EAST LANCASHIRE
HEALTH AUTHORITY

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

November 1997

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

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

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

W Ashworth

Chairman

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INQUIRY INTO THE CIRCUMSTANCES SURROUNDING

THE DEATHS OF

MR MICHAEL HORNER AND MRS HAZEL HORNER

Chairman: W. J. Williams, Esq.

EAST LANCASHIRE HEALTH AUTHORITY - NOVEMBER 1997

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Appendices

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

INTRODUCTION

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

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

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

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

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

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

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

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

[1] 14th March 1996

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CHRONOLOGY OF EVENTS IN THE ILLNESS OF

MR MICHAEL HORNER

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

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

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

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

OUTPATIENT CARE

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

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

The Drs Datta - general practitioners

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

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

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

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

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

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

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

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

Dr Ian Blake - senior registrar

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

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

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

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

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

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

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

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

Dr N Purandare - senior registrar

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

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

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

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

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

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

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

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

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

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

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

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

'for further assessment.'

Mr Fullalove - community psychiatric nurse

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

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

Dr K C Gupta - consultant psychiatrist

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

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

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

Dr D Franks - consultant psychiatrist

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

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IN-PATIENT CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

72. Dr Franks told us he had seen Mr Horner around the ward. He seemed pleasant and unremarkable. He had not altered his medication while he was an inpatient because he felt it was best to make one change at a time and evaluate it. They had made the big change of removing him from his marital situation to the ward. He thought it was striking that he interacted so well with the nurses on the ward, and that he had settled in very well, being bright and active. There was a dramatic difference, more than any of the team had expected, as a result of his admission. As a result, his view of the importance of medical drug treatment had declined. He thought that the admission had had a considerable effect on Mrs Horner, which was parallel to the situation where the carer of a dementing relative obtained respite care, and then, after experiencing freedom from the stresses of caring, was not prepared to go back to it. In his opinion, Mr Horner was not sectionable at any time.

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THE PRINCIPLES AND PROCESS OF CARE

Putting suicide into context

73. In 1992 the Health of the Nation White Paper launched a strategic health initiative in England. It selected five key areas, of which one was mental illness. Objectives and targets were set in each key area and the White Paper set a framework for the initiation, development, monitoring and review of the strategy.

74. The objective of the mental illness key area is that of reducing ill health and death caused by mental illness. The targets are:

- to improve significantly the health and social functioning of mentally ill people;
- to reduce the overall suicide rate by at least 15% by the year 2000, and

- to reduce the suicide rate of severely mentally ill people by at least 33% by the year 2000.

75. The Report explains that the incidence of suicide in men is more than twice that of women and that for men hanging is the second most used method. It also correlates causes and concludes that the most likely characteristics which lead to suicide are:

Male	√
Bereavement in childhood	
Divorced - widowed - single	about to be
Family history of mood disorder, alcoholism or suicide	
History of deliberate self harm	√
Living alone (socially isolated)	about to be
Physical illness	√
Psychiatric and personality disorder	√
Social classes 1 and 5	
Unemployed or retired	√

We have ticked those characteristics we believe apply to Mr Horner.

Care Programme Approach

76. The basic principles governing the discharge and continuing care of all mentally ill people are embodied in the Care Programme Approach (CPA), which authorities were required to introduce in 1991,[2] and which were re-affirmed in HSG(94)27. The Care Programme Approach applies whether or not a patient has been detained compulsorily under the Mental Health Act.

77. The essential elements of an effective care programme are:

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[2] Health Circular (90) 23/Local Authority Social Services Letter (90)11.

- systematic assessment of health and social care needs (including accommodation);

- a care plan agreed between the relevant professional staff, the patient and his or her carers and recorded in writing;

- the allocation of a key worker, and

- regular review.

Those taking the decisions must be satisfied that these conditions are fulfilled before any patient is discharged.

78. It is essential for the success of a continuing care plan that decisions and actions are systematically recorded, and that communications between members of the care team are clear. The patient and others involved (including as necessary the carer, health and social services staff and GP) should be aware of the contents of the plan and should know:

- its first review date;
- information relating to any past violence or assessed risk of violence on the part of the patient;
- the name of the key worker (which should be prominently identified in clinical notes, care plan and computer records);
- how the key worker or other service providers can be contacted if problems arise, and
- what to do if the patient fails to attend for treatment or to meet other requirements or commitments.

CPA Register and Supervision Register

79. All patients referred to specialist psychiatric services must be assessed against the criteria for CPA Register and Supervision Register. Recommendations from the Department of Health suggest the following points are key indicators to be considered:

i) past history;
ii) self reporting by patient;
iii) observation of behaviour and mental state;
iv) discrepancies between what is reported and what is observed;
v) psychological observations including psychological tests;
vi) statistics derived from studies of related cases, and
vii) prediction indicators derived from research.

80. A consultant psychiatrist must ensure that consideration for inclusion on the CPA Register or Supervision Register takes place at least once during a period of inpatient stay, day care or as seems appropriate. This should take place within a ward or team meeting, and the primary nurse or key worker, whether ward-based or department-based, will be responsible for ensuring that CPA Register forms are completed and inputted into the CPA Register or Supervision Register database.

Discharge policy

81. The 1991 Blackburn, Hyndburn and Ribble Valley Healthcare NHS Trust Mental Health Unit policy for discharge was the policy in effect when Mr Horner was an inpatient.

82. It recognises that the CPA with its emphasis on systematic assessment of health and social care needs, requires close inter-disciplinary and inter-personal working, particularly at critical times such as when discharge from hospital is being considered, and stipulates that:

- all discharges should be the subject of a discharge and aftercare meeting. The policy recognises that the meeting '....might be part of a regular ward multi-disciplinary meeting.....but.....an aftercare plan is to be made (and) all those expected to contribute to the plan will be informed and expected to attend for that item.....;

- the multi-disciplinary team has a responsibility to discuss future plans for discharge and (obtain) agreement for individual responsibility, including who is to be the key worker;

- the proposed key worker must attend the pre-discharge meeting in order to confirm acceptance of key worker responsibility;

- discharge plans should be discussed well in advance of the planned date, and discharge should not take place until the patient's home circumstances have been assessed. Wherever possible, the patient and/or his carer must be fully involved in any discussion about aftercare. The views of any relevant relative, friend or supporter of the patient must also be considered. Agreement and understanding of the aftercare plan must be reached with the patient, his/her carer and the key worker if appropriate;

- discharge plans should address what to do if the patient fails to attend for treatment or to meet other requirements or commitments (such as) how the key worker or other service providers can be contacted if problems arise;

- senior ward nurses and/or primary nurses are responsible for informing the patient, relatives or carers of the anticipated dates of discharge and ascertaining the whereabouts of the door key etc. They should also record in the nursing record all actions taken .....and communications..... made;

- medical staff are responsible for sending a full written report to the general practitioner and completing the discharge record, including the aftercare plan and outpatient follow up arrangements in the medical notes.

83. It also emphasises that the primary nurse at ward level will act as co-ordinator, ensuring that documentation is completed and communication actioned.

Primary nursing

84. The Primary Nursing Protocol in use during Mr Horner's stay, stipulates that all new patients will be admitted by a primary nurse on duty at that point in time, and that on the rare occasions that no-one designated to act as a primary nurse is on duty when an admission arrives, the patient must be allocated to a primary nurse on the next shift. This is the usual practice in mental health wards.

85. In addition, each patient also has an associate nurse. This nurse is often on

the opposite shift to the primary nurse so as to provide widespread cover for the patient.

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COMMENTARY AND ANALYSIS

Outpatient Care

86. We note that in the 12 months of Mr Horner's outpatient care he was seen by two senior registrars on a total of 12 occasions, and that Mrs Horner was also seen seven times. There was a domiciliary visit by a consultant psychiatrist, ten home visits by a community psychiatric nurse and two GPs were involved. We have examined all the written records that are obtainable for the period and interviewed all those concerned with Mr Horner's care.

87. Although we find the resources made available to him were impressive, we consider that care and treatment deriving from them were rather disappointing. Dr Purandare referred Mr Horner to the CPN, "to have him assessed in a different environment and to occupy him." Mr Fullalove received the referral on the *8th December 1995* and met Mr Horner for the first time on *11th December*. Later that day, Mr Fullalove wrote to Dr Purandare describing the consultation. He did not write again until *26th February,* and there is no record of telephone conversations or meetings in the meantime, even though he had seen Mr Horner on eight more occasions. His reason for writing on *26th February* was to inform Dr Purandare that Mr Horner had overdosed the previous evening. His next letter was to Dr Franks on *19th March* to tell him that during a ward visit, Mr Horner had told him he had thought of hanging himself by a belt from the curtain rails in the male dormitory. Mr Fullalove wrote extensively in his CPN notes, but there is no evidence that such notes were ever seen by anyone else, or that the information contained in them had a significant effect on Mr Horner's treatment by the other members of the team.

Diagnosis

88. Dr Datta's referral letter of *25th January 1995* referred to Mr Horner's *'depression following his loss of job due to ill health'*, to his improvement with Prothiaden, and his change to another anti-depressant, Prozac, because of side-effects. Dr Blake wrote to Dr Datta on *13th March* 1995, saying that his impression was that Mr Horner had *'a reactive type of depression with symptoms of anxiety* ...

precipitated by a change in his lifestyle'. He felt that his mood was normal when he saw him and that he was benefiting from the medication. However, on *22nd May 1995*, he *'gave him the benefit of the doubt that he was depressed and ... decided to add Lithium as an adjunct to his anti-depressant'*. There were references to Mrs Horner saying that he was less argumentative on Lithium.

89. The working diagnosis thereafter appears to have been reactive depression.

90. Although Dr Purandare originally intended to review Mr Horner's medication while he was an inpatient, in fact this was continued unchanged, with no record of a discussion about its appropriateness being recorded. **In view of the apparent dramatic improvement in Mr Horner while an inpatient and when removed from his marital situation, it would have been appropriate to consider reducing or stopping medication while he could have been observed,** particularly the Lithium, which is a potentially hazardous treatment, involving regular monitoring by blood tests to ensure that the proper dosage is used.

91. In retrospect it seems reasonable to conclude, that although at times during his outpatient care, Mr Horner was not taking his medication regularly, as his wife reported, that he did take it for most of the time, and that he did benefit from it. It was probably modifying, and to some extent, masking his depressive illness. However, he was taking it while an inpatient, until only one and a half days before his death, and even if he had stopped it immediately on discharge, this would be unlikely to have had any significant effect in that short period.

92. It seems reasonable on balance to conclude that Mr Horner was suffering from a mental illness, namely depression, and that the most appropriate choice from the 'Classification of Mental and Behavioural Disorders'[3] - used in NHS hospitals throughout the country - would be F32 depressive episode. Three grades of severity are given in the classification, mild, moderate and severe. During his outpatient care, the diagnosis of F32.1, moderate depressive episode seems

[3] World Health Organisation, Geneva (1992) ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines

reasonable, at times verging on F32.2, a severe depressive episode without psychotic symptoms in which *'the sufferer usually shows considerable distress or agitation .....loss of self esteem or feelings of uselessness or guilt are likely to be prominent, and suicide is a distinct danger in particularly severe cases.'* During his inpatient stay to most staff, except the occupational therapist, he did not appear to need care at all.

93. There is no clear evidence that Mr Horner had manic mood swings - ie was suffering from manic disorder or manic depressive disorder, or that he suffered from recurrent depressive disorder. It therefore seems best to view his depression as one continuous illness, perhaps beginning in *June 1994*, and continuing until his death in *March 1996.*

94. In addition, it seems appropriate to consider the diagnosis of a personality disorder in view of his lifelong jealous behaviour and associated marital difficulties. Personality disorders are characterised by *'markedly disharmonious attitudes and behaviour involving usually several areas of functioning, e.g. affectivity, arousal, impulse control, ways of perceiving and thinking and style of relating to others. The abnormal behaviour pattern is also enduring, of long-standing and not limited to episodes of mental illness.'*

95. F60.0 paranoid personality disorder appears the most appropriate diagnosis, as it is characterised by *'excessive sensitiveness to setbacks and rebuffs, a tendency to bear grudges persistently, suspiciousness and a pervasive tendency to distort experience by misconstruing the neutral or friendly actions of others as hostile or contemptuous, a combativeness and tenacious sense of personal rights out of keeping with the actual situation, and recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner'*. We note also Mr Horner's suspicions that his business partners were cheating him.

96. In conclusion, **the appropriate diagnosis appears to be F32.1 moderate depressive episode, sometimes verging on F32.2 severe depressive episode without psychotic symptoms, with a lifelong F60.0 paranoid personality disorder, characterised by recurrent suspicions, without justification, regarding the sexual fidelity of the spouse.**

97. A focus on the biological aspects of depressive diagnosis might have led to a trial of different anti-depressants, further benefit to Mr Horner, and a focus on the paranoid aspects of his personality, in particular his jealousy, which was largely concealed by the family, should have led to a greater appreciation of his danger to Mrs Horner. **Geographical separation is the most important action to take when dealing with severe jealousy, and the failure to appreciate this probably contributed to Mr Horner being discharged home before his wife had moved out.**

Interviewing patients in ward rounds

98. This is a controversial topic, on which consultant psychiatrists have differing views. Dr Franks would have some support from colleagues across the country for his disinclination to see patients in ward rounds, but it is noteworthy that his fellow consultants in Blackburn did make a practice of interviewing patients in ward rounds, and that the nursing staff preferred this. (We note that a number of patients on ward F4 complained that they did not see their consultant). It also seems logical that a consultant would be better able to make a decision about a patient if he had actually interviewed him, whether alone in private, or publicly with his team in a ward round. An interview in a ward round provides an opportunity to assess a patient's progress, to plan care, and above all to negotiate, face to face with the patient, the acceptability of, and modify where necessary, a plan for treatment and discharge.

99. We do not of course know whether Mr Horner actually discussed his discharge that weekend with his wife, but we think he probably did: Dr Purandare said he thought Mr Horner was a truthful man and if it was untrue, it seems a rather elaborate lie for an informal patient to tell to get a discharge. Certainly the team believed him, and Dr Purandare felt was appropriate to discharge him at that point, with the level of follow up referred to in paragraph 140. Whether if Dr Franks had chaired the ward round, considering his greater experience and his (alleged) decision the previous Friday, he would have acquiesced, we can only speculate.

Staff attitudes

100. We have heard from many of the ward staff that Mr Horner was very helpful, always shaven, wore a tie and a smart waistcoat, formed good relationships with other patients on the ward (except for the one incident with a fellow patient who was in any case considered to be rather disagreeable), and actually took an interest in caring for at least two other patients. He was generous, and apart from the occasional dark mood was usually affable and agreeable. He caused no trouble, he was clearly not sectionable, he ate well and was quite undemanding. Additionally he had been admitted for assessment only, and he was graded CPA level 1 - the lowest category. Neither of his daughters visited him and it was known he had had some rows with his wife during the last few years and that she was leaving him - indeed she served separation papers on him whilst he was on the ward. Putting all this together, there is an impression - although nobody ever voiced it - that there was something of a 'halo effect' around Mr Horner. This, we believe, contributed to a diminution of interest in him during his stay on the ward. **His illness did not really seem to be taken seriously.**

101. Add to this the absence of a primary nurse. Her duty would have been to take a close interest in him, to speak to his daughters and to Mrs Horner and Mr Fullalove. She should then have discovered the dark side of his personality and demeanour: the suicide note reveals him to be resentful, vindictive, angry, manipulative, aggressive and violent.

Discharge sequence

102. In the course of our deliberations, we naturally turned much of our attention to the events immediately before the deaths of Mr and Mrs Horner.

103. We are mindful that Mr Horner was a voluntary patient and as such could come and go - and indeed did so - as he wished. He could also have discharged himself from the hospital ward at any time. However, Dr Purandare told us that Mr Horner was an agreeable man who had a compliant personality and he, Dr Purandare, felt that had he invited Mr Horner to stay as an inpatient for a few days more, then he would have done so. We are also aware that at that time there was

no pressure on beds.

104. The nursing notes of the *14th March* stated Mr Horner would be discharged in two weeks time, and Mrs Horner told her GP on *Monday 18th March* that she thought her husband would be discharged at the end of the week.

105. The entry in the nursing notes by Staff Nurse Knowles - whose notes are quite the most comprehensive of any of the nursing notes we saw - records that at the *Friday 22nd March* multidisciplinary team meeting, Dr Franks decided that as Mrs Horner was to move out of the family home soon, Mr Horner should not be discharged until that removal had taken place. Dr Kodali was present at both the Friday and the Monday meetings, and at interview was unable to confirm or otherwise that this decision had been made. The medical notes (which she was responsible for writing up) do not record the decision and some of the others who were present at the Friday meeting told us they had no knowledge of it either. Dr Franks himself cannot remember making this decision, but added that he could not imagine the team would have been insistent on Mr Horner being discharged if they had known that Mrs Horner was going to move out on the Friday - only three days after his actual discharge, particularly when there was no great pressure on beds at that point.

106. On *Monday 25th March* Mr Horner asked Sister Dewhurst whether he could be discharged, because he had agreed with his wife over the weekend that they would share their accommodation until she found other premises. Dr Franks was on leave that day so Dr Purandare took the ward round and, as was the practice on ward F4, he read only the medical notes. As they did not record Dr Franks' decision, he authorised the discharge of Mr Horner. He decided this with the background knowledge that according to the medical notes of the *15th March*, he was to be discharged some time the following week. He had told Mr Horner on the *19th March* that he could not be kept on the ward for much longer, and that he was thinking of discharge next week.

107. **Dr Purandare had limited knowledge of the violent side of Mr Horner's personality. He had asked Mrs Horner several times whether her husband was violent toward her and she had always indicated that he was not. Tragically he did not know what Mr Fullalove and Dr Craig knew or what**

Mrs Horner and her daughters had told Staff Nurse Knowles, and which was recorded in the nursing notes: that Mr Horner was obsessive, violent and aggressive.

108. He also knew Mr Horner had attempted suicide twice and threatened it on at least two other occasions. **With this in mind, we believe a full risk assessment, in accordance with HSG (94) 27 and the Health of the Nation report, should have been carried out when considering Mr Horner's discharge.**

Post discharge events

109. Mr Horner returned home on the afternoon of *Tuesday, 26th March*, and was therefore home for about 30 hours before the tragic deaths occurred. During that time, he returned to another ward to visit a patient with whom he was friendly, to fit a watch strap for her. This patient told us she thought Mr Horner seemed somewhat disturbed that day and she understood it was because he was due to see his solicitor. In fact she misunderstood him: he had already seen his solicitor that morning. His solicitor found him quite normal and agreeable. Because of the misunderstanding by his patient friend, and her concern for him, at about 9.30 pm she telephoned to enquire how he had got on with the solicitor. She told us he seemed normal on the telephone and the conversation was cordial but brief. Earlier that same evening, Mrs Wilkins spoke to her mother, who was at the time packing but nevertheless seemed composed. At 10.09 pm Mr Fullalove's telephone answering machine recorded a message from Mr Horner saying "Pete, I need you." What actually happened during that critical 40 minutes we will never know, and we cannot say with any certainty that it was directly connected with the treatment he received whilst under the care of Queen's Park Hospital. **However, we consider that the discharge of Mr Horner to home whilst his wife was still there, packing with a view to moving out within three days, was most unfortunate and probably contributed to her tragic death.**

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ISSUES OF CONCERN

The internal review

110. The Health of the Nation report requires that in cases of the suicide of mentally ill people in contact with the specialist mental health services, there must be a local multi-disciplinary audit. Additionally, NHS Executive Guidelines HSG (94)27 provides that, in the event of a serious violent incident, management must undertake (inter alia) *"an immediate investigation to identify and rectify possible shortcomings in operational procedures with particular reference to the Care Programme Approach."*[4]

111. At one of his monthly meetings with Mr J L Thomas, the chief executive of the Trust, the service manager Mr Philip Hesketh was charged with arranging and co-ordinating this work. However no terms of reference were developed nor were any notes or log kept of the process. In fact the only written documentation available from the Trust are the notes of the review meeting. These notes also went to the Trust Board.

112. The service manager and the consultant psychiatrist set *23rd April 1996* as the date for the review meeting. In the meantime the ward manager was charged with obtaining statements from those staff who had key involvement with Mr Horner. The selection of those staff was made by Mr Hesketh and the ward manager. There is no evidence of any member of staff being interviewed.

113. Invitations to the review meeting were verbal and no record of who was invited was kept, but it is believed that all who were invited did attend. Mr Hesketh could not explain why the ward SHO, the primary nurse, the occupational therapist, the CPA co-ordinator or Staff Nurse Knowles - the only inpatient nurse

[4] paragraphs 76 to 80.

to have spoken to Mrs Horner - had not been invited. Those who did attend were Dr Franks, Dr Purandare, senior Staff Nurse Dodds, Nursing Assistant Yates, Ward Manager Bradley, CPN Fullalove and the legal liaison officer to the Trust, Ms M. Atkins. Mr Hesketh both chaired the meeting and wrote the report. We were told that Mr Horner's notes were reviewed, but the outcome was not recorded.

114. The chief executive felt the review team's report complied with HSG(94)27, bearing in mind that an inquest was imminent and there would be an external inquiry. He was of the opinion that an internal review was not mandatory if there was to be an external inquiry. However, he was not aware that statements had been obtained from only half of the ward staff, and not at all from either the occupational therapist or the ward doctor. **He agreed with the panel's view that the investigating officer should not have also been the disciplinary officer, as was the case with Mr Hesketh, and that the recommendations and conclusions of the review were, on reflection, *"not robust enough."***

115. We conclude:

- **that insufficient consideration was given to the requirements of HSG(94)27, in the belief that a review was not mandatory because a further inquiry would take place. Indeed, HSG (94)27 is quite specific: the purpose is to investigate not review;**

- **the review should have been conducted by staff unconnected with the care of Mr Horner;**

- **the investigations of the review were not carried out thoroughly:**

  i) there were no staff interviews;
  ii) there was selectivity in seeking statements from the ward nursing staff and witnesses;
  iii) the omission of the ward doctor and the primary nurse from the investigation was incorrect and suggests a less than impartial, fair and open investigating process;
  iv) the discrepancy around Dr Franks' view of the timing of the discharge and whether Dr Franks' view was known to Dr

Purandare at the time of discharge, was not brought to light;

v) **it failed to identify and comment upon the numerous shortcomings in the following of procedures and protocols,[5] other than to note that after the reported hanging attempt '....the care plan should have reflected this' and '....the Primary Nursing System was not robust enough in this case to pick up this problem.' However, it continues, 'it is unlikely that this problem had any effect on the eventual outcome....'**

vi) **the desirability of Mrs Horner being advised of her husband's discharge was recognised, but dismissed because she was 'not to be a significant carer in the future.'**

vii) **the lack of communication with the patient's family, so essential in the assessment of risk, was not dealt with at all.**

- **the approach to the Internal Review had an air of complacency about it, and the recommendations in the report were consequently insubstantial.**

116. We also note the absence of any records of the meeting other than the final report, and that, in violation of the Trust's own policy, no action sheet was prepared, setting out changes in procedure as a consequence of the review.

<u>Care Programme Approach</u>

117. The basic principles of CPA are referred to in paragraphs 76 to 80.

118. There is no evidence in either the medical or the nursing notes of any meeting or discussion of Mr Horner's CPA requirements, and no-one who gave evidence to us remembered such a meeting.

119. The care programme summary sheet - completed on the *8th March* - by the primary nurse, does not answer the following questions:

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[5] paragraphs 61,118,119,121, 126,142,143,158.

Present treatment setting	Honos scores[6]
Most recent assessment/review	Key worker
Primary nurse	Diagnosis
Existing care plan	Last date for next review

120. **We believe that the level of missing information on the form reveals an indifference to CPA. We note that health authorities were charged with the implementation of CPA at its introduction in *1991*, and that the East Lancashire Health Authority was mistaken in accepting that a CPA level I assessment did not necessitate a care plan.**

Care Plan

121. The care plan written by the admitting nurse - whilst adequate in itself - was not signed. Neither the primary nurse, associate nurse, ward manager or team leader corrected this error. Nor was it ever re-written to reflect changes in problems, goals or nursing action.

122. The evaluation sheets show one entry by the primary nurse[7] which states '*CPA I completed - does not require level II, no evidence of manic depressive illness.*' There is one entry from the associate nurse: *'To continue.'*[8]

Primary Nurse

123. On the first ward staff meeting held by the ward manager,[9] (who took up the post on 3rd July 1995), problems were recorded with Primary Nursing. At the second staff meeting problems with observation policy were noted. Primary nursing and care planning were discussed at five more meetings during *1995*, and twice more - once after Mr Horner's discharge - in *1996*. During Mr Horner's stay it is recorded that patients were asking who their primary nurse was.

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[6] Health of the Nation score

[7] 8th *March*

[8] 16th *March*

[9] *25th July 1995*

124. When a patient is admitted to a psychiatric ward, the primary nurse is required to complete a CPA 'trigger' document in order to help determine which level of care the patient requires. The trigger document asks whether the person is at significant risk of suicide or serious self-harm, and whether he/she is at significant risk of serious violence to others. To both questions the primary nurse on *8th March 1996*: eight days after admission, answered, NO.

125. Mr Horner was admitted by a student nurse who was in her last week or two of training, and the primary nurse was allocated by the staff nurse who was on duty with her. However, the primary nurse was not due to come on duty for another 48 hours. The associate nurse came on duty 24 hours after Mr Horner's admission.

126. The primary nurse started her leave on *14th March* and the associate nurse was not on duty after *16th March* because of sickness. Neither nurse returned to work until after Mr Horner's discharge. **His nursing care was not allocated to any other primary nurse.**

127. In evidence it was clear that there was much confusion surrounding primary Nursing on the ward during this period, and the ward policy at the time was certainly not followed.

128. A document[10] given to the panel by the ward manager sets out to clarify the roles of the ward manager, team leader, primary nurse, and associate nurse.

129. It does not however address the key issues of the deficiencies highlighted by Mr Horner's case:

- who provides cover when the primary nurse is on annual leave, off sick or away for training, or
- the conflict between the ward manager's role and her job description.[11]

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[10] The F4 Primary Nursing System, incorporated within a team approach', [10]

[11] Protocol - to guide and direct overall activity and development of teams. Job description - responsible over a 24 hour period for the overall management of the ward including staffing arrangements, nursing programmes, ward policy, standards of care and ward procedures.

130. The protocol states that it is the responsibility of the ward manager to designate primary and associate nurses, but the deputy ward manager's job description includes that responsibility. In the event, neither of them appeared to take on this task, either at time of discharge or when annual leave and sickness took both primary and associate nurses away.

131. Many of the nurses interviewed about the period of Mr Horner's stay, referred to the four primary nurse groupings being divided into two teams.[12] This structure was to provide a team leader, one of whose responsibilities was to review care plans. **That clearly did not happen.**

132. The nursing staff communication with Mrs Horner was seriously inadequate. There is only one recorded face to face conversation with Mrs Horner and that was on *4th March*. No other member of the nursing staff attempted to speak to her throughout Mr Horner's stay.

133. **We consider that the absence of a primary nurse for the last 12 days of Mr Horner's stay in F4 contributed to the seriousness of his illness being unrecognised, his consequent lack of treatment and his inadequately planned discharge.**

The 22nd March ward round

134. On *22nd March* the medical notes record *'to be discharged next week.'* Three days later they note *'for discharge on 26.3.96.'* The team knew they were going to consider discharge aftercare and they made no attempt to involve the CPN, Mrs Horner or indeed Mr Horner. We are unable to ascertain if the occupational therapist was present as no record was kept of people attending the multi-disciplinary meetings.

135. **The different understandings of nursing and medical staff from the same ward round[13] is clearly highlighted and is of concern. A contributory cause of this seems to be the practice of not sharing medical and nursing notes.**

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[12] Ward meeting minutes of *6th and 25th September 1996* and an undated meeting in *November 1996.*

[13] paragraphs 66 and 105

Mr Horner's care on the ward

136. Notwithstanding our comment that Dr Franks' practice of not interviewing patients in the ward round did not make a significant difference to the outcome of this case[14] **we believe the *quality* of Mr Horner's care would have been improved if Dr Franks had taken a closer personal involvement in that care.** As consultant he chaired all the ward rounds/multidisciplinary team meetings during the admission, except for the final one on *Monday 25th March*, when he was on leave. During this time he never himself interviewed Mr Horner, either jointly in the ward round, as appears to have been the practice of most of the other Blackburn consultants, or alone in private. This meant that he had to rely entirely on the assessments and notes of Dr Purandare, his senior registrar, which seem to have been thorough and fairly complete, and on the work of Dr Kodali, his senior house officer. Her notes were limited, after her initial assessment, to recording the ward round discussion, and provide no evidence that she actually interviewed Mr Horner in any formal way. Dr Franks told us that he was aware that Dr Kodali's clinical notes casenotes were sparse. This was particularly crucial when Dr. Kodali failed to record Dr Franks' decision (noted in the nursing record) that Mr Horner should not be discharged until Mrs Horner had left the matrimonial home. As a result, Dr Purandare, chairing the final ward round on *Monday* 25th *March*, was unaware of this recommendation, and acceded to Mr Horner's request for discharge.

Discharge

137. Mrs Horner was seen by Dr Purandare on *14th March* and that was the latest recorded date any member of the team spoke to Mrs Horner about plans for Mr Horner's discharge. Mr Horner was asked to discuss arrangements with Mrs Horner but, given the stresses of their relationship and the fact Mr Horner did not inform his wife of his admission, it was an error of judgement to rely on communication by the patient.

138. After *14th March* the view seemed to prevail that as Mrs Horner would not

[14] paragraph 99

be physically caring for Mr Horner she was not recognised as a carer. We note they had been married for 32 years and that as far as the ward knew they would be sharing a home for a month or so. It was also clear that Mr Horner's illness was having a dramatic effect on Mrs Horner's life, and Mrs Horner had tried to support Mr Horner emotionally for many years.

139. We also note that discharge should not take place until the patient's home circumstances have been assessed. **This clearly did not happen**, despite the fact that messages had been passed on via Mr Fullalove that Mrs Horner was going to leave the matrimonial home, and indeed was set to move out on *Friday 29th March 1996.*

140. The medical notes of *25th March* record:

> On Lithium 800 mg liquid nocte 200 gm/5 ml
> Prozac 20 mg mane
> Follow up day hospital - 2 days/week
> Occupational therapy - 3 days/week
> Inform CPN Pete Fullalove.
> (signed) Kodali.

141. This medical record is not an agreed multi-disciplinary care plan with an allocated key worker. A copy of it was not given to Mr Horner or Mrs Horner and there is no mention of outpatient follow up.

142. Mr Horner's discharge day was *26th March.* The medical notes do not have an entry for that day. The nursing notes say *'for discharge this pm.'* We established at interview that Mr Horner attended the projective art session in occupational therapy that afternoon where it is recorded *'to be discharged today,'* suggesting that the OT department did not know until that day. There is no record of whether he:

- was alone or accompanied when he left the hospital;
- had any letters, medication, appointments or contact numbers;

- took all his belongings;
- or even at what time Mr Horner left the hospital.

It raises the issue of when a discharge is complete.

Observation policy

143. The medical notes of *14th March* record that Dr Purandare requested that Mr Horner has *"closer observation."* The nursing notes of the same day record, *'Dr Purandare has requested we observe Mr Horner quite closely over the next 24 hours.'* **However, there is no note in Mr Horner's care plan to reflect any closer observation having taken place, and we established at interview that no-one remembered being asked to observe him.**

144. There is disagreement as to whether the ward staff learned of Mr Horner's alleged attempted suicide on 19th or 20th March,[15] but whichever it was, **the care plan was not amended nor was the Trust's observation policy complied with.**

Purchaser's Contract

145. The service contact which exists between East Lancashire Health Authority and the Blackburn Hyndburn and Ribble Valley Healthcare NHS Trust, is quite general and unspecific in character. It uses words like adequate, acceptable and better: words which make monitoring and measurement extremely difficult.

146. It does however specify that only professionally trained staff should undertake assessments and care planning, and it supports the patient's charter rights: that all patients have the right to be referred to a consultant acceptable to them.

147. The only mention of CPA is to ask for quarterly returns on people eligible for CPA, when in fact every person who comes in contact with the service is

[15] paragraph 61

eligible.

Have things improved?

148. We were naturally concerned to know whether the in-patient care which Mr Horner received was typical and whether it has improved. We therefore asked for the case notes of two patients who were admitted to ward F4 at the same time and examined them. One patient was admitted the same day and the other was admitted the day before. In the case of the patient who was admitted on the same day, the admission process and care plan were completed by a qualified nurse, and the care plan was reviewed and rewritten four times before he was discharged 3½ months later. However, many of the nursing notes were not countersigned by qualified staff; CPA level 11 forms were not completed prior to discharge, and whilst it was noted that the patient's son accompanied him at discharge, no other information was recorded.

149. The case notes of the other patient reveal that the admission details were not signed and the care plan had initials only. The patient was seen in the ward round and his mother was also seen twice. The care plan was reviewed 2½ weeks after admission, but there was no alteration to it. There was no recognition in the care plan of leave taken or preparation for discharge. The notes were not countersigned by qualified staff.

150. Panel member Mrs Hayward visited the ward at 5.30 pm on *April 16th 1997.* She found there were four patients on observations and she checked their notes to see whether the Trust observation policy was being followed.

151. *Patient A* was on 15 minute observations. This was recorded on the Nobo board and there was evidence of the observations in the care plan but not in the medical notes. It was also noted that nursing assistants were signing notes and their entries were not being countersigned - especially at night.

152. *Patient B* was on 30 minute observations. This too was recorded on the Nobo board and there was evidence of the observations in the care plan and the medical notes. All signings were correct.

153. *Patient C* was on 1:1 observations. All entries and signings were correct.

154. *Patient D* was on 5 minute observations. This was recorded on the Nobo board. Other findings were:

April 13th 10 minutes observations noted in care plan - review in 24 hours - not done.

April 15th 12 minute *'observations still in place'*

April 16th *'Strict 5 minute observations maintained'.*

There was no mention of observations in the medical notes and concern was recorded that the patient had not been seen by a doctor since admission. This was rectified by ward doctor seeing the patient on *April 16th* , - there had been a ward round on *April 14th* .

155. We note the Mental Health Act Commission visited QPH on *16/17th January 1997* and (inter alia) made the following comments:

- a CPA co-ordinator was now in post and there had been improvements in documentation;
- all acute patients were included in CPA and all staff had undertaken care and responsibility training;
- there was a significant time lag between the receipt of documents and their being passed to the wards;
- that patients were still being discharged without completion of documentation or the key worker being informed until after the event;
- that CPNs had a very heavy workload.

Staff duty rosters

156. It has taken the panel considerable time and effort to ascertain which staff were on duty at key times and dates. The duty rotas are obviously not altered to reflect all changes made to them because of sickness, annual leave, overtime or a change of duties.

157. Even when staff were asked to confirm their duties from the positive return wage sheet, there was some uncertainty. We wonder what the person who authorises the positive return sheet checks it against.

158. This process was further hindered by the fact that the nursing notes did not comply with UKCC Standards[16].

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[16] UKCC Standards for Records and Record Keeping 1993, *or its replacement,* Guidelines for Professional Practice 1996.

SUMMARY

159. We were asked to comment on:

the quality of professional care Mr Horner received immediately prior to his death;

160. There were three staff groups who provided care for Mr Horner: the doctors, the nurses and the OTs. We note that as an outpatient:

- his GP prescribed two successive antidepressants;
- his hospital doctor prescribed lithium;
- his hospital doctor introduced a CPN;
- he was referred to Relate for marital therapy;
- a consultant made a domiciliary visit at the request of his GP following a suicidal threat;
- although a formal risk assessment was not recorded, the team caring for him (GP, SR, CPN) saw both Mr and Mrs Horner, and considered the risks of suicide carefully and what action they could reasonably take, including finally an assessment admission.

161. His outpatient care was therefore largely good, in contrast to his inpatient care, where his smart appearance and helpfulness on the ward seems to have led to his underlying difficulties being largely ignored.[17] The question of suicide was hardly considered, apart from Dr Kodali's initial admission history taking. His medication was not reviewed and it appears that only the art group occupational therapist actually explored his problems with him, and so elicited the history of his alleged attempt to hang himself on the ward, which she correctly reported to the ward staff.

162. It is clear that the ward operated in a rather chaotic though well-meaning way, with many staff taking a relaxed attitude to their formal duties. There was

[17] paragraph 100

however a few exemplary exceptions, where staff recorded detailed and comprehensive notes, demonstrating that they had an intelligent, thorough and concerned approach to their work. The generally laissez-faire attitude of the majority stemmed from the almost non-existent ward management, which permitted a widespread flouting of policies and a poor standard of patient care.

163. This resulted in the inpatient nursing care leaving much to be desired. The medical care would have been improved by a more accurate diagnosis, a reassessment of Mr Horner's medication, better assessment and recording of his progress by the SHO, and more direct involvement by Dr Franks.

164. However, it must be stressed that this tragedy might still have occurred even if his inpatient care had been more thorough. This is because though Mr Horner's suicide was predictable - and indeed was almost regarded as ultimately inevitable - albeit much later than it occurred; the killing of Mrs Horner was not to be expected. Although there were clues pointing to Mr Horner's potential for violence, Mrs Horner herself had successfully kept the details of his aggression within the family for many years - only beginning to reveal them partially in the final stages of his care.

the suitability of that care in view of his history and assessed health and social care needs;

165. There were no social services staff involved in this case, and we could not discover whether a social care needs assessment had ever taken place. It would seem that with Mr and Mrs Horner's favourable social circumstances and the close involvement of a CPN trained in psychotherapy, there was no obvious need for social work involvement. We conclude therefore that his outpatient care was suitable, but if his morbid jealousy had been recognised, it might have been more successful.

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

166. This report demonstrates departures from the Trust's care plan policy in paragraphs 61 and 121; the primary nurse policy in paragraph 126 and the

observation policy in paragraph 143; Departures from National policies are referred to in paragraphs 118 and 119 (CPA); paragraph 139 - 142 (HSG (94) 37) and 158 (UKCC).

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

167. The decision to discharge Mr Horner on *26th March* was a misjudgement, for two reasons. The first was that Mrs Horner had not been consulted, and Dr Franks' decision on *22nd March* (to keep Mr Horner in hospital until Mrs Horner had moved out of the family home) had not been communicated. The second was that the diagnosis of morbid jealousy had not been made, in part because Mrs Horner had put the family reputation before her own best interests. If this had been recognised, the need for the geographical separation of the jealous husband from his potential victim wife should have been considered.

the extent to which carers were involved in his discharge;

168. We have shown that notwithstanding the Trust's discharge policy to involve carers,[18] no carers were consulted about Mr Horner's discharge. We can understand this: neither daughter lived sufficiently close enough to be a main carer, even if they had wanted to be involved. Indeed, Mrs Wilkins had specifically told the ward she did not want *'contact or responsibility for her father'*. In addition, Mrs Horner had served a separation order on her husband and it was known she was moving from the family home. We recognise that even patients who have a propensity for suicide cannot be kept in hospital wards forever, but nevertheless we think that the decision to discharge a patient in these circumstances, without a full risk assessment, was unwise.

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

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[18] paragraph 82

169. Mental health emergencies are dealt with either by patients going directly to the A&E department or by the police being involved and usually taking the patient to the A&E department. Thereafter, according to the judgement of the medical staff on duty, the on call mental health medical staff may be involved. This policy is adequate for the general population as a whole, but the panel believe that the Trust should consider an out-of-hours service for known patients and their carers to obtain help, advice and guidance. These are listed in our recommendations for improvement in paragraph 179.

the effectiveness of the communication between the various agencies;

170. As none of the social services were involved in this case this issue does not arise. The communications between the GP and the hospital were adequate and we have commented on the communications between the CPN and the medical staff in paragraph 87.

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

171. The resources in the community were more than adequate to meet his needs, and we were impressed by the outpatient care he received, even though it could have been marginally improved by better communication between disciplines.

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RECOMMENDATIONS

FOR THE HEALTH AUTHORITY

172. That the contract between the ELHA and the Trust be re-written using more specific language to make monitoring and performance measurement possible. It should also refer to a patients' right to see a consultant within a week of admission and at intervals of not less than six weeks during the inpatient stay and within a week of discharge.

173. To carry out regular monitoring - which need not be time consuming.[19]

174. The purchaser's role in improving the quality and efficiency of the service should be carried out by:

- ensuring all Trust policies - including CPA - and procedures are being carried out thoroughly;
- establishing multi-disciplinary audit meetings on suicide;
- establishing a suicide prevention group;
- ensuring a clinical audit is held following all suicides of known patients, as specified in the Health of the Nation report.

FOR THE TRUST

175. Strengthen nursing management so as to ensure the Trust policies on:

Primary Nursing; Risk Assessment; Observations;

and national circulars on:

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[19] paragraphs 150 to 154 refer.

are fully implemented and subject to frequent and vigorous monitoring.

176. Improve communication between those staff who care for patients by introducing 'shared' records into which all the health professionals involved in the care and treatment of an individual make entries in a single record in accordance with a broadly agreed local protocol.[16]

177. Forbid the use of the Nobo board as the single channel of communication for such important information as the frequency of observations.

178. Establish a proper organisation for internal inspections so that any deficiencies can be recorded and corrected.

179. Establish support for patients known to the Trust which provides for:

- 24 hr on call CPN service;
- office hours telephone lines to be switched over to wards during evenings, weekends and public holidays, (with appropriate training for ward staff in handling these calls,) so that clients can seek help and advice;
- RMN availability to local A & E unit;
- issue cards for clients with a history of self harm which tell them how they can obtain help in a crisis.

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[16] UKCC Standards for Records and Record Keeping 1993, *or its replacement,* Guidelines for Professional Practice 1996.

EVIDENCE TAKEN FROM

* Mrs Michelle Wilkins (elder daughter of Mr and Mrs Horner)

Mr Horner medical record no 283913P

Community Psychiatric Nurse Record

Occupational Therapy Record

GP Record for Mr Horner

GP Record for Mrs Horner

Suicide notes

Autopsy report for Mr Horner

Autopsy report for Mrs Horner

* *Vivien Aspey*	Director of Primary & Community Care ELHA
Gausiya Bade (nee Sange)	Nursing Assistant, Ward F4, QPH
* *Ian Blake*	Consultant Psychiatrist, Burnley General Hospital
Diane Bradley	Ward Manager, Ward F4, QPH
* *Ian Brunt*	Solicitor, Howarth Nuttall
* *Susannah Craig*	GP, Shadsworth Road Surgery