fair. My impression is that this man is suffering from a depressive episode of moderate severity with somatic syndrome. This episode has probably been precipitated by difficulties at work and has been perpetuated by both these difficulties and financial and relationship worries. GE was unsure what dose of Dothiepin he was taking. He will clarify this with you and if he is not on the maximum dose, I think it should be increased gradually to **Dothiepin 225mg per day in divided doses** If however he is on this dose of Dothiepin already I think we should consider

	a switch of anti-depressant. I hope by the time you receive this letter I will have had chance to discuss GE over the phone. I have arranged to see him in out-patients in four weeks time."
23.02.98	Consultant Psychiatrist A also telephones the General Practitioner to discuss present medication and increasing dosage and when to review. GE seen by General Practitioner, when Dothiepin dosages are discussed and confirmed. Medical certificate for one month "depression".
17.03.98	GE seen by General Practitioner. GE reports problems with his wife and that "near divorce". GE also reports urinary problems of frequency and dribbling which could be a side effect of Dothiepin or an indication of prostate problems. Now on 225mg Dothiepin at night and to be reviewed by Consultant Psychiatrist A. Medical certificate for one month "depression".
20.03.98	GE seen by Consultant Psychiatrist A. Notes of consultation fully reflected in report to General Practitioner.
25.03.98	Letter Consultant Psychiatrist A to General Practitioner. "I reviewed GE in Clinic on 20.03.98. He tells me that his mood has picked up slightly since I last saw him. His sleep is disturbed but he clearly spends a lot of time lying awake thinking about the current relationship that he is in, his problems at work and his life in general. His appetite is good at present and he is putting on some weight. He says his concentration is poor but there are no thoughts of self harm. Although he is still with his current partner, they appear to be in the throes of a separation. I gather they are planning to live together for a short period for financial reasons until she finds somewhere else to live. He remarked about this separation "in some ways I feel happy". He is still avoiding tackling his difficulties at work and has not returned to discuss this with his boss. I told him I think he needs to get this sorted out and he admitted that he would probably feel a lot better when this is done. I have told him to continue with **Dothiepin 225mg per day** I have also encouraged him to attend Citizens Advice Bureau for their thoughts on the various options he has with regard to returning to work. He will be seen again in two months time."
31.03.98	GE attends Medical Centre for Hepatitis A booster.
20.04.98	GE seen by General Practitioner. GE reports feeling about the same and is taking early retirement from work. Dothiepin 225mg at night prescribed (one month) and medical certificate for one month "depression". Noted that he has an appointment to see psychiatrist on 12.05.98.

12.05.98	GE seen by Consultant Psychiatrist B, whose notes are reflected in his report to the General Practitioner, which reads "I reviewed this patient in the clinic on 12.05.98. He remains moderately depressed. His work, he says, forced him to retire and his last day at work is 13.05.98. He is also in the process of splitting up from his partner and is selling the house. I discussed the possibility of him having further counselling support perhaps from RELATE but he did not feel the need for any further support. I would suggest you continue his **Dothiepin at a dose of 225mg nocte (at night)** and he will be reviewed in clinic in September."
15.05.98	Letter from Trustee of Pension Fund, X Ltd to Consultant Psychiatrist B, following GE's retirement at 50 and asking to retire on ill-health grounds, for which Trustees require confirmation that GE will never be fit again to take up work of any kind.
18.05.98	GE seen by General Practitioner. GE reports that work have "retired" him and he feels this should be on ill-health grounds (as does Consultant Psychiatrist B). Work will be in touch. To continue Dothiepin 225mg every day, in divided doses. GE to see psychiatrist again in September. Medical certificate for one month "depression".
21.05.98	Consultant Psychiatrist B writes to Pension Fund Trustee asking for GE's written consent to provide report.
23.06.98	GE attends General Practitioner to sign consent for disclosure of medical information to employers.
29.06.98	Similar consent to disclosure of medical information to employers, received by Psychiatric Services.
06.98	GE purchases camper van. GE and his second wife now living at their new and final address in Holbeck , Leeds.
30.06.98	Letter Consultant Psychiatrist B to Trustee at X Ltd "Further to your letter of 15 May and my subsequent receipt of written permission from GE to release medical information, I have to say that I have only seen this man very briefly on one occasion on 12 May in the Outpatient Clinic. However, I reviewed his notes and it is on this basis that I give this report. You may actually find it more useful to get information from his General Practitioner. GE has about a 9 month history of a depressive illness of moderate severity. This seems to be precipitated by difficulties at work and has been perpetuated by both these and difficulties with finances and in his relationship. It is difficult to know how long he will continue to be depressed as this probably depends largely on his life's circumstances. He doesn't seem to have made any great improvement on antidepressant medication. I can certainly see no reason in principle why GE should not however make a full recovery in time

	and be fit to take up work again."
15.07.98	GE seen by General Practitioner. GE reports some improvement, and going on holiday with his sister to a naturist camp and looking forward to it. To be seen when returns. Six weeks supply of medication and medical certificate for six weeks "depression".
17.08.98	GE seen by General Practitioner. GE reports he has been told that he has early cataract in his left eye while on holiday - no letter from optician. Had tablets stolen while away. GE reports poor sleep and low since he had no tablets. New prescription for Dothiepin and to see optician in Leeds. Will need medical certificate.
18.08.98	GE seen by Consultant Psychiatrist C whose notes, impression and plan are fully reflected in letter to General Practitioner.
19.08.98	Letter Consultant Psychiatrist C to General Practitioner: "I reviewed GE in clinic on 18.08.98, earlier than planned at his request. Unfortunately I did not have his notes but by his account it appears that he has suffered a depressive disorder which began in November 1997 following pressure at work. He was treated with Dothiepin by yourself and has seen my predecessors in clinic since March. His mood improved with treatment but two weeks ago he stopped his anti-depressants so he could drive whilst on holiday. His wife and daughter were on separate holidays. While without medication, his mood became depressed again and this appears to have been exacerbated by him being caught videoing scantily clad people on the beach. He tells me that he was reported to the Police and he thinks charges may be pressed. He restarted Dothiepin 225mg daily yesterday and has had something of a headache since. At interview GE appeared depressed but his affect was still reactive. He described depression of mood, biological symptoms of depression and depressive thinking, including ideas of hopelessness two days ago. These have improved since he restarted the medication and he has no suicidal ideas at present. His guilt over being caught videoing people on the beach appears to be out of proportion to the crime, but his description of his personality suggests obsessional traits and I think has a bearing on this. I think it is clear that his depression has returned because of stopping medication but appears to be improving again. I have suggested he take **Dothiepin 75mg bd (twice a day) for the next few days and then return to Dothiepin 75mgms om (each morning) and 150mg nocte (at night)** I will review him on 08.09.98 as planned."
Aug 1998	Undocumented, undated report of admission to hospital for treatment, overnight stay.
26.08.98	GE seen by General Practitioner. GE reports feeling better now he has recommenced Dothiepin and seen Psychiatrist. Medical certificate for one month given.

08.09.98	GE reviewed by Consultant Psychiatrist C, whose notes, impression and plan are reflected in report to General Practitioner.
09.09.98	Letter Consultant Psychiatrist C to General Practitioner: "I reviewed this patient in clinic today. He has improved since restarting the anti-depressants and now thinks his videoing while on holiday was not as serious as he thought. He has had no contact from the Police yet, but he still thinks they are likely to get in touch. At interview there are still some symptoms of depression but these were markedly improved. I suggest he continues **Dothiepin 75mg om (each morning) 150mg nocte (at night)** and I will review him in two months."
23.09.98	GE seen by General Practitioner. GE reports feeling a lot better. Dothiepin repeated. Medical certificate for one month.
14.10.98	GE seen by General Practitioner. GE reports much improved, and going to his sister's for a while. To see again in six weeks. Medical certificate for six months, Dothiepin to continue.
03.11.98	GE reviewed by Consultant Psychiatrist C, whose notes, impression and plan are reflected in letter to General Practitioner: "I reviewed this patient in clinic today. He complains of persisting depression and insomnia. He still has some morbid guilt about videoing people on the beach while on holiday but tells me that he and his wife are now getting on better. A further difficulty is that his pension since leaving work has still not been sorted out. I suggest he tail off and stop the Dothiepin and start **Paroxetine 20mg daily** In addition I have given him a supply of **Temazepam 10 - 20mg nocte (at night) prn (when required)** but have advised him that he should not continue these for more than four weeks. He declined the offer of help from the Community Mental Health team at this stage as he would like to deal with his problems himself and I have referred him to the Citizens Advice Bureau. It will be two months before I can see him again. Should he come to see you before this and his depression not be improved after four weeks of Paroxetine I would recommend increasing this by 10mg every four weeks to a maximum of 50mg daily."
24.11.98	GE seen by General Practitioner. GE reports when last saw Psychiatrist, he was advised to reduce Dothiepin and start Paroxetine, as he is still very depressed and not improving. Advised to increase Paroxetine by 10mg every four weeks, and has had two weeks so far, therefore Paroxetine 20mg one every day, a two week supply and see again in two weeks. Medical certificate

	for two months.
08.12.98	GE seen by General Practitioner. GE reports improved, cheerful, sleep still poor. General Practitioner prescribes Paroxetine 30mg one every day for one month, then to start Paroxetine 20mg two every day (two weeks and to review when medical certificate will be due).
Dec 1998	GE's sister stores property for GE, who has left his second wife and is living in a camper van.
15.12.98	GE's second wife's employers seek medical information.
14.01.99	Letter from General Practitioner to GE's second wife's employers expressing hope she will be able to return to work soon.
19.01.99	GE seen by General Practitioner. GE reports very much improved. General Practitioner increases Paroxetine to 40mg now. GE is going away for two months and seeing Consultant Psychiatrist C before he leaves.
26.01.99	GE reviewed by Consultant Psychiatrist C whose notes, impression and plan are reflected in report to General Practitioner.
27.01.99	Letter Consultant Psychiatrist C to General Practitioner: "I reviewed this patient in clinic on 26th January 1999. He tells me that he is having a trial separation from his wife and is going to spend time with relatives in Lincolnshire and the South. His mood had improved greatly, though he feels a degree of depression again. At interview he appeared much improved, he reports loss of appetite and some weight loss, and impaired enjoyment. He also has initial and late insomnia. However his depressive thinking is much improved with no hopelessness, no loss of confidence and no morbid guilt. His depression overall appears much improved although some return of symptoms due to his relationship difficulties. These may improve with time away from his wife. I have given him the details of RELATE. He continues taking **Paroxetine 50mg daily** and I have prescribed **Zopiclone 7.5 mg nocte (at night) for five nights**. I will see him again in two months." In the clinical notes, Consultant Psychiatrist C noted that a referral to RELATE was declined.
29.01.99	GE leaves a note, with a key, for his second wife's daughter, at her place of work, indicating he has given up everything to travel, and has left his second wife. In early 1999 GE begins visiting Y Pallets Yard, Brighouse.
09.03.99	GE seen by General Practitioner. GE reports now on 50mg Paroxetine daily and to be seen by Consultant Psychiatrist C in two months. General Practitioner prescribes Paroxetine for two months and medical certificate for two months "depression".

13/14.03.99	GE's motor scooter stolen.
24.03.99	GE's second wife's employers again contact General Practitioner for medical information.
07.04.99	Report by General Practitioner to GE's second wife's employers about ability to return to work.
12.04.99	General Practitioner reports convalescent stay form completed.
30.04.99	GE reviewed by Consultant Psychiatrist C whose notes, impression and plan are reflected in report to General Practitioner.
04.05.99	Letter Consultant Psychiatrist C to General Practitioner: "I reviewed this patient in clinic 30.04.99. He and his wife have separated and he is living in a mobile home. Despite this his mood remains stable. He is uncertain what the future holds for him and his wife and thinks there may be a possibility of a reconciliation but is uncertain whether he wishes this. I have suggested he continue attending RELATE to talk this through. He continues on **Paroxetine 50mg daily** I will review him in three weeks."
04.05.99	GE seen by General Practitioner. GE reports has seen Consultant Psychiatrist C and is to stay on medication till next seen in three months' time. Repeat prescription for Paroxetine 50mg each day. Medical certificate for two months "depression". Also GE reports reduced vision left eye and a film over it. On examination, General Practitioner notes "? Dense cataract". To refer back to Consultant Eye Surgeon. General Practitioner letter of referral to Consultant Eye Surgeon reads: "I wonder if you would be kind enough to see this chap again in your clinic. You saw him in 1996 when I believe an early cataract was diagnosed in the left eye. He is now complaining that he can see very little out of the left eye and he feels as though there is a mist over it. On examination he does appear to have a dense cataract in the left eye, and I would be grateful if he could be seen in clinic again." Psychiatric Services now note GE's current address as "now of PO Box X, Armley, Leeds."
09.05.99	GE's second wife retires from work.
June 1999	GE buys motor scooter.
03.06.99	Letter from Eye Department to General Practitioner, GE now having significant visual difficulties due to dense cataract in his left eye, reducing his vision to counting fingers, listed for left cataract surgery with an intraocular lens implant.

29.06.99	GE seen by General Practitioner. GE reports mental state unchanged, to see Psychiatrist in August. Paroxetine 50mg continued. Medical certificate for two months. Noted to be on waiting list for cataract operation.
28.06.99	Appointment with Consultant Psychiatrist C cancelled by secretary "due to circumstances beyond our control", to be seen on 17.09.99.
31.08.99	GE seen by General Practitioner. GE reports mental state unchanged, saw Consultant Psychiatrist C and remains on Paroxetine 50mg. DHSS have asked for six month certificate. Medical certificate for six months "depression".
17.09.99	GE reviewed by Consultant Psychiatrist C whose notes, impression and plan are reflected in report to .
21.09.99	Letter Consultant Psychiatrist C to General Practitioner: "I reviewed this man in clinic 17.9.99. I think he is improved, he was more cheerful and able to smile. He still has some symptoms of depression including irritability, insomnia and his appetite is still impaired. He is optimistic about the future and has no morbid guilt. He hopes to improve his social life after Christmas he tells me and he and his wife are attending RELATE though it is not going too well. I think his last two problems are maintaining his depression. I recommend he continue **Paroxetine 50mg daily** for the time being. He again declined an offer of help from the Community Mental Health Team but would maybe consider it if he has difficulty reducing his social isolation when I see him in three months."
Late 09.99	GE and his second wife go on holiday together.
11.10.99	7pm GE's second wife's son and girlfriend leave GE's home address for girlfriend's address. At about 11pm GE murders his second wife then dismembers and disposes of her body.
12.10.99	GE attends the Eye Department at Leeds General Infirmary. Eye drops and medical examination. GE is collected and taken home by GE's second wife's son.
22.10.99	GE seen by another General Practitioner. GE reports a letter from his second wife with an address in Liverpool in which she says she thinks she has got AIDS. GE ?delusional. GE is advised to contact the Police.
26.10.99	GE attends Seacroft Hospital for AIDS test.
27.10.99	General Practitioner records shows Incapacity Benefit Form completed. GE attends Eye Clinic for cataract operation, as a day patient. GE discharged that day. Discharge advice note to General Practitioner confirming surgery and drugs upon discharge.
04.11.99	GE attends Eye Clinic for routine post-operative check.

	Letter from Consultant, Eye Department to General Practitioner: "GE's left eye is doing well… The eye is settling well and he is delighted with the visual result. We will see him in ten weeks' time and refract him at that stage."
09.11.99	GE seen by General Practitioner who notes: "Wife has disappeared. ? Suicide. Not sleeping. Currently on Paroxetine 20mg od (every day). Due to see Consultant Psychiatrist C. Asked for "something to help him Sleep" - Rx Atarax 25mg i on(56)" (one each night)
10.11.99	Note by General Practitioner: "I telephoned Consultant Psychiatrist C's sec. He has not contacted her himself. In view of recent events (wife's disappearance) and his low mood, expedite appt - she will arrange for him to be seen in 2/7 time."
12.11.99	Note by Consultant Psychiatrist C: "Urgent OPA - GP request. Low. Wife's clothes found on beach - no trace of her. DNA. Discuss with GP - letter."
16.11.99	Letter Consultant Psychiatrist C to General Practitioner: "I arranged to see this patient in clinic today, 12.11.99, at your request, but he failed to attend. I understand that his wife's clothes had been found on the beach at Bridlington and there is no trace of her. Presumably you have seen him recently. I will arrange another appointment for him. Please let me know if there is anything else you would like me to do."
19.11.99	Note by Consultant Psychiatrist C: "DNA. Should already have appointment."
25.11.99	Letter Consultant Psychiatrist C to General Practitioner: "This patient failed to attend another appointment with me today. He does have another appointment with me on 30th November 1999. If you want me to send him another appointment before then please let me know. PS: I understand from the media that this patient has now been arrested in connection with the disappearance of his wife."
26.11.99	Consultant Psychiatrist C speaks with Trust Medical Director and writes to him with a review of the clinical management of GE's care and then

	concludes: "Having reviewed his case notes, there has been no indication that GE posed any risk to his wife. There do not appear to have been any clear risk factors present, in particular as far as is known GE had no history of violence, did not misuse alcohol, and though he had experienced suicidal ideas at times has not expressed any homicidal ideas. He had experienced what I think was morbid guilt for a period of time, but while I think his guilt was out of proportion to his act, I do not think this was delusional. There is nothing to indicate that he had any delusional beliefs concerning his wife." On the same date, Consultant Psychiatrist C passes GE's case notes to the Trust's Director of Nursing and Quality.

OUTLINE CHRONOLOGY OF STEPS TAKEN BY GE FOLLOWING MURDER OF HIS SECOND WIFE

DATE	EVENT
11.10.99	3pm GE learns he will be alone at home that night with his second wife, as her son will be staying with his girlfriend. At 7pm son and girlfriend leave. 11pm – midnight GE murders his second wife.
12.10.99	In the early hours, GE transports his second wife's dismembered body to Y Pallets Yard about 15 miles away and incinerates the body in a fire in an oil drum. 8.30am GE leaves by bus for appointment at Eye Clinic, LGI. GE indicates that his second wife is shopping and is to meet him later and, when she "fails" to do so, he asks her son to drive him home. Upon arrival home, her son finds a note on the door, apparently from her. 11am GE apparently telephones the Eye Clinic for an appointment. 4.30pm GE apparently finds note on bed, allegedly from his second wife, indicating she has gone away to sort things out. Suitcase and holdall with large amount of clothes, passport and birth certificate also missing.
19.10.99	GE visits his second wife's friend in Liverpool and advises her of his second wife's disappearance. GE shows a letter which the friend thinks is in his second wife's handwriting.
21.10.99	GE's second wife's daughter receives greeting card at home, postmarked Liverpool, in which her mother apparently states she has been unfaithful twice to GE and that she may have AIDS. The daughter believes it is in her mother's handwriting. GE contacts a friend of his second wife in Morecambe, who is concerned that it is out of character for GE's second wife to leave without telling anyone.
25.10.99	GE again visits his second wife's friend in Liverpool.
26.10.99	GE posts letters in Liverpool, supposedly from his second wife. GE attends Seacroft Hospital for AIDS test, result negative. GE's second wife's son opens letter postmarked Liverpool, apparently from his mother and addressed to GE's home. The letter states that she is sorting herself out and attending an AIDS clinic. Her son does not think it is in his mother's handwriting.
29.10.99	GE books holiday in Spain for 6-9 November.
01.11.99	GE's sister telephones and GE arranges to visit her at home on 03.11.99, to collect possessions.
02.11.99	GE acquires Nissan Micra from a car hire firm at Headingley.

03.11.99	GE drives to visit sister and brother.
04.11.99	GE attends Eye Clinic. GE's second wife's handbag, containing her passport and birth certificate, together with two empty Vodka bottles and an empty paracetamol packet are found on a beach at Cleethorpes. Handbag contained left luggage locker key at Cleethorpes Railway Station. Locker contained black holdall of a woman's clothing identified as belonging to her. Holdall returned to locker until 13.11.99. Police initiate "Missing from Home" report resulting in GE's home at C Road being searched for the first time. GE and his second wife's fourth wedding anniversary.
05.11.99	GE cancels holiday in Spain.
06.11.99	GE's second wife's friend in Liverpool give local Police letters written by GE's second wife before her disappearance. Police visit GE at home, who is allegedly nervous when asked about letters supposedly left by his wife. GE gives Radio Humberside interview, with emotional plea for his second wife to contact her family.
07.11.99	GE visits Cleethorpes with his second wife's daughter and husband, and also visits Grimsby Police Station. Walks on seafront, but not where the handbag was found.
08.11.99	GE attends Holbeck Police Station, Leeds to hand in documents including a letter allegedly from his second wife on the date she disappeared.
09.11.99	Holbeck Police receive GE's second wife's letters to her friend via Liverpool Police.
10.11.99	9.15am GE asks Bank what information they would provide to the Police about a customer's account. GE learns that some ATMs have cameras taking pictures of customers when a card is inserted. GE checks with a second bank. GE gives interviews to Viking Radio and Radio Aire. Report released to local press.
11.11.99	GE attends Holbeck Police Station and provides bank statement for his second wife's account. Four withdrawals, each of £200 had been made in Leeds and Grimsby. Police subsequently obtain bank statement which shows that 13 transactions, each of £200, were made in Liverpool, Leeds and Manchester Airport, showing £2,600 had been withdrawn since her disappearance. Police engage forensic document examiner who confirms that the three letters handed to the Police by GE were written by the same person. However, the handwriting differs significantly from the samples supplied by GE's second wife's friend in Liverpool.
12.11.99	GE visits Aire Valley Marina and pays to store camper van for three months, specifically booked in his son's name. GE telephones his son to apologise for

	not telling him of GE's second wife's disappearance and that he would be sending him the spare keys for the camper van.
13.11.99	GE's son takes possession of camper van. Keys were sent via Pateley Bridge post office. On the same day, his son receives letter with receipts from Aire Valley Marina.
14.11.99	GE attends Holbeck Police Station where he remains for three hours giving information about his second wife, consistent with that relayed to the Police earlier.
15.11.99	GE telephones his second wife's daughter to speak urgently about her mother, wishing to speak in private as he has not told her everything. GE tells her he is going to see a solicitor, then he is going to the Police. The daughter asks him to tell her first. GE says that he read the letter the day her mother left, checked the camper van and found between £2,600 and £3,000 missing from the vehicle. GE says he searched the house and found her mother's credit cards and purse with £85 in it and that he had thoughts of getting back what was his. He indicated he would sort it out when her mother got home. The daughter found that GE was becoming confusing and told him to go to the Police. 4.45pm GE attends Holbeck Police Station after an earlier telephone call. GE alleges that his second wife has taken £3,000 from his camper van on the day she disappeared. He reports that he found her purse and bank cards and that he had periodically made withdrawals. 5.00pm GE is cautioned and arrested on suspicion of his second wife's murder.
16.11.99	11.00am GE interview under caution commences, delayed from previous evening when he was deemed unfit to be interviewed as he had not taken his prescribed medication, nor seen a Police surgeon. Further delay occasioned by his lawyer challenging the legality of his arrest. GE interviewed on five occasions, maintaining a "no comment" response throughout. Warrant of further detention granted by Leeds Magistrates. GE provides DNA sample.
17.11.99	GE released from custody. Movements subsequently monitored by Police. Safe deposit box discovered in GE's name, containing two rings earlier alleged by GE to have been worn by his second wife at the time she disappeared. GE further interviewed and told of handwriting expert's findings and of having been seen putting something in the boot of a car early one morning. GE continued to make "no comment" response. GE provides handwriting samples - a slow exercise. In the evening, GE is released on Police bail pending further enquiries.
18.11.99	GE purchases hat from charity shop in Armley.

	GE phones his son at about 2.15pm, wanting to sort out documentation, and arranges to meet the next day. GE visits bank wishing to invest £12,000, GE insisting it must be on 19.11.99 as he is leaving the country indefinitely. Appointment made for GE at 3pm on 19.11.99, when he would also withdraw £200 in cash.
19.11.99	6.45am GE's son meets GE who signs over the camper van and hands him the documents. GE indicated he would need the scooter until 2pm. GE tells his son that he used his second wife's bank card to recoup £2,500 which she had taken from the camper van. 8.50am An unidentified man buys a dark blue heavy woollen overcoat from a charity shop in Armley, later identified as a coat in GE's possession. 9.15am Police covertly search dustbin at GE's home, recovering numerous items of evidence. 9.20am GE again visits the bank, removes items from a safe custody box and places them in a large carrier bag from a charity shop. GE also withdraws £200. GE again travels to Otley by motor scooter, to the river, sorts the items in his carrier bag and discards a video tape and a camcorder tape into the river. He is also observed attempting to set fire to items in a bin. GE is under continuing surveillance by the Police who recover the items from the river. GE makes his way to Leeds/Bradford Airport by bus and on foot. GE checks the price of a single ticket to London then, at another booking desk, purchases a ticket to Amsterdam. GE visits a toilet area at the Airport and changes his appearance, now wearing a hat and dark blue overcoat and glasses. GE asks a cleaner if he can discard other clothes in their bin. At 12.30pm GE is cautioned and arrested on suspicion of obtaining a passport by deception. He was found in possession of a second passport, a flight ticket, a newspaper and £4920 in cash (his other passport having been surrendered as a condition of bail). GE detained at Holbeck Police Station on suspicion of deception. 1.50pm Police execute a search warrant on GE's safe custody box. Items recovered include three items of jewellery taped together. 2pm A search of GE's home reveals a note stating that his second wife had gone to Cleethorpes for a few days. 3.30pm GE is arrested on suspicion of the murder of his second wife. 4.35pm GE is interviewed in the presence of his lawyer. GE relates the events of the night of 11.10.99. He admits to having struck his second wife with a candlestick and then strangling her. He describes how he took her body to the Pallet Yard and burned it in an oil drum. He denies dismembering the body. 5.52pm GE was cautioned and charged with the murder of his second wife

	between 1 October and 15 October 1999, contrary to common law.

REVIEW OF CLINICAL MANAGEMENT

The Inquiry is very grateful to Consultant Psychiatrist A and to Consultant Psychiatrist C who both gave evidence to the Inquiry on two occasions, and also to the General Practitioner.

The Inquiry Panel has looked very carefully at all of the hospital and General Practitioner records, and has questioned these clinicians closely. The Panel is completely satisfied that the clinical care given to GE was of a consistently high standard. There is no culpable act or omission on the part of these clinicians identified.

From the point of view of General Practitioner care, although GE was not registered with the General Practitioner who saw him most frequently, it is remarkable and commendable that, throughout the period of psychiatric assessment and care, the General Practitioner to whom GE turned for help saw him on virtually every occasion. While a presentation of moderate to severe depression may frequently be encountered in general practice, there was never any impression that the General Practitioner regarded this as a matter of routine. It is known that the General Practitioner tried to monitor and treat GE's depression for about three months, before it became clear that a second opinion from a specialist psychiatrist should be obtained. The referral was clear and appropriate and enabled the first psychiatrist, Consultant Psychiatrist A to take matters on.

Thereafter, the General Practitioner not only took responsibility for GE's medication and sickness certification, but continued to see GE very regularly, relating his attendances to recent or up-coming hospital outpatient appointments and the clinical information that was regularly received from the hospital.

It was clear that the General Practitioner had a full knowledge of the patient. It is also clear that GE trusted the General Practitioner and maintained good contact. From the clinical chronology, it is clear that GE never confided anything to the General Practitioner that could have suggested that GE posed any risk to his second wife.

Issues of communication frequently arise in inquiries of this nature. The General Practitioner demonstrated extremely good communication with the patient and with the hospital. The Inquiry is therefore confident, not only that the General Practitioner gave GE exemplary care, but also would have recognised risk factors and taken appropriate steps, if these had manifested themselves. They did not do so.

As an ancillary point, the General Practitioner's notes were clearly written and intelligible. Not only was this of assistance to the Inquiry, but it means that any colleague consulting the General Practitioner's notes would have had no difficulty in determining the steps taken in connection with GE's care. The illegibility of a doctor's handwriting is a notorious source of difficulty. The General Practitioner's notes enabled a clear account to be given, and enabled the Inquiry to approach the General Practitioner's account with confidence. These factors cannot be underestimated in this process, particularly when it arises some years after the events.

With regard to the hospital doctors:

Consultant Psychiatrist A

Consultant Psychiatrist A's specialist training had taken place in Leeds and he was accordingly reasonably aware of protocols and procedures, before he took up this, his first Locum Consultant Psychiatrist post, in which capacity he saw GE on 23.02.98 and 20.03.98. The General Practitioner's referral was addressed to him personally and dated 30.01.98. Although there were matters in GE's clinical presentation that the General Practitioner found rather worrying, this was not an urgent referral and the response time for a first appointment was satisfactory. It is known that Consultant Psychiatrist A allocated 1-1½ hours to the first consultation with GE, which was satisfactory. Consultant Psychiatrist A clearly addressed the matter thoroughly and took a comprehensive history. He recorded a clinical impression of a depressive episode of moderate severity with somatic syndrome, and he determined to ensure that the patient's medication was thoroughly checked in conjunction with the General Practitioner. He also determined to review GE's care with a follow-up outpatient appointment. He reported fully to the General Practitioner on his findings. All of this reflected a good quality of care and communication.

On 20.03.98, Consultant Psychiatrist A proposed to continue outpatient review two months later, confirmed the patient's medication and advised him of issues to be addressed. He also advised the involvement of a third party agency (CAB). All of this was appropriate. His report to the General Practitioner was correct and reflected good care and communication.

Consultant Psychiatrist B

Consultant Psychiatrist B was employed as a Locum Consultant Psychiatrist and saw GE on one occasion, 12.05.98. His records are reasonably clear and he appears to have followed on the pattern of care instituted by Consultant Psychiatrist A and reported appropriately to the General Practitioner. Consultant Psychiatrist B was not asked to be interviewed by the Inquiry Panel. It is not thought that there is any gap in the Inquiry's understanding of the sequence of events. Consultant Psychiatrist B's report to the General Practitioner was appropriate and continued proper communication. Consultant Psychiatrist B was also briefly involved in dealing with GE's employer's pension fund trustee to whom he addressed a report, as required.

Consultant Psychiatrist C

Consultant Psychiatrist C was appointed as a Consultant Psychiatrist in August 1998, when he took over responsibility for GE's care. He saw GE on the following dates:

18.08.98, 08.09.98, 03.11.98
26.01.99, 30.04.99 and 17.09.99.

Although GE was not due to be seen until 08.09.98, Consultant Psychiatrist C saw him earlier upon request and spent 1-1½ hours with him on the first occasion, as if GE was a new patient. Consultant Psychiatrist C saw him without his notes on that occasion. He formed the same view as Consultant Psychiatrist A, but quite independently. He proposed continuing the same medication, but reviewing dosage, aware that he would see the patient again in about three week's time. Consultant Psychiatrist C reported appropriately to the General Practitioner and, from the outset, demonstrated good standards of care and communication.

Based upon his clinical notes and his recollection of the patient, it was clear to the Inquiry that Consultant Psychiatrist C addressed himself thoroughly to GE's case on each time that he saw him. He took careful note of what his patient told him. By November 1998, he decided to change GE's medication from Dothiepin to Paroxetine, the dose of which he monitored and adjusted accordingly. He also advised the involvement of a third party agency (RELATE) and understood that this was being followed up. On the last occasion that GE consulted him, Consultant Psychiatrist C was considering a referral to the Community Mental Health Team, but understandably that could not be explored before GE was arrested in connection with the disappearance of his second wife. This was the second consultation when referral to the Community Mental Health Team was considered. At that stage (November 1999) Consultant Psychiatrist C was alerted to GE's arrest and took steps to report the matter appropriately to management. His summary at that time, addressed to the Medical Director of the Trust, in terms of whether GE had posed any risk to his second wife, is set out at the conclusion of the Clinical Chronology, and is a summary with which the Inquiry concurs.

Generally, in his care of the patient and in his reports to the General Practitioner, Consultant Psychiatrist C demonstrated the same good standards of care and communication.

In a letter to the Inquiry (after he was interviewed at HMP Wormwood Scrubs) GE wrote:

"*... when someone go's to the Doctor's with a pain, The Doctor can soon find out what wrong, then treat you accordingly, But when it your mind, this must be very hard to treat, Because the Doctor can only work with what people tell them, So I would like to say a big thank you to all the people who look after me when I was going through a very difficult time in my life.*"

The Inquiry has looked carefully as to whether GE deliberately misled his treating clinicians. There are some inconsistencies.

On 15.07.98 he prospectively reported to his General Practitioner that he was going on holiday with his sister to a naturist camp. On 18.08.98 he was seen by his new Consultant Psychiatrist C, who was not given to understand that GE had visited a naturist camp, but was told a slightly different story, that GE was caught videoing scantily clad people on the beach, for which he was reported to the Police.

In the same context, on 17.08.98, GE reported to his General Practitioner that his normal medication (Dothiepin) had been stolen while on holiday, but he informed Consultant Psychiatrist C on 18.08.98 that he had discontinued medication while on holiday for two weeks, as he was driving his vehicle.

There is also the question of attendance at RELATE. The Inquiry was much assisted by the attendance of a witness from RELATE who was able to give detailed evidence of its operation in general but, later, confirmed that, after careful enquiry, it was sure that neither GE nor his second wife (individually or together) had contacted RELATE or attended for counselling.

It is noteworthy that the clinicians encouraged the involvement of third party agencies (CAB, RELATE) while GE was under their care. The involvement of RELATE really follows GE's consultation with Consultant Psychiatrist C on 26.01.99 when, at least, the details of how to

contact RELATE were given. On 30.04.99 Consultant Psychiatrist C suggested that "he continue attending RELATE to talk this through" and Consultant Psychiatrist C clearly was given to understand that GE (with or without his second wife) had taken up this suggestion.

At review on 17.09.99 (the last time seen) Consultant Psychiatrist C understood GE to say that "he hopes to improve his social life after Christmas, he tells me he and his wife are attending RELATE though it is not going too well".

One can speculate that the patient may tell the psychiatrist what he thinks he wants to hear about such issues, where, for example, the patient does not wish to pursue a particular topic and considers it more easily deflected by a "white lie" than by a denial.

In the general scheme of things, these are discrepancies and inconsistencies that only emerge upon most careful scrutiny and which at the time would not have been apparent and, even if they were, may not have been of clinical significance. They may indicate a capacity for deception on GE's part. Bearing in mind the overwhelming deception that was pursued following his wife's death, these matters pale into insignificance.

GE's Second Wife's Health

Although it is known that GE's second wife underwent certain hospital investigations as an outpatient, these involved nothing that is relevant to GE's clinical management. In particular, GE's suggestion that his second wife suffered from AIDS was without foundation.

TRUST'S INTERNAL REVIEW

On 26.11.99, Consultant Psychiatrist C, telephoned the Trust's Medical Director. While there is some doubt as to the Medical Director's precise title at that time, he was regarded by Consultant Psychiatrist C as the medical representative within Trust Management, to whom he should report the emerging picture which suggested that his patient, GE may have murdered his second wife and that GE had been arrested on suspicion of that murder. As should be clear elsewhere, the Inquiry is not adversely critical of the steps taken by the clinicians involved in this case. That being so, the Inquiry's view is that there are no steps that should have been taken by the clinicians which would have affected the outcome here. It was therefore a somewhat academic but hopefully useful exercise, that the Inquiry turned its attention to the circumstances in which this case was brought to the attention of management, and the steps that management took to deal with it.

While there was some uncertainty as to the precise content of the telephone conversation between the two doctors on 26.11.99, there seems little doubt but that Consultant Psychiatrist C was requested to write to the Medical Director with a report and at the same time to send the records to the Trust's Director of Nursing and Quality (DNQ) (which he did the same day). This would have been an opportune moment for the Medical Director to make Consultant Psychiatrist C aware of the review and investigatory procedures that would follow. At that stage, Consultant Psychiatrist C was not advised to take any further steps and had no clear idea where matters might be heading (particularly as, at that stage, he only knew that his patient had been charged with the murder of his wife, but had no idea as to the outcome of any criminal process).

It should be recorded at this stage that Consultant Psychiatrist A, who has remained an employee of the Trust throughout, knew nothing more about this case (from March 1998) until September 2001, when he was asked about the case and made some additional comments. Thereafter, he heard nothing more about the case, until he was asked to attend this Inquiry Panel.

The sequence at the time appears to have been:

1. Serious untoward incident report

This is attached as Appendix D. Presumably upon the basis of a verbal report by the Medical Director to the DNQ on 26.11.99 (the same day upon which Consultant Psychiatrist C spoke with the Medical Director) the DNQ submitted a "serious untoward incident report" to the Regional Director of Public Health and Healthcare, NHS Executive, Northern and Yorkshire Region and to Leeds Health Authority.

By this point, the DNQ had been at pains to establish the legal status (informal) of the patient and the type of incident that he was charged with, the murder of his wife. The DNQ recorded the incident description as:

"Wife's clothes were found on the beach at Cleethorpes. Rang Consultant Psychiatrist C for an urgent appointment for GE, but GE did not keep appointment. GE has subsequently been charged with the murder of his wife - more details to follow."

The DNQ noted further action as "management review to take place, co-ordinated by the Director of Nursing and Quality".

The Inquiry understands that there is variance between Regional Offices as to the extent to which they ensure local action is taken to establish an internal review, for example in a case of homicide nominating suitable external people (such as a forensic psychiatrist) to be on the panel. In this case, the Regional Office does not appear to have taken such action.

2. Management review

This is dated January 2000 and was conducted by the DNQ. It is attached as Appendix E. It comprised a review of some of the background details relating to GE being charged with the murder of his second wife (as were publicly available) and a review of the clinical records. The management review is brief and is a succinct summary of the clinical notes.

Under "incident details" it refers three times to the discovery of GE's wife's clothes on a beach near Bridlington between 12 and 16 November 1999. By the time these "incident details" were recounted, it was widely reported that GE had been charged with the murder of his second wife on or about 11 October 1999, but it is appreciated that this management review in January 2000 was compiled before the criminal trial. With regard to the "Conclusion" section of this management review, the following numbered paragraphs merit comment:

2.01 It might more accurately be stated that Consultant Psychiatrist A's involvement ended on 20.03.98 and Consultant Psychiatrist B's involvement began on 18.08.98.

2.02 The degree of severity of the depression (moderate/severe) should be noted.

2.03 The offering of appointments that were not kept occurred only in November 1999, more than a month after the murder.

2.04 The interval between appointments is suggested as "a month to six weeks" but were as follows:

18.08.98 - 08.09.98 - the latter was a pre-arranged appointment, and 18.08.98 was added at short notice, at the patient's request.

08.09.98 - 03.11.98 - that is roughly two months.

03.11.98 - 26.01.99 - that is nearly three months.

26.01.99 - 30.04.99 - that is three months.

28.06.99 - appointment cancelled by Consultant Psychiatrist C.

30.04.99 - 17.09.99 - that is five months.

It is unclear why shorter intervals were stated, when the actual intervals were appropriate.

2.05 Agreed.

2.06 It was clear from the outset of treatment that GE's difficulties in his relationship with his second wife were (with work stresses) recognised as the underlying causes of his depression. His relationship with his second wife was explored in some detail. Referral to RELATE was advised and there are frequent references to separation (actual and threatened) between them.

2.07 Agreed.

2.08 Agreed.

The DNQ indicated that this "management review" would go to both the Regional Health Authority and to Leeds Health Authority, for information. The DNQ agreed that, having broadly concluded that there were no major issues arising out of this case, it was effectively shelved, pending the outcome of Police inquiries and due legal process.

GE's trial took place at Leeds Crown Court on 23.10.00, 02.11.00 and 03.11.00, when GE's plea of guilty to a charge of murder was accepted, and he was given a sentence of life imprisonment. This was widely reported. The Trust has been asked about link liaison policies with the Police, particularly relating to a homicide or a suicide in the community. It was acknowledged that, at the time, there was not strong Police liaison and, for whatever specific reason, the Trust was unaware of the outcome of the criminal process from the Police, but also did not pick up on this from widespread media reporting. It was agreed that, until the time of the trial, internal inquiry had really gone "off the boil" but it was also made clear that there is now much closer liaison with the Police, which may have stimulated the next step to have taken place sooner. In any event (as mentioned later) there is a different "clinical critical review process" now which should encourage the Trust to review a case of this nature sooner, even before the conclusion of all legal process.

3. Internal review

It was not until 26.09.01 that the Trust concluded a confidential Internal Review, chaired by a non-Executive Director of the Trust assisted by the DNQ and the Associate Medical Director. A copy of the report is attached as Appendix F.

It was intended that the panel should include an external Medical Director, who was unavailable at short notice, and the Associate Medical Director took part.

Shortly before this review process, Consultant Psychiatrist A and Consultant Psychiatrist C were sent a "pack" comprising the clinical notes and their comments to the review panel are included in the report at sections 6 and 7. In his evidence to the Inquiry, the DNQ stated that the time lapse between the Court case and setting up the internal review was longer than it should have been. He also indicated that the Trust had not viewed the review as a matter of urgency. In respect of clinicians being

aware of the processes that followed such an incident, he acknowledged that there were gaps in information.

In the "internal review" report section 4 "incident details" states "GE was charged and convicted of murdering (name of GE's first wife) some time between 12 and 16 November 1998." Not only is the victim wrongly named, but the date of the murder (11.10.98) was widely known and reported and to put it back a month (in terms of understanding the clinical sequence) is an unfortunate inaccuracy.

With regard to section 5 "psychiatric history and care prior to the event" this is effectively a recital of the "previous psychiatric history" in the "management review" report also composed by the DNQ, with some minor alterations and a little expansion. The impression is that this section 5 was composed by reference to the clinical notes, but before Consultant Psychiatrist A and Consultant Psychiatrist C were invited to comment.

Section 8 of the "report of the internal review" sets out various findings which must be read in conjunction with the "action plan".

INTERNAL REVIEW "CONCLUSIONS AND RECOMMENDATIONS"

8.1 Risk management

This is clearly stated, but acknowledges the "time penalty that this will impose". Some tick box format seems to be anticipated. The Inquiry considers it unlikely that this format would disclose anything positive in a case such as GE. Such an approach may readily apply to patients on enhanced CPA, but realism must apply.

8.2 Involvement of relatives

The clinicians readily explained that, while it may be helpful to meet with relatives (in this case, if GE's second wife had also attended) it is not for the clinician to be unduly proactive in securing the input of a third party.

8.6 Care planning

The patient's non-attendance at outpatient appointments in November 1999 can indeed be "deduced to be attributable to the index offence mainly" (if not entirely). It should be made clear that this is the only period when there was non-attendance at outpatient appointments. It is also worthy of note that the patient's address, as known to the Trust, had changed to a PO box in Armley and that may have been used for the purpose of sending appointment cards but (apparently unknown to the hospital) GE had been living at C Road since about June 1998. Clearly that is not a significant factor in explaining non-attendance.

Reference is made to "a standard CPA". In evidence, Consultant Psychiatrist A and Consultant Psychiatrist C spoke of "level 1", which appeared to be the category description used in 1998/1999. The recommendation of the internal review panel (comprising entirely officers of the Trust including a nurse and a psychiatrist) is "that CPA documentation should be completed". The Trust did not provide any forms at

the time for "level 1" cases. The clinicians considered that accepting a referral, reporting to the referrer and making arrangements for outpatient review by the treating consultant should be categorised as "level 1". All cases accepted by Psychiatric Services were recognised to fall within CPA requirements, but "level 1" required no further formalisation other than recording in the clinical notes. The Consultant's letter to the General Practitioner and the follow-up arrangements were the documentary evidence of "level 1" CPA. Neither Consultant Psychiatrist A nor Consultant Psychiatrist C appears to have been asked about such categorisation by the internal review panel.

In this context, the Trust produced two relevant documents.

The first was called "Leeds Community and Mental Health Services Teaching NHS Trust - Care Programme Approach Handbook". This was marked "final draft" and dated February 1995. It is referred to as the "1995 Handbook".

The second document is called "The Care Programme Approach - A manual for the guidance of staff working in and with the Mental Health Services in Leeds" and is dated January 2000. It is referred to as the "2000 Handbook" and some referred to it as the "Orange Handbook".

The Inquiry was assured that the 1995 Handbook (although marked "final draft") was as in force at the relevant time. It was also indicated that there was also other advice circulating in 1998. As the Trust as a whole did not work uniformly to the same guidance, it was not clear that the Consultants had necessarily seen or worked to the 1995 Handbook. It appeared that there was some fragmentation of Psychiatric Services between sectors and sites. The whole thrust of this 1995 Handbook, in reference to CPA, was to give guidance to what were then known as "level 2 or level 3" and would now be called "enhanced" CPA. It spoke repeatedly of the allocation of a Key Worker (with multi-disciplinary managerial and professional support) but it was clear from the criteria in this document that neither Consultant Psychiatrist A nor Consultant Psychiatrist C should have considered GE as likely to benefit from a formal care programme, in that it related to more "severe" cases. While all patients (including patients in the community, not in-patients) should be considered for a care programme, the mandatory part of the 1995 Handbook related to patients where:

(a) there is a mandatory aftercare requirement under Section 117 of the Mental Health Act 1983;

(b) there is a requirement for input from more than one agency and where complications with co-ordination of services between agencies can be anticipated;

(c) the patient has required a continuous period of in-patient treatment for more than six months and is being prepared for discharge.

There was also reference to a need to assess that the individual case fell within the resources to provide the care programme.

To the extent that Consultant Psychiatrist A and Consultant Psychiatrist C considered CPA, they considered this to be level 1 without further need of formalisation, other than a report to the General Practitioner and the making of follow-up arrangements. The Inquiry entirely agrees with that approach, as long as the assessment decision is recorded in the clinical notes.

Against that background, it is unclear what, if any, omission was identified by the internal review, leading to the recommendation that CPA documentation should be completed. The panel heard that, on a patient's records, the letter to the General Practitioner might be stamped "standard CPA". In GE's case, the panel would have considered that to have been more than enough.

There are very many patients known to Psychiatric Services who would fall into this category. It seems unrealistic and unnecessary to add a further tier of documentation.

The Inquiry was reminded that this is an evolving situation and, since CPA began in the early 1990's, it has been implemented in different ways in different parts of the country.

The Inquiry has accordingly looked prospectively at the 2000 Handbook. It sets out "the Two Level Approach" of standard and enhanced CPA and states that standard CPA applies to "service users" who:

(a) require the support or intervention of one agency or discipline or require low key support from more than one agency or discipline;

(b) are able to self manage their mental health problem;

(c) have an active informal support network;

(d) pose little danger to themselves or others;

(e) are more likely to maintain an appropriate contact with services.

There is a flowchart relating to patients in the community which is reproduced as Appendix H. If this had applied in GE's case, it would not have passed beyond the first two boxes, adopting the criteria set out.

Thus, it seemed to the Inquiry that the recommendation in para 8.6 of the internal review sought to establish an unnecessary additional tier of documentation, over and above that which was readily apparent upon any reading of GE's records. There are resource issues which do not appear to have been taken into account. Consultant Psychiatrist A and Consultant Psychiatrist C should not be thought to have omitted CPA documentation that could have assisted in the clinical management of this case, in risk assessment or in the overall outcome. Moreover, everything should be done to avoid imposing unnecessary documentation requirements upon clinicians, when appropriate entries in the clinical notes will suffice.

8.9 Preparation for internal and independent inquiries

It became quite clear that, when he reported this matter to the Medical Director, Consultant Psychiatrist C had little if any idea of where this might go, except that there might be a criminal case. The clinician is, in such circumstances, entitled to best possible advice. He may or may not seek such advice from his own medical defence organisation, but the Trust should ensure that advice (at least in preliminary, outline form) is available to the clinician in such circumstances. He should be made aware of the involvement of the coroner and of the Police, and the likely course of events. He should be given advice how to deal with Police enquiries and requests for clinical notes and clinical information, particularly if the patient has not furnished consent. He should be guided through the Trust's policies (particularly, now, the incident reporting and management procedure) and the provisions for critical incident review and internal review. The provisions of HSC(94)27 and the inevitability of an external inquiry should be explained. The clinician should have outline guidance what to do in the event of litigation or complaint and should be aware of advice and support in dealing with the media. All of this should be dealt with by careful explanation of what will certainly happen, what may happen and what is unlikely. There should be collective experience utilised in this context. The clinician should not be excluded from management review and it is inappropriate for management to review a case and form judgements about it without the involvement of clinicians in the fact-finding process or in awareness of management's conclusions.

After the report of the internal review was prepared by the Panel in September 2001, two things were proposed.

Firstly is was proposed that the Associate Medical Director would take the report and discuss it with Consultant Psychiatrist C and Consultant Psychiatrist A. That was not done.

Secondly, it was proposed that this review would be reported to the Trust Board. While it appears that a verbal update may have been given to the Board of progress in the internal review procedure, the report itself does not seem to have been presented to or adopted by the Board.

Furthermore, the panel was surprised to discover that the Medical Director stated that he was wholly unaware of this report until about a week before he gave evidence to the Inquiry in April 2002.

This is all the more surprising if one looks at the action plan attached to the internal review report, which requires various steps to be taken by the Medical Director. It seemed apparent to the panel that, having compiled the report, it was shelved.

Given the realities of this case, it is not appropriate for this Inquiry to comment in detail upon the provisions and directions made by the Trust with regard to enhanced CPA.

There has been some delay in obtaining documentation from the Trust when requested by the Inquiry and the DNQ, accepting this, explained that there had been at least one other inquiry in process during the relevant time. The Trust has to determine the

resources it makes available in responding to an inquiry of this nature. It may be that there is already another inquiry that would look at the provision for patients on enhanced CPA. This Inquiry lacks the concrete example from which to make such further investigation.

TRUST'S IMMEDIATE RESPONSE

When it became apparent to Consultant Psychiatrist C, on about 26 November 1999, that his patient had been arrested upon suspicion of murder and might have committed that act, there were no immediate written guidelines as to what he should do in such precise circumstances. The Inquiry does not consider that there should be a protocol for every situation and it is hoped and expected that homicide will be rare in the extreme. What Consultant Psychiatrist C did was correct, in any event. It is the subsequent failure of the Trust to keep him informed of developments relating to his patient that is criticised.

Nevertheless, the Inquiry's attention was drawn to the Trust's "incident reporting and management procedure" issued in September 2001, from which could be extrapolated what a clinician should do if it became apparent that a known patient might be involved in a homicide in the community.

Attached as Appendix G to this report are Appendix A and Appendix B to this September 2001 procedure. The following points emerge:

(a) the initial responsibility to attend and investigate the matter devolves upon the clinical services manager;

(b) there is a strict timescale which, if observed, would ensure that the time delays in this case would not occur;

(c) it is expected that the Trust should not passively await the outcome of legal procedures (coroner's inquest, criminal trial etc) but should be instructed by the Chief Executive to take steps to investigate a matter. This reflects a proper attitude that, if lessons are to be learned from a particular incident, then the sooner they are the learned the better.

In Appendix B to this procedure, examples of "serious untoward incidents" are given which encompass homicide or serious injury of a member of staff in the course of their NHS duties and "the death or serious injury of a patient or a member of the public which is alleged to be at the hands of a patient while on NHS premises". The Inquiry sees no reason to include the words "while on NHS premises" in this context. Homicides in the community should not be excluded.

The next question addressed by the Inquiry concerned information to be given to the relatives of a patient and/or a victim in a case of this nature. Certainly there were no guidelines for the clinicians and the view was clearly expressed that there may be some staff within the Trust who are better trained or prepared to deal with relatives in such extreme circumstances, which should not necessarily be a task that falls upon the lead clinician. The Inquiry suggests this is the correct approach and would add that the lead clinician may, in the minds of bereaved relatives, be the "prime suspect" in any complaint about clinical care, which may include an assumption that, if something has gone wrong, it must be someone's fault. The

distress of the clinician and the lack of experience in such situations may be important factors.

There was little if any evidence of support being offered to the individual clinician when the likelihood of a murder arose. Essentially the Inquiry is content that the Medical Director would have asked Consultant Psychiatrist C if he needed support in some form, and the latter may have declined. It is far from clear what specifically could have been offered in this context. It is recognised that the Trust now formally recognises the need for support of its staff in such cases. Little if anything may really be required. There was nothing put on Consultant Psychiatrist C's personnel file when he first reported this matter to the Medical Director in 1999, or subsequently.

CONCLUSIONS AND RECOMMENDATIONS

It is generally recognised that homicides by patients in the community, known to psychiatric services are rare but, as matters stand, they require investigation by an independent inquiry.

This Inquiry is wholly satisfied as to the standards of care given by the clinicians to GE.

There are, in these circumstances, only a few recommendations that arise and which the Inquiry commends to the Strategic Health Authority for implementation:

Care and Treatment

1 The Trust should ensure that lead clinicians (Consultant Psychiatrists, whether substantive or locum) have clear induction and guidance into the implementation of the care programme approach and are fully aware of the documentation required by the Trust, so that there is total consistency.

2 At the same time that recommendation 1 is implemented, Trust management should ensure that, in cases of patients on standard CPA, documentation requirements are kept to an absolute minimum.

3 The Trust should ensure that where documentation is produced (such as the CPA manual) that includes a review date, that review date is observed and, even if there is no amendment to the document concerned, that is verifiable. Where such review has not taken place as intended, the oversight should be made good.

4 The Trust should ensure that there is a regular check of those attending outpatient clinics, that the home address known to Psychiatric Services is up-to-date and is correct.

Management

5 The Trust should ensure that there is clear guidance for all those involved in the clinical care of patients in the community, as to the formal steps that they should take, if and when something goes wrong. The Trust should ensure that its staff have a clear understanding of its "incident reporting and management procedure" protocols from time to time in force.

6 Where appropriate, the Trust should ensure that individual clinicians have access to legal advice as to the various avenues (including inquiries) down which a case may go.

7 The Trust should ensure, in implementing its serious untoward incident follow-up action procedure, that care is taken to investigate cases, at whatever level, as quickly as possible and, wherever possible, without waiting for the conclusion of external investigation and legal procedures. The Chief Executive's discretion in this area should always take the need for speed into account.

8 The Trust should ensure that it continues to address the issue, that the investigation of a serious untoward incident should involve various individuals and should not devolve unduly into the hands of one director.

9 The Trust should ensure that, in an internal review in a case of homicide or another event of similar significance, there is some external representation on the Panel of Inquiry.

10 The Trust should ensure that its stated procedure, that the report of an internal Panel of Inquiry is sent to the Trust Board, is followed.

11 The Trust should ensure that, if there is an action plan that emerges from such a report, it is circulated to all those who may be involved in its implementation, for discussion and for action.

There are, additionally, the following general recommendations that the Inquiry makes which do not fall directly to the Strategic Health Authority for implementation, but which should be referred to the Department of Health and other appropriate agencies for consideration.

12 Consideration should be given by the Department of Health to making a direction that the terms of HSC(94)27 do not apply where, as here, the patient pleads guilty to a charge of murder and the Court is satisfied that it is appropriate to deal with the case on that basis.

13 Further consideration should be given by the Department of Health to the issue, whether inquiries under HSC(94)27 should now be ended, with responsibility transferred to the National Patients Safety Agency, as outlined by the Minister in July 2001. Until the situation is resolved, the present inquiry system can be perceived to be flawed and lacking in transparency.

14 However such enquiries are to be regulated, those charged with their conduct should have clear powers to compel the attendance of a witness or the production of documents, particularly clinical records. The situation where the patient who kills might block an inquiry, by refusal to authorise clinicians to disclose details of care, should not arise.