REPORT OF THE INDEPENDENT INQUIRY INTO THE TREATMENT AND CARE OF PETER RICHARD WINSHIP

JUNE 1997

A REPORT COMMISSIONED BY

Nottingham Health Authority

THE STONE COTTAGE
CHAPEL CORNER
POTTER HEIGHAM
NORFOLK NR29 5LR
01692-670772 (PHONE/FAX)

Report of the Independent Inquiry into the Treatment and Care of **Peter Richard Winship**

A report commissioned by

Nottingham Health Authority

June 1997

PREFACE

We were jointly commissioned in February 1997 by Nottingham Health Authority to undertake this Inquiry.

We now present our Report, having followed the Terms of Reference which were specified to us and the Procedure which was subsequently adopted and issued to all witnesses and their representatives.

Mr Hugh Chapman
Chairman

Dr Jim Higgins
Medical Advisor

Mr Tom Sandford
Nurse Advisor

ACKNOWLEDGEMENTS

Our grateful thanks are due to all of the following:-

Officers of the Nottingham Health Authority for their assistance throughout, with particular reference to Bernadette Maughan and Anne Smith.

Emma Norton for her typing skills.

John McFadyen and Melanie Sursham from Leicestershire Health Authority who provided expert advice and assistance to Nottingham Health Authority.

Staff of Margaret Wort and Co. for their highly efficient transcription services.

All of the witnesses of fact (and especially Mrs Winship and Miss Winship) for their openness and co-operation in a process which was personally demanding and at times stressful.

Robert Nisbet, Peter Winship's Social Worker for his assistance in co-ordinating the Inquiry Panel's interview with Peter Winship.

CONTENTS

REPORT OF THE INQUIRY INTO THE TREATMENT AND CARE OF PETER RICHARD WINSHIP

1. THE OFFENCE

1.1 At Nottingham Crown Court on 06.12.96 Peter Richard Winship ("Mr Winship") pleaded guilty to a charge of manslaughter and was made the subject of a hospital order under Section 37 of the Mental Health Act 1983 and a restriction order under Section 41 of the Act. He would return to Arnold Lodge, where he had been detained for assessment of his mental condition following the killing of his father on 22.07.96.

1.2 In a forensic psychiatric report dated 02.12.96 considered by the Court when disposing of the case it is recorded that "In my view Mr Winship suffers from paranoid schizophrenia (and) has been developing this illness, which is of insidious onset, over the past two or three years".

2. EARLY PERSONAL HISTORY AND DEVELOPMENT

2.1 Peter Richard Winship (Mr Winship) was born on 22.07.76. He has a sister three years his elder. His parents separated when he was four years old because of parental disharmony and violence associated with his father's increasingly heavy drinking. He and his sister remained with their mother in the parental home until he left home to live on his own at the age of sixteen years. His father left to live in Macedon House, Hyson Green, Nottingham, specialist accommodation for those with a serious alcohol problem. His father did not work. His mother continued to work as a warden in an elderly persons complex in West Bridgford.

2.2 There is no history of psychiatric illness in Mr Winship's family apart from depression and anxiety associated with his father's drinking problem.

2.3 It would appear that Mr Winship's physical and emotional development was normal. He attended local primary and secondary schools and eventually achieved a pass in six or seven GCSE's. His aim to sit three A levels at College was frustrated by his increasing psychological deterioration. At school he was a rather shy boy with only a narrow group of friends. He was bullied. He is a Christian and was regularly involved with the local church until 1995.

2.4 Throughout his life Mr Winship kept in touch with his father by regular visits to him at his accommodation. His father made infrequent visits to his ex-wife's home which were usually uncomfortable.

2.5 As he grew older Mr Winship became increasingly concerned about the breakup of his parents' marriage: why it had happened, who was responsible, who was the more responsible, his mother or his father? These preoccupations caused difficulties in his relationship with his mother and caused him to feel depressed, ruminating about what role he might have played in his parents' marital break-up. In addition he was concerned about his acne and at the time of his first presentation to his General Practitioner, Dr K G Bratt, with symptoms of depression he also felt under pressure from the GCSE's he was about to take.

3. THE PSYCHIATRIC HISTORY AND TREATMENT AS RECORDED IN THE HOSPITAL AND COMMUNITY CARE NOTES

3.1 On 01.05.92, at the age of almost sixteen years, Mr Winship made an appointment to see Dr Bratt. Only after discussing the treatment of his acne did he mention not only that he was feeling depressed but also that he had recently taken a substantial amount of paracetamol and alcohol. A referral to a psychiatrist was declined and Dr Bratt started a course of antidepressant medication, Dothiepin. He was seen again on 15.05.92. He described no benefit from medication. His mother phoned Dr Bratt to describe a history of six weeks of aggressive behaviour, odd behaviour, drinking and examination pressure.

3.2 On 07.07.92 Dr Bratt referred Mr Winship to Dr Baruah, Consultant Psychiatrist for the area covered by the Rushcliffe Mental Health Team. In the intervening period no progress had been made. Mr Winship could not or would not tolerate Dothiepin. He was continuing to drink heavily and his mood remained low. His mother and sister were expressing concerns about his condition.

3.3 Dr Baruah saw Mr Winship at his home and in a letter to Dr Bratt dated 20.07.92 Dr Baruah described his findings: a history of anxiety and depression associated with the breakup of his parents' marriage, increased alcohol consumption, the episode of self injury, disappointment at an inability to find a spiritual answer to his questions. Dr Baruah's formulation was an identity crisis in an adolescent. He could not detect any evidence of a depressive illness and he did not favour restarting the antidepressant which Mr Winship had stopped. Dr Baruah made a follow-up appointment for eight weeks and referred Mr Winship for a series of counselling sessions by Mrs Sarah Dunphy, community psychiatric nurse, who also worked in the Rushcliffe Mental Health Team.

3.4 Mrs Dunphy met Mr Winship for the first time on 20.07.92. He discussed his bad temper towards his mother, his pessimism about the future, his depression and ruminations about self injury. He did not want his mother to be informed of the appointment and he was offered weekly contact. He did not keep his next two appointments despite reminders and after discussion between Mrs Dunphy and Dr Baruah he was discharged from Mrs Dunphy's care on 15.09.92. He also failed to attend the follow-up appointment with Dr Baruah on 18.09.92 and was discharged from his care. In a letter to Dr Bratt dated 21.09.92 Dr Baruah advised re-referral in the event of further concerns.

3.5 Mr Winship then wrote to Mrs Dunphy on 17.11.92 and was offered an appointment on 20.11.92. He repeated his concerns about his feelings, his studies and his drinking and seemed keen to have further sessions at weekly intervals. By 26.01.93 he had had six sessions and on that date he said that he felt well. However he discussed some remaining worries, for example fleeting thoughts of killing someone, events in the

Boys Brigade and outer body experiences. He was unwilling to elaborate on these subjects. He next saw Mrs Dunphy on 01.02.93. His previous worries had abated and he felt in control. He asked for an appointment in three months. He was assessed by Dr Baruah on 22.01.93 and no features of a depressive illness were noted. Although Dr Baruah noted feelings of anger towards himself and his father no follow-up appointment was offered.

3.6 Mr Winship made another appointment to see Mrs Dunphy on 04.03.93. Dr Bratt who had seen him on 19.02.93 had recommended that he do this. Dr Bratt was still concerned about his complaints of depression, anxiety and poor concentration. He prescribed a small dose of Flupenthixol (a major tranquilliser and antipsychotic drug which is also prescribed in very small doses as an antidepressant).

3.7 On 10.03.93 Mr Winship made an urgent appointment with Mrs Dunphy. He reported that the evening before he had experienced a surge of emotions resulting in morbid thoughts of death and suicide, but not his own. His mind was spinning but he had no thoughts. He was not in control of his mind and his body and he had been experiencing day dreams which were quite vivid. Mrs Dunphy questioned him about these new developments and reported the denial of hallucinations and passivity feelings. She was however sufficiently concerned to discuss the case with Dr Baruah and colleagues.

3.8 Mr Winship was seen again the following day when he reported that he felt much better and his comments of the previous day were not repeated. He missed his next appointment on 18.03.93 but then had a sequence of weekly appointments only two of which he missed. During some fifteen sessions he talked of suicidal thoughts, concerns about his parents' separation and feelings of guilt. He was encouraged to analyse his feelings about his parents and himself and to dwell on his achievements and assets rather than his failures and perceived weaknesses. During this period Dr Bratt stopped Flupenthixol on 19.04.93 as it did not seem to be effective and replaced it with Fluoxetine (an antidepressant). On 26.04.93 Dr Bratt added Temazepam (a hypnotic) to help him sleep. Despite minor improvement Dr Bratt replaced

Temazepam with a small dose of Thioridazine (a major tranquillizer and antipsychotic) on 11.05.93 and substituted Zimovane (a hypnotic) for Thioridazine on 24.05.93. Because of continuing lack of progress Dr Bratt wrote to Dr Baruah on 26.05.93 for his advice. Dr Baruah replied after a discussion with Mrs Dunphy. Dr Bratt did not feel that his patient had been fully frank with Mrs Dunphy during his sessions with her but by 17.06.93 Dr Bratt recorded that Mr Winship was "improving nicely, now". His only medication was a reduced dose of Fluoxetine.

3.9 On 30.06.93 Mr Winship turned up to see Mrs Dunphy complaining of increased drinking and suicidal thoughts. In view of his distressed state she felt that an assessment by a psychiatrist was required. He was seen that evening by the duty psychiatrist at the A & E Department at Queen's Medical Centre, Nottingham. By this time he had settled, said the risk of suicide was very low and denied psychotic features but he was offered admission because of Mrs Dunphy's account. He declined this and as he was not felt to be detainable under the Mental Health Act he was allowed to leave.

3.10 He was seen by Mrs Dunphy the following day and his weekly sessions resumed. He appeared to be improving but was admitted to hospital on 15.07.93 after having tried to electrocute himself the previous day. He had reported this to Dr Bratt and he was admitted to Ward A44 of Queen's Medical Centre. When seen by Dr Price, SHO in psychiatry, at 19.30 hours Mr Winship gave an account of his family background and his concerns about it. He described his rather isolated life in his own bedsit and limited contact with his mother and father. He complained that in the preceding three days he had deteriorated, had been delirious, almost hallucinating with his mind playing tricks on him, and had been thinking sadistic things which he could not be more specific about because he didn't know. Dr Price did not feel that, at the time of the examination, his patient was experiencing abnormal thoughts and he found it difficult to estimate the extent of risk of further self injury.

3.11 Mr Winship was reviewed later that evening by Dr Fox, psychiatric Registrar. By this time he appeared cheerful but it was questioned whether he was masking his

underlying mood. He talked openly of his previous suicidal thoughts and attempted electrocution. Dr Fox could detect no abnormal signs and felt that the presentation was best explained by a maturing personality with family problems. He felt that there was a low probability of a current depressive illness. After discussion with Dr Baruah admission was offered and accepted.

3.12 On 19.07.93 consideration was given to a referral to the Child and Adolescent Psychiatry Services in view of Mr Winship's age and the assessment that his difficulties lay in his family problems. After discussion with Professor Pearce such a referral was not thought to be indicated.

3.13 Mr Winship remained in hospital between 15.07.93 and 01.11.93. He was seen by Dr Baruah at weekly ward rounds and in between he was seen by a succession of junior psychiatrists. For the most part he appeared settled but there were repeated episodes when he reported psychological distress at his feeling of emptiness and an inability to open up to people. On a number of occasions he threatened self injury and claimed to have taken an overdose.

3.14 The diagnosis made was of an adolescent maturational process, not a depressive illness. His treatment with Fluoxetine continued and throughout his stay he was prescribed small but varying doses of Thioridazine for anxiety and stress.

3.15 Towards the end of his stay he was felt to be becoming manipulative and dependent on the hospital environment. He sought to delay his discharge to find better accommodation. It was thought that he should be discharged but in view of his obvious need for continuing support he was referred to and accepted by the Psychiatric Day Hospital at Queen's Medical Centre run by Professor E Szabadi. He was discharged to bed & breakfast accommodation on 01.11.93. The only medication he was receiving was Fluoxetine.

3.16 Mr Winship started attendance at the Psychiatric Day Hospital the following day. He was assessed briefly and the principal feature observed was his pseudophilosophical

thinking on the meaning of life. His family difficulties and limited social life were again commented upon. His own estimate that he was not mentally ill was endorsed.

3.17 Early in December he asked for an assessment by Professor Szabadi and a lengthy interview took place. He talked about his philosophical and scientific pre-occupations, his difficulties with his mother, his obsession with death and self injury, his dubious relationship with his father, his ambiguous sexual identity, his tenuous grasp of reality, a feeling that he should be put down and his boredom with life. Professor Szabadi did not think that these features in an adolescent, in the absence of other more characteristic features, indicated mental illness.

3.18 Mr Winship was then seen at roughly weekly intervals at the Day Hospital. Initially he did not want his medication varied although he did not feel that it was helping him. He found new accommodation. By 01.02.94 all medication had been stopped with his consent and plans were being laid for his eventual discharge in four to six weeks time. On 10.02.94 he was seen by Professor Szabadi's Registrar who commented on his continuing moderate depressive symptoms. Mr Winship's anxiety and depression continued to increase and he was prescribed first Thioridazine and then Lofepramine (an antidepressant). By 10.03.94 some improvement was reported, his drive had returned and he was speaking of an Open University Course. An ambivalent attitude to his father was recorded. However by 05.04.94 Mr Winship was reporting no benefit from medication and asking if a hypnotherapist might help. This was discouraged. Medication was stopped. On 14.04.94 he appeared objectively bright with no evidence of depression. A discharge date was set for 21.05.94. On 22.04.94 after discussion of various medications available he decided to try a low dose of Stelazine (a major tranquilliser and antipsychotic). On 27.04.94 his tension appeared reduced but he was still complaining of episodes of anxiety since taking Stelazine.

3.19 In the early hours of 10.05.94 Mr Winship was admitted via the A & E Department to Ward A44 at Queen's Medical Centre for a crisis admission after phoning personally. He was seen in the A & E Department by Dr Schuman, a psychiatric SHO, to whom he gave a history of extreme agitation, distress and active suicidal ideation over a

period of about six hours. He gave an account of his past history and of more recent experiences of being confused, with ambivalence towards mother and about hate and love and suicide, and thoughts of suicide. He reported seeing blood running down a wall and spiders which weren't there. Dr Schuman recorded "only one brief visual hallucination in the past". He had been thinking for two days that someone was in the next room but when he went to investigate no one was there. Everything was bizarre and unreal with him feeling like a third party looking at himself. Mr Winship repeated his account of an unhappy childhood, the favouritism his mother showed to his sister, his father's possible physical abuse of him, his own temper tantrums and more recent withdrawal.

3.20 Dr Schuman was impressed by his patient's level of distress and the risk of self harm. He noted marked features of clinical depression and raised the question of psychotic features; possible visual hallucinations, passivity phenomena, auditory hallucinations and delusional experiences. He arranged for him to be closely observed and prescribed a single dose of Temazepam. He noted that he had been drinking.

3.21 Mr Winship was assessed again at 11.30 by another junior psychiatrist. He elaborated on events of the previous day, a visit by his father with both drinking, having two or three pints of beer himself, his father leaving at 22.00 and then feelings of isolation and depression, leading to his contacting the hospital. He still felt down, ambivalent about self injury and anxious about the future. Mental state examination described poor eye contact and rushed but coherent speech, a low but not depressed mood and persisting ambivalent thoughts about suicide.

3.22 By the evening of 10.05.94 he had settled sufficiently to be allowed home in the company of his mother to collect his belongings. By the following day he had settled further. After discussion it was agreed that because of Mr Winship's change of permanent address he should transfer to the care of Dr Ahmad, Consultant Psychiatrist, and the South and West Nottingham Community Mental Health Team. It was also agreed that he should, as he wished, be discharged from Ward A44 to return to the Psychiatric Day Hospital to continue with the discharge plan which involved a

new keyworker, Clare Marshall, a clinical psychologist, who worked with the South and West Nottingham Team.

3.23 Mr Winship returned to the Day Hospital on 12.05.94. He continued to appear restless and distressed with little eye contact. He did not appear consistently depressed. He requested to have an antidepressant and Paroxetine was prescribed.

3.24 On 17.05.94 he again attended the A & E Department complaining of distress and suicidal thoughts but after being seen by Dr Blagdon, Senior Registrar, he went home. At the Day Hospital on 18.05.94 he revealed that his father had visited him on the previous day. When he had told his father of his suicidal intentions his father contacted the hospital and was told to contact his General Practitioner, Dr Bratt. He in turn referred him for urgent assessment by a psychiatrist with the expectation of his admission to hospital. In discussion Mr Winship was apologetic for his behaviour the previous night but claimed to be still feeling suicidal. He claimed to be getting great relief from Stelazine and asked that this be increased. This was agreed.

3.25 On 26.05.94 his case was reviewed by Professor Szabadi as he was continuing to speak of suicidal ideas and was claiming that he did not feel safe to go home and again wanted to be admitted to hospital. An overnight admission was arranged to Ward A42 and a brief routine admission history by a junior psychiatrist raised nothing new. On 27.05.94 he was seen by his keyworker at the Day Hospital, Mr Glyn Williams, and it was agreed that he should be transferred back to the Day Hospital and be seen by Clare Marshall and then discharged to her out-patient care. He was prescribed Paroxetine and Stelazine.

3.26 Mr Winship was then seen on 21 occasions by Clare Marshall between 14.06.94 and 08.11.94, at approximately weekly intervals. Initially the sessions centred on strategies to enable him to reintegrate into the community, restart his studies and broaden his social horizons. His views of himself were explored, particularly his feelings of depression, low self worth and of suicide and what these meant, their value to him in controlling others and how he might cope with them more effectively. His feelings

about his parents emerged on several occasions, how he felt disappointed by both, how neither had shown him appropriate affection. On two early occasions he expressed considerable anger towards his parents. On 14.04.94 he said he hated his father but loved his mother and on 27.07.94 he talked of murderous feelings towards his parents and to a trusted older man alleged to have sexually abused him. Towards the end of the sessions Mr Winship indicated that he had developed a degree of affection for Clare Marshall. He then found it particularly difficult when she indicated that she would be leaving her position in late November 1994. He did not keep his final appointment with her on 16.11.94.

3.27 Clare Marshall wrote to Dr Bratt on 16.11.94 to advise him that she was concluding her sessions with Mr Winship. She described him as a resistant client at times who found it difficult to cope with any challenge to his ideas or belief systems. She wondered whether his ego boundaries were too fragile at that time to cope with psychotherapy. She stated that she was to be replaced by another keyworker but believed that this should not be done without an interval in order to allow him to come to terms with her departure before starting with a new keyworker. While she considered that he had made steady progress since he had met her she felt that there might be a return of his previous pattern of suicide attempts and admissions to hospital which she saw as adolescent acting out rather than as indications of a new intention to harm himself.

3.28 During the early stages of his involvement with Clare Marshall, Mr Winship had four attendances at hospital within the period of a month. On 05.06.94 he attended the A & E Department complaining of suicidal feelings and holding a knife to his wrist. After assessment he was allowed home. On 16.06.94 he attended his General Practitioner with apparent side effects of Trifluoperazine. On 11.06.94 he attended the A & E Department threatening to shoot himself saying that he had bought a gun. He complained of depression, family difficulties, philosophical questioning and lack of social support. He was felt to be experiencing another depressive episode in the setting of personality difficulties and was admitted for observation. He was discharged on 14.06.94 after being reviewed by Dr Ahmad. He returned to the A& E

Department on 22.06.94 threatening to take an overdose. He also complained of 'auditory hallucinations' and that his mother wanted to kill him. As he persisted in his assertion that he would take an overdose if sent home he was admitted. He was smelling of alcohol. Less than six hours later he was insisting on leaving but was prevailed upon to stay. On assessment on 24.06.94 no enduring depression was noted and he was allowed weekend leave. On his return on 28.06.94 he was discharged after a report of a productive and successful weekend. He was seen by Dr Bratt on 01.07.94 and prescribed Nitrazepam. He presented to A & E later that day claiming to have taken an overdose of them. Despite the absence of evidence of a depressive illness or any other disorder he was offered admission but declined it.

3.29 He was seen by Dr Bratt on five further occasions before his next admission to hospital on 13.11.94. During this period Dr Bratt was aware that Peter Winship was attending Clare Marshall. At the appointments with Dr Bratt Mr Winship continued to report tension, anxiety and depression. Initially he was prescribed Paroxetine and Nitrazepam but because of reported severe nightmares attempts were made to withdraw Nitrazepam. Dr Kendrick, Dr Bratt's partner who saw Mr Winship in Dr Bratt's absence, prescribed Trifluoperazine on 10.08.94. On 23.09.94 Mr Winship informed Dr Bratt that he felt dizzy, his head was spinning, his heart was beating fast and he could not focus. He felt his ears were attached to a power source with someone turning him on and off. He was very worried about his physical wellbeing. Dr Bratt did not consider these complaints to be auditory hallucinations but a form of tinnitus and tachycardia and as a result wrote a detailed letter of referral to the appropriate specialist Professor J Hampton, a physician, who some time later reported that the symptoms complained of were side effects of medication. At this interview on 23.09.94 Dr Bratt remained concerned about the continuing prescription of Nitrazepam and in an attempt to reduce and withdraw it started Dothiepin (a sedative antidepressant) in the hope that this could replace Nitrazepam.

3.30 Mr Winship was then admitted overnight to the Admissions Ward of Queen's Medical Centre between 13.11.94 and 14.11.94. He had taken an overdose of Dothiepin and developed a tachycardia. He was seen by a psychiatrist who did not think there had

been suicidal intent. He demanded to leave and did so before his tachycardia had settled. The psychiatrist, Dr S Sommers, wrote to Dr Ahmad describing the consultation in detail and asking whether in the absence of psychiatric review during the period when Mr Winship was seeing Clare Marshall, a psychiatric out-patient appointment could be sent to him. The clinical picture at this point was dominated by panic attacks and distress. Mr Winship reported that he had been hearing people crying but exploration revealed no abnormal thoughts or perceptions.

3.31 On 18.11.94 Mr Winship was admitted informally and briefly to Queen's Medical Centre. He arrived in the early hours of the morning and took his discharge later that day. He had been arrested for breach of the peace and had been seen by the Senior Registrar on call. On admission Mr Winship reported that he had been transferred from one keyworker to another earlier that week and as a consequence had started drinking heavily. He had wanted to die and had phoned his vicar. He complained of seeing his uncle, an experience he knew to be unreal. He went to Trent Bridge and was picked up by the police. A mental state examination was undertaken and proved difficult because of his intoxication and his unwillingness to discuss matters in detail, stating simply that he was depressed, wanted to die and would try to kill himself if allowed to leave. No delusional material was elicited and no abnormal perceptions noted except the reported "pseudo hallucinations".

3.32 Mr Winship was reviewed later that day. He complained of confusion and depression building up over the last few weeks. He reported hearing voices from the past but denied experiences of true auditory hallucinations. He still felt very suicidal but had no plan and denied a wish to die. He said he was able to cope at home, and that he would go and see his General Practitioner that day. The issues were discussed with Mr Gary Bevis who had been allocated as replacement for Clare Marshall. Mr Winship left hospital without telling staff. He did not visit Dr Bratt.

3.33 On 27.11.94 following a home visit by a duty General Practitioner, Mr Winship was admitted to Queen's Medical Centre at 01.30. He was seen by the duty psychiatrist, Dr S Amin, who was aware of his previous history and the diagnosis of a chronic

dysthymia with personality difficulties. Dr Amin took a detailed history of recent events and conducted a mental state examination before writing an account of his view of the case.

3.34 Mr Winship told Dr Amin that his recent discharge from hospital had all been due to a misunderstanding. In the preceding 4 days he had started hearing voices telling him to kill his father, speaking to him of vindication and revenge. This had frightened him. He had been having dreams of stabbing his father but had made no plans regarding this. He had not felt depressed but the voices were distorting his mind and he was unable to distinguish between reality and illusion. He had had no illicit drug use recently nor had he had thoughts of self harm. His appetite and sleep had been poor. He had been drinking more than 30 units of alcohol per week. He had been taking his medication as prescribed: Trifluoperazine, Paroxetine, Nitrazepam and medication for acne.

3.35 Dr Amin found Mr Winship to be anxious at the interview but he was alert. His speech was coherent but hesitant at times. There was no evidence of formal thought disorder. Subjectively his mood was confused. Objectively he seemed euthymic but perplexed. Dr Amin could detect nothing psychotic in his presentation (though earlier in the note he commented "?pseudo hallucination" at the point where Mr Winship was talking of voices telling him to kill his father). He had obsessional ruminations, having bad thoughts about Dr Ahmad about which he declined to elaborate but which made him frightened of seeing Dr Ahmad. There were no current auditory hallucinations. There was full orientation and no clouding of consciousness. Insight was assessed as limited as Mr Winship was unsure of his state of mind but wanted to stay in hospital to protect his father.

3.36 Dr Amin's assessment of the case was that there was a long history of chronic dysthymia and personality difficulties with a four day history of auditory hallucinations telling Mr Winship to harm his father, leading to increased anxiety and fear for father's safety. He did not appear depressed. Dr Amin considered that his patient should be admitted informally on a crisis intervention basis. In view of his

numerous recent psychiatric contacts and unpredictable discharge he should be seen every thirty minutes. Dothiepin was to be stopped as there seemed no rationale for this.

3.37 Mr Winship was seen by Dr Ahmad the following day. He described having 'psychotic' episodes and having had 'hallucinatory voices telling him to kill his dad'. He denied feelings of depression but was still getting "paranoid thoughts" and was afraid to go out in case he would kill himself to avoid harm to others. He wanted his medication increased and admitted to drinking relatively large amounts of lager and whisky. Dr Ahmad's impression was of "?? transient psychotic state in a man with personality disorder." There should be no change in his treatment pro tem. He should continue on close observations with a check every thirty minutes.

3.38 Mr Winship was reviewed later by Dr Fisher, SHO to Dr Ahmad. There had been no further complaints of auditory hallucinations but he was still complaining of paranoid feelings and there were mixed psychotic symptoms. He appeared to be eating and sleeping well without any signs of anxiety. Dr Fisher felt that he should remain on the ward for observation and his level of observation should be reduced to that of the generality of patients.

3.39 At 18.30 on 29.11.94 the duty psychiatrist was asked to see Mr Winship urgently. He had gone off the ward that afternoon and phoned from a pub to say that he was distressed by voices and by a friend who was having problems. He returned to the ward via the A & E Department. He was now saying that he wanted to go home, to kill himself, had nothing to live for, was evil, deserved to die and could hear his uncle's voice telling him to kill himself. The duty psychiatrist described him as weepy and distressed but found it difficult to assess his mood because he was expressing two 'dichotomous' positions, first that he was better and second that he had no future and wanted to die. His thoughts were preoccupied with ideas of worthlessness and hopelessness, negative about himself, his past and his future. He was expressing derogatory second-person auditory hallucinations in clear consciousness. His insight into his problem was that he did not believe he was mentally ill.

3.40 The duty psychiatrist's impression was of longstanding personality difficulties with significant alcohol abuse and transient second-person auditory hallucinations. The diagnosis seemed that of a borderline personality +/- alcoholic hallucinosis +/- underlying psychotic condition +/- feigned psychosis. As these secondary features could not be excluded and Mr Winship was determined to leave hospital he should be detained under Section 5(2) of the Mental Health Act (an emergency procedure for the detention for up to 72 hours of patients already in hospital on an informal basis). This policy was discussed with and endorsed by Dr Cantrell duty Senior Registrar in psychiatry.

3.41 Mr Winship was reviewed by Dr Fisher on 01.12.94. At this interview he was continuing to state that he was not depressed but confused. He did not feel he could distinguish between what was going on in his head and around him. He thought that voices he heard were intense imagination, "talks of murder and suicide, voice of his uncle." He did not feel suicidal but rational. He was sleeping well but was suffering from a heavy cold. He was prepared to remain in hospital voluntarily. Dr Fisher felt he was improving.

3.42 On 02.12.94 Dr Fisher felt that his patient seemed to be functioning adequately on the ward. It was therefore not appropriate for him to be detained under Section 2 of the Mental Health Act. A cognitive behavioural approach was to be adopted by his keyworker on the ward.

3.43 Mr Winship was seen by Dr Ahmad later on 02.12.94. He did not find any psychotic symptoms with Mr Winship mostly describing feelings of anxiety and panic attacks and 'as if he is hearing voices' and 'as if he is having psychotic experiences'. These experiences made him feel 'confused' and he found it difficult to work out whether they were 'real experiences' or 'his own thoughts'. He wanted to drink to get over the experiences and craved alcohol. Dr Ahmad did not think that Mr Winship described any enduring depressive symptoms although when anxiety built up he felt that he could not go on and thought of suicide. He had no suicidal thoughts at the time and

was willing to stay in hospital. Therefore the Section 5(2) detention should be allowed to lapse.

3.44 Mr Winship was seen regularly by various members of the psychiatric team during his 26 day admission. He was seen a further six times by Dr Fisher and once by Dr Ahmad. He appeared progressively more settled and was keen to remain in hospital. No evidence was noted of enduring depressive or psychotic symptoms. Mr Winship doubted that he had been psychotic and asked that Trifluoperazine be stopped. This was reduced with the view of eventually stopping it and this was finally done on 20.12.94. He was regularly off the ward in the company of friends and adhered to the drinking limits imposed.

3.45 On 22.12.94 Mr Winship returned to the ward. He was seen urgently by Dr Fisher at 22.20. He had been drinking. He was abusive to staff and threw ashtrays about. He was restrained forcibly. He was crying but unable to say what his problems were except 'life'. He was seen again at 22.50 and was insisting on leaving. As he was apologetic for his previous behaviour, was not expressing ideas of self-injury and had shown few signs of symptoms or mental illness during this admission Dr Fisher after discussion with Dr Thatcher, Senior Registrar, allowed him to discharge himself. Mr Winship was not considered to be detainable under the Mental Health Act.

3.46 Dr Fisher wrote a discharge letter to Dr Bratt dated 03.01.95. In this she gave a resume of Mr Winship's admission stating that he showed no signs or symptoms of enduring mental illness and as a result of this Trifluoperazine had been stopped. She described how the plan had been that he should remain in the ward until Gary Bevis could support him in the community but Mr Winship insisted on his discharge. In the letter Dr Fisher reported "no signs or symptoms of enduring mental illness noted. Poor coping strategies". Mr Bevis also received a copy of this letter.

3.47 Although Mr Winship remained under the care of the South and West Team with Dr Ahmad as Responsible Medical Officer, Mr Bevis and Dr Bratt were in practice responsible for his care until his next admission to hospital on 31.10.95, 11 months

later. Mr Bevis wrote to Dr Bratt on three occasions describing the content of his contacts with Mr Winship. Dr Ahmad received copies on a least the first two occasions.

3.48 Mr Bevis saw Mr Winship on sixteen occasions at weekly or two weekly intervals between 19.01.95 and 09.08.95 when, by agreement, regular contact was terminated. Mr Winship did not keep three appointments early on.

3.49 Mr Bevis's detailed notes describe the content of the sessions. Initially Mr Winship spoke of his distress at the termination of his contact with Clare Marshall and its consequences, hospitalisation, depression, increased alcohol consumption and use of prostitutes. Later sessions dealt with his need to have Mr Bevis appreciate the validity of 'his illness' and his feeling of being 'too ill' to make changes and therefore feeling stuck. After four sessions a plan of action was agreed, comprising a referral to specialist psychotherapy services, attendance at a low key academic course and continuing supportive sessions with Mr Bevis. On 20.03.95 Mr Winship reported an improvement in his condition with less dependence on his mother who had gone on holiday, an improvement in his relationship with his father and an ability to accept responsibility for a dispute with a friend. Nevertheless at subsequent meetings his opinion of his problems in terms of illness re-emerged. On 03.04.95 he reported disengagement from his church. On 07.05.95 he revealed that at the age of fifteen he had been raped by someone he had trusted. He had reported this to his mother who did not believe him but other boys went to the police to report similar experiences. There was a discussion with Mr Bevis about how he felt and what action, if any, he might take. Mr Winship described how such events provoked thoughts of self injury associated with an inability to get angry and instead to adopt what he thought to be an intellectually superior stance. By 24.05.95 however he was being appropriately angry at this abuse and seemed to have surmounted this episode without his customary ways of decompensating. By July and August 1995 he seemed to have developed a degree of stability. The interval between appointments had been increased and Mr Bevis felt that it was appropriate to stop regular appointments as his patient was himself feeling

that being in therapy was an indication that he was ill, something he wanted to stop. Contact was terminated on 09.08.95.

3.50 During his contacts with Mr Bevis Mr Winship continued to attend Dr Bratt and appeared to be doing well. He was prescribed only Dothiepin. Dr Bratt approved of the referral to specialist psychotherapy services. On 06.06.95 Dr Bratt was called to a police station after police officers had stopped Mr Winship jumping from Trent Bridge. However when Dr Bratt saw him he found him apologetic, regretful and lacking suicidal intent. By 05.07.95 Mr Winship appeared settled again.

3.51 On 21.08.95 Dr Bratt found Mr Winship anxious again. He had not completed the questionnaire sent to him by the psychotherapy services and revealed that he had discharged himself from contacts with Mr Bevis. Dr Bratt received a letter from Mr Bevis dated 22.08.95 describing the termination of sessions. At his next visit on 15.09.95 Mr Winship appeared very anxious and ambivalent about the psychotherapy referral. Propranolol (an anxiolytic) was added to his prescription of Dothiepin.

3.52 On the evening of 31.10.95 Mr Winship was admitted overnight to Queen's Medical Centre after an overdose of Propanolol and Nitrazepam preceded by three pints of beer. He reported that he had lately felt tense, angry and frustrated, triggered by childhood memories. Mental state examination revealed him to be relaxed, not depressed, without suicidal thoughts or psychotic phenomena. The overdose was felt to be impulsive and Mr Winship did not want any psychiatric follow up.

3.53 Dr Bratt then saw Mr Winship on 17.10.95, 18.12.95 and 25.01.96 finding him well and repeating his prescription of Dothiepin.

3.54 On 27.03.96 Dr Bratt found Mr Winship less well, depressed and with vivid dreams. Dr Bratt referred him to Mr Bevis in a letter dated 28.03.96.

3.55 Mr Bevis saw Mr Winship again on 25.04.96. Events in the intervening period were reviewed revealing a deterioration of mood in the last two to three months associated

with thoughts of low self-esteem, poor sleep and vivid dreams. There were however no ideas of self injury or increased alcohol consumption. Mr Bevis felt that his client had coped well for six months without psychiatric support and that improvements were due to Mr Winship's own efforts. Monthly meetings were agreed to re-focus his coping strategies. On 15.05.96 Mr Winship is reported as describing satisfactory general progress. His sleep pattern had improved since restarting Nitrazepam but his vivid dreams were persistent and were focused on at his next session. Mr Winship felt he had turned a corner and was more positive about his future. His mood was more stable with fewer pronounced symptoms of depressive illness although his mood remained bound in complex cognitions rather than overt manifestations. It was agreed that he should continue with his medication, Mr Bevis would liaise with his General Practitioner and another appointment was arranged for one month.

3.56 Mr Winship did not keep his appointment with Mr Bevis on 26.06.96 because of influenza. A new appointment was offered for 10.07.96 but it was not kept.

3.57 Dr Bratt saw Mr Winship on 02.05.96 when he reported that he felt much better after having resumed contact with Mr Bevis. He was less tense and calmer. On 05.06.96 he attended again regarding a flare up of acne and appeared well. On 17.06.96 he was 'not all that good again' with a one week history of marked insomnia and increased agitation. Nitrazepam was prescribed and an appointment given for two weeks time. This was the last occasion on which Dr Bratt saw his patient.

4. SUMMARY OF ORAL EVIDENCE

4.1 **Dr R K Baruah: Consultant Psychiatrist**

4.1.1 His initial impression of Mr Winship was of a young man, not yet sixteen years old, who was traumatised by the breakup of his parents' marriage and who was under pressure from examinations. He thought that his mother did not care much for his father, who had a drink problem. When Dr Baruah first met Mr Winship he had taken an overdose in association with alcohol. He did not think that Mr Winship was

mentally ill but needed support; hence his referral to Sarah Dunphy, CPN, as key worker. This was not initially productive although contact was resumed and Mrs Dunphy kept Dr Baruah informed. Mr Winship was then admitted to hospital after attempting to electrocute himself. He had already been prescribed an antidepressant and was prescribed an anti-psychotic drug as a non-specific tranquillising agent. Consideration was given to a referral to adolescent psychiatry services but this was agreed to be inappropriate. As there were difficulties in weaning him from hospital it was felt appropriate to refer Mr Winship to the psychiatric Day Hospital run by Professor Szabadi.

4.1.2 At no time did Dr Baruah consider that Mr Winship was suffering from a psychosis. The possibility of a formal psychiatric illness, early schizophrenia or an affective illness, had been considered but there was no evidence for either throughout his out-patient contacts or lengthy admission to hospital. Mr Winship was felt to have a psychological disorder rather than a psychiatric illness.

4.1.3 In answer to a question Dr Baruah said "I do not think there was any clear indication that Social Services ought to have been involved."

4.2 **Professor E Szabadi: Consultant Psychiatrist**

4.2.1 Professor Szabadi is in charge of the Psychiatric Day Hospital. This has two functions, first to provide support for patients from the community or from the in-patient unit at Queen's Medical Centre and second to provide further medical opinion on more difficult patients who require intensive daily input. Mr Winship was clearly in the former category.

4.2.2 Because of his history, and like all other patients referred to the Day Hospital, Mr Winship was carefully assessed by his key worker and junior psychiatrists and his case presented to Professor Szabadi for his opinion. Mr Winship requested a personal interview with Professor Szabadi and this was granted. An interview of more that an

hour took place. Professor Szabadi reviewed Mr Winship's case at regular weekly meetings, on occasion in some depth.

4.2.3 At his early lengthy interview with Mr Winship Professor Szabadi had been impressed with his change in personality, ambivalence and pseudo-philosophical ideas. Although Mr Winship expressed no psychotic ideas Professor Szabadi nevertheless considered whether he might be suffering from incipient schizophrenia but decided that there was insufficient evidence to support such a diagnosis.

4.2.4 Throughout his contact with Mr Winship Professor Szabadi saw no cause to change his initial view of his patient. He noted his young age, his disrupted background, his suicidal attempts and his drinking. He shared the view of Dr Baruah that Mr Winship had adolescent maturational problems which might benefit from social support to alleviate his isolation, and from assistance with his communication skills. Professor Szabadi did not feel that the electrocution episode represented a genuine suicide attempt.

4.2.5 The view of the multidisciplinary team was therefore that Mr Winship was an immature individual with emotional difficulties; with mood swings arising not from a depressive illness but the interaction of his personality and stress. At no time was he noted to be a risk to others.

4.2.6 During his stay at the Day Hospital Mr Winship settled down and plans were made for him to move to more suitable accommodation. Although he was prescribed antidepressants and an antipsychotic for non-specific relief from anxiety and tension his improvement was attributed to his regular attendance and support from staff. His key worker liaised in Mr Winship's interests with Social Services colleagues.

4.2.7 As Mr Winship was changing his address to one in a different catchment area he was referred back not to Dr Baruah but to Dr Ahmad.

4.2.8 Professor Szabadi was unable to provide evidence of attempts to involve Mr Winship's family in treatment or other plans, although there was some contact with Mr Winship's mother. He was also unsure of the operation of the Care Programme Approach in Mr Winship's case.

4.3 Clare Marshall: Chartered Clinical Psychologist

4.3.1 Clare Marshall worked for half of her time with the South and West Nottingham Mental Health Team and for the other half with the Nottingham forensic psychiatry services.

4.3.2 She worked within a multidisciplinary team which screened all new referrals before deciding upon which member was the most suitable to offer support and treatment to a newly referred patient.

4.3.3 She had a particular interest in the needs of young people, and she chose to become Mr Winship's keyworker.

4.3.4 Prior to undertaking the treatment of Mr Winship Clare Marshall discussed his case with staff of the Day Hospital and with Sarah Dunphy CPN. She talked also to Dr Ahmad, Mr Winship's new consultant psychiatrist, and with her immediate clinical supervisor. The only documentary evidence available to Miss Marshall when she took on the case was the discharge letter from the Day Hospital. She did not read the case notes of Queen's Medical Centre though could have had access to them. She did not think it necessary to ask for and to read the records which Mrs Dunphy and another previous keyworker had made about Mr Winship.

4.3.5 Her initial assessment was that Mr Winship was suffering from two related problems, first anxiety and depression and second inadequate socialisation and isolation. Both of these had resulted in admissions to hospital and were felt to be behind his reluctance to be discharged.

4.3.6 She saw her role as supportive counselling and gentle exploration of Mr Winship's difficulties at weekly sessions, and organising opportunities for socialising. Individual sessions were considered essential as it was not thought that he could cope with group work, all the more so because he was reluctant to allow the participation of others in his case, particularly his mother, father and sister, a reflection of the complex psychodynamics within his family. During the short period of her involvement with Mr Winship it did not seem appropriate to Miss Marshall that she should try to overcome that reluctance.

4.3.7 Besides the presenting complaints Mr Winship later revealed other important information. On a number of occasions he described angry feelings towards his parents, particularly his father, even a murderous fantasy about his father but Miss Marshall never considered that these were the result of mental illness or that he would be likely to act on them. It seemed to her more likely that he would internalise such feelings about others and act in a self injurious way as he had already done. Mr Winship also revealed episodes of sexual abuse by a clergyman which Miss Marshall was confident he would deal with in a similar fashion.

4.3.8 Death was a preoccupation for Mr Winship. He was fascinated by the idea of his own death and was interested in philosophy, particularly existential philosophy. Discussion of these topics attracted him and seemed to be a useful way of approaching and understanding his difficulties.

4.3.9 Because of her forensic experience Clare Marshall was accustomed to assessing risk in the patients she was involved with. She felt she knew Mr Winship well. She viewed his condition as neurotic rather than psychotic. He took advantage of the benefits of seeming unwell. She did not consider him a risk to others, very much more a risk to himself. She was very surprised about the eventual outcome.

4.3.10 During the time of her contact with Mr Winship Miss Marshall had no occasion to get in touch with his GP Dr Bratt, her only communication with him being a letter which

she wrote to him when her treatment of Mr Winship ended. She did not regard her contact with her patient as falling formally within the Care Programme Approach, which she thought had not been fully developed at that time.

4.3.11 As her involvement with Mr Winship progressed she became aware of his attraction to her. When she knew that she would be moving away from Nottingham to a new post she was conscious of the effects that the ending of their therapeutic relationship might have on him: first, the withdrawal of the support which had had obvious beneficial effects as measured by the reduction of his self injury, attendances at the A & E Department and admissions to hospital and second the loss of a rewarding relationship with a young woman. As a result she brought Mr Winship's case back to the team and it was agreed that he should be followed up by Mr Gary Bevis, but only after a period to allow him to come to terms with her departure. This was explained to Mr Winship and it was pointed out that in the interim he still had access to other members of the team and to the support groups to which he had been introduced.

4.4 Mr Gary Bevis: Community Psychiatric Nurse

4.4.1 Mr Gary Bevis was (and is) the Team Manager of the South and West Nottingham Community Mental Health Team. Besides his considerable administrative and supervisory duties he carried an individual caseload.

4.4.2 Like other members of the team he undertook the supervision of individuals referred to the service but only after an initial assessment by two members of the team, not necessarily involving a psychiatrist. Psychiatric advice was however always available and problems would be discussed at multidisciplinary team meetings.

4.4.3 The demands on the Community Mental Health Team were considerable. There were referrals by General Practitioners of individuals with psychological problems and a permanent caseload of those with a continuing serious mental illness. Allocating the proper balance of support to these two different groups was often difficult.

4.4.4 When the case was initially allocated to him he felt that he had the appropriate skills to help Mr Winship. He knew about and was agreeable to the proposed gap between Clare Marshall's involvement and his own. He attended a pre-discharge meeting in hospital following Mr Winship's admission in December 1994. He had read Clare Marshall's records, but not those of Mr Winship's previous keyworkers. At the time it was not the practice for relevant notes to follow the patient. Mr Bevis did not speak to Mrs Dunphy or Ms Kelleher.

4.4.5 In the initial stages Mr Bevis felt that Mr Winship was uneasy about him and was testing him out. Afterwards they developed a useful therapeutic relationship. The view that he formed of Mr Winship was that he did not suffer from a major mental illness but was a vulnerable young man whose difficulties were around his behaviour and development and his relationships with other people.

4.4.6 He felt that Mr Winship had lapsed into an illness mode and was very dependent on psychiatric services. His relationships with his family had always been difficult. He found his mother controlling and he had had conflicts with her. His father had never matched up to what he felt his father should be and had major problems of his own.

4.4.7 He had conflicts with his sister particularly over religious issues when his beliefs in Christianity were being challenged by his experiences. His sister was frequently away at University.

4.4.8 Mr Bevis was aware that at the time of some of Mr Winship's admissions to hospital it had been suspected that he might have been transiently psychotic but his own experience of his client was that these were not true psychotic experiences, rather that Mr Winship was expressing some of his own thoughts. He knew these experiences had been looked at closely by the psychiatrists, most recently Dr Ahmad. Mr Bevis himself thought that Mr Winship's problems were "more to do with his personality and his development as an individual than ..... that he was responding to some significant illness".

4.4.9 Mr Bevis therefore saw his role in his sessions with Mr Winship as implementing a brief therapy model, focusing on positive elements and building on them to enable Mr Winship to move away from negative and maladaptive ones.

4.4.10 Mr Winship seemed to respond to such an approach although it emerged that there were deep rooted issues arising from his childhood which might be better dealt with by more specialised practitioners from the Psychotherapy Services. He discussed a referral with Mr Winship, made the initial contact and encouraged him to respond to the psychotherapy questionnaire which was sent to him.

4.4.11 Mr Bevis did not feel that family work was indicated. Mr Winship had difficulties in relationships with his family. He did not want his family to be involved. His relationship with his mother was difficult and although he did keep contact with his father his feelings about him were ambivalent and changeable.

4.4.12 As time went on Mr Winship appeared to improve. Mr Bevis thought that the case could be dealt with at the lowest level of the Care Programme Approach. He felt that he was competent to manage on his own, as his client's key worker. He had the opportunity to consider cases in what he described as a nursing peer group and at meetings with clinicians but he could remember discussing Mr Winship on only one occasion.

4.4.13 Initial contact with Mr Winship was terminated in August 1995 because of the progress that had been made. Mr Bevis informed Dr Bratt of this. Dr Bratt re-referred Mr Winship in late March 1996. This referral would have been received by the multidisciplinary team but as it had been made specifically to him , and as there was no indication that anything new had developed, it seemed appropriate for him to take the case on again without the need for another multidisciplinary assessment, or review by a psychiatrist. This was common practice, accepted by all members of the team. If there had been a perceived need for a discussion with a psychiatrist, or for a psychiatric examination, this could easily have been arranged.

4.4.14 Since the killing of Mr Winship's father Mr Bevis has questioned whether he might have viewed his client's case differently. He has experience of dealing with those with serious personality difficulties and those with insidiously developing mental illness. He makes constant assessments of the former group to evaluate whether they are changing to the latter. He did not feel that this applied to Mr Winship and while risks are always inherent in the supervision of psychiatric patients he felt that it was unlikely that his client would injure others. The more apparent risk was of self injury.

4.5 Dr Ahmad

4.5.1 Dr Ahmad became the responsible consultant psychiatrist two years after Mr Winship's initial contact with the psychiatric services. He was subsequently responsible for Mr Winship's case while he was in hospital, and during his periods of supervision in the community by Clare Marshall and Gary Bevis, in his role as consultant psychiatrist to the Community Mental Health Team.

4.5.2 He first became aware of Mr Winship following his admission to hospital on 10.05.94. He discussed with Dr A Schuman, his SHO, the clinical material he had elicited in the A & E Department because although Mr Winship was still Dr Baruah's patient and was attending the Day Hospital Dr Schuman was under Dr Ahmad's supervision. The diagnosis of schizophrenia was raised but in view of the transient nature of the possible psychotic symptoms and the absence of similar symptoms at subsequent examination and during his attendance at the Day Hospital there did not seem evidence to support such a diagnosis. He was aware of the view of the case taken by Dr Baruah following a lengthy in-patient admission.

4.5.3 He took over Mr Winship's case in June 1994. He first met Mr Winship during his brief admissions on 14.06.94 and 22.06.94. On the three occasions he interviewed Mr Winship there were no psychotic symptoms and he considered Mr Winship to be a young man with fluctuating dysthymia and fluctuating depressive symptoms. Because of his presentation prior to his admission the diagnosis of schizophrenia was again considered but Dr Ahmad could not detect any enduring features of psychosis. There

was nothing to support the diagnosis of schizophrenia. In his experience some vulnerable and rather fragile personalities under stress, and especially when drinking, can develop transient psychotic episodes or mild alcohol induced psychoses or alcohol induced paranoia, or experience hallucinatory effects. Dr Ahmad thought that the experiences reported might not be true hallucinatory experiences but possibly a hysterical dissociative state of some kind.

4.5.4 He next examined Mr Winship on 28.11.94, the morning following his admission from the A & E Department where he had been assessed and reported on in detail by Dr Amin, SHO. He was aware of the content of Dr Amin's notes. Because of the serious content of what Mr Winship had said he pursued all the major issues. Mr Winship said that he was not then hearing what might be hallucinatory voices and described his previous experiences as being "as if he was hearing" hallucinatory voices. Dr Ahmad therefore, formed the view that these experiences had not been of a true hallucinatory nature. As regards thoughts and dreams about killing his father Mr Winship told him that he had been having such experiences but they had gone; he did not feel that he would ever do such a thing. Dr Ahmad did not consider that such thoughts were based on delusional beliefs about his father. He again considered whether Mr Winship might be suffering from schizophrenia or any other illness, exacerbated by the stress of changing from one community key worker to another, but there was nothing to indicate that he had an enduring psychotic disorder. His impression was of a possible transient psychotic episode in a man who was drinking heavily and who was under stress. Nevertheless he was sufficiently concerned about Mr Winship to advise close observations on the ward.

4.5.5 Mr Winship was subsequently detained under Section 5(2) of the Mental Health Act after complaining to an SHO of thoughts that he was evil and deserved to die.
Mr Winship had left the ward and had been drinking. Dr Ahmad did not support the SHOs suggestion that Mr Winship might be suffering from alcoholic hallucinosis but still remained in doubt whether Mr Winship was having true psychotic experiences or transient psychotic episodes. After more than two days' detention under Section 5(2) it was felt that there were no grounds for continuing Mr Winship's detention under

Section 2 of the Mental Health Act. He was willing to stay in hospital and to accept the treatment prescribed.

4.5.6 It mattered to Dr Ahmad whether Mr Winship was truly and enduringly psychotic or not for if he were psychotic and had talked of killing his father the risk would be clearly greater and the management would be different. The medical treatment would be different and the potential victim could be alerted. The police might have to be involved. Confidentiality could be overruled. It was therefore very important to decide whether or not Mr Winship was suffering from an enduring psychotic illness. He therefore took care to review Mr Winship's history, went over his experiences with him in detail and followed his performance as an in-patient. During all of this he did not consider that Mr Winship was suffering from an enduring mental illness.

4.5.7 After Mr Winship had settled down and had not deteriorated after the antipsychotic drug was stopped Dr Ahmad turned to planning Mr Winship's discharge. He convened a meeting of himself, his SHO, the keyworker on the ward and Mr Gary Bevis who was to take over Mr Winship's care in the community. Because of the anticipated gap before Mr Bevis could see him it was planned that Mr Winship should remain in hospital until the date of the proposed first meeting.

4.5.8 Unfortunately Mr Winship returned to the ward on the evening of 22.12.94 after drinking quite heavily. He was distressed and destructive and was demanding to leave. He was assessed by Dr K Fisher, his SHO, who knew Mr Winship well. She did not consider him mentally ill nor a risk to himself. After discussion with the Senior Registrar there were no grounds to detain Mr Winship so he was allowed to leave.

4.5.9 Dr Ahmad never saw Mr Winship again after this. Although he was the consultant in charge in the community Mr Winship's care was provided by the Community Mental Health Team of which he was a member. In view of the large numbers of referrals the only effective way to manage the caseload was to allocate cases to the appropriate member. Some patients required continuous care by a psychiatrist and one or other

members of the Team. Some did not and as Mr Winship, after extensive investigation and observation in hospital, was not thought to have a mental illness and as he was not keen to see a psychiatrist as an out-patient, it seemed appropriate that Mr Bevis should take the sole supervisory role.

4.5.10 There were longstanding arrangements about how non-psychiatric members of the Team could obtain the advice of a psychiatrist on the case being supervised. Initially the arrangement was that Dr Ahmad was available every Thursday morning for one hour to discuss issues raised by any of the CPNs. However because of increasing workloads not all CPNs could attend every week. It was agreed that Mr Bevis, as Clinical Team Manager, would advise his CPN colleagues and after prior discussion with Mr Bevis they would meet Dr Ahmad. This was the arrangement for those who would now be on Level 1 of the Care Programme Approach. It was different with regular joint reviews of those who would be on what is now Level 2. Besides this formal arrangement for supervision it was clearly understood by all the members of the Team that any member of the team could ask for Dr Ahmad's opinion on a clinical matter at any time and this usually did not prove difficult as he was often at the Team base conducting reviews or seeing new patients.

4.5.11 Mr Winship was not considered to warrant supervision under Care Programme Approach Level 2 because of the view taken of his condition and because he was not considered a risk to others or a serious risk to himself. Dr Ahmad was therefore quite content that Mr Bevis should take on the case alone. He was confident of Mr Bevis' abilities and he knew that he would communicate reliably with the General Practitioner.

4.5.12 Mr Winship's subsequent progress was testimony to the effectiveness of this approach with only one attendance at the A & E Department during the next 10 months. Even then his patient was still not thought to be suffering from a mental health problem. He read the letter which the SHO who saw Mr Winship had written to Dr Bratt.

4.5.13 Mr Winship was re-referred by his General Practitioner six months later. Dr Ahmad was not involved. The usual practice was for new referrals to attend an allocation meeting but in a case such as Mr Winship who was well known to a member of the Team that member would see the individual first and only report back if there were issues of concern. He did not recall whether Mr Bevis discussed the case with him or whether he read the letter which Mr Bevis wrote to Dr Bratt.

4.6 Dr Bratt

4.6.1 Dr Bratt's evidence was given principally as a commentary on the very detailed written statement he had provided to the Inquiry. Dr Bratt has been the only person continuously involved with Mr Winship. He saw Mr Winship regularly to respond to episodes of distress, to monitor and prescribe medication suggested by psychiatrists, to vary his medication and prescribe some of his own choosing and for a number of periods he was the sole practitioner involved with Mr Winship, particularly during the period between October 1995 and March 1996.

4.6.2 He saw Mr Winship as a considerably distressed young man, hence his early referral to a psychiatrist. He felt it was his role to accept the assessments made by the psychiatrists and to prescribe and monitor regularly the treatment suggested. Although the psychiatrists and some of the key workers involved (particularly Mr Bevis) kept him informed by letter he was sometimes exasperated because he felt that, on occasions, insufficient hospital support was being offered to his patient.

4.6.3 Dr Bratt knew of the difficulties in diagnosis and his own experience of Mr Winship led him to the view that he was a depressed young man with personal and family difficulties, one who at times was a considerable risk to himself as evidenced by his serious suicide attempts. However he never noted any signs or symptoms of psychosis nor did he have any additional evidence.

5. COMMENTS ON DOCUMENTARY AND ORAL EVIDENCE AND ON THE CONTRIBUTIONS OF MR WINSHIP'S CARERS

5.1 Dr R K Baruah

5.1.1 Dr Baruah responded promptly to the request of Dr Bratt to assess Mr Winship. He saw him at his home. In view of Mr Winship's age, his dysfunctional family background, drinking, non-specific depressive symptoms and self injury under the influence of alcohol it was appropriate for Dr Baruah to view Mr Winship's problems as reactive to adolescence and his social circumstances and not as arising from a psychotic illness. Support and counselling by a CPN was a proper course to adopt.

5.1.2 Throughout numerous sessions with Sarah Dunphy Mr Winship revealed repeated distress and some perplexity about the separation of his parents and the reason for it, and although he mentioned morbid thoughts about death and suicide and made fleeting remarks about his thought processes there does not seem to have been evidence to support a diagnosis of psychiatric illness. Sarah Dunphy did discuss the progress of her sessions with Dr Baruah.

5.1.3 Before Mr Winship was admitted to hospital on 15.07.93 he did mention some unusual symptoms, but only briefly and without elaboration and in the context of his pre-existing psycho-social difficulties. While he was not thought to be suffering from a psychotic illness admission to hospital was nevertheless offered after discussion with Dr Baruah. During his sixteen week admission to hospital he was seen regularly by Dr Baruah and his junior staff. Mr Winship settled quickly and he was never felt to be showing any signs of mental illness nor was felt to be complaining of any symptoms of mental illness. On the other hand he was perceived to be a psychologically distressed young man who was becoming dependent on hospital for support and was seeking to prolong his stay. Rather than discharge him without support Dr Baruah referred him to the Day Hospital and Professor Szabadi.

5.1.4 It is our view that Dr Baruah acted appropriately and came to a view of Mr Winship's case appropriate to his own contact with his patient and to the information provided to him by Mr Winship, by Sarah Dunphy and by junior psychiatric staff acting under his supervision.

5.2 Professor Szabadi

5.2.1 Professor Szabadi is in charge of the Day Hospital. There are mechanisms to ensure the comprehensive initial assessment and subsequent regular review of all patients referred there. Professor Szabadi conducted a lengthy interview with Mr Winship. He was aware of Mr Winship's history and although he noted a change in his personality, ambivalence and preoccupation with pseudo philosophical ideas he did not feel that in a seventeen year old man from his background there was any case to be made that he was suffering from a mental illness, although this diagnosis was considered. Subsequent experience of Mr Winship in the Day Hospital, and his admission to Queen's Medical Centre on 10.05.94, did not cause Professor Szabadi to alter his opinion.

5.2.2 In our view Professor Szabadi, on the clinical evidence available to him either obtained directly or through junior medical staff and nursing staff, was justified in diagnosing Mr Winship's condition as arising from adolescent questioning of the roots of his parents' disharmony and his own psychological problems. Professor Szabadi did consider whether such a presentation might be an early manifestation of a schizophrenic illness but he had insufficient data to make such a diagnosis, which would have had considerable implications for future management and treatment.

5.3 Clare Marshall

5.3.1 Clare Marshall took on Mr Winship's case on the basis of a multidisciplinary assessment by members of the South and West Nottingham Mental Health Team. She

obtained information about his case from Sarah Dunphy his previous community supervisor and read the discharge summary from the Day Hospital.

5.3.2 She saw Mr Winship on 21 occasions between 14.06.94 and 08.11.94. She offered regular supportive psychotherapy on an individual basis, not more dynamic psychotherapy, which she felt would be too intrusive, nor group psychotherapy for which his personal and social limitations made him unsuitable.

5.3.3 She explored his feelings of tension and depression and his drinking pattern. She discussed his feelings about his parents, particularly aggressive feelings about his father. She discussed his interest in death and in existential philosophy. She felt that their contacts were of benefit as judged by his performance at their meetings and his reduced rate of attendance at the A & E Department with symptoms of distress and threats of self injury.

5.3.4 Clare Marshall kept detailed notes of the contacts with Mr Winship and discussed the case, as necessary, in an informal way with other members of the team, including Dr Ahmad. She also discussed it with her immediate supervisor.

5.3.5 Miss Marshall never considered Mr Winship to be suffering from a formal psychiatric illness and never felt him to be psychotic. She therefore offered him supportive psychotherapy. She never considered him a risk to others only a risk to himself, and a diminishing one.

5.3.6 She noted transference feelings and considered that although Mr Winship undoubtedly needed continuing support, her departure would best be managed by a period when he had no immediate access to a specific therapist, just the Team as a whole.

5.3.7 We consider that Clare Marshall undertook the community support of Mr Winship in an enthusiastic and reliable manner. She made detailed notes of her interviews and communicated her views to others at meetings of the Community Mental Health

Team. There was no evidence available to her to contradict her view that Mr Winship had psychological problems and not a mental illness and that her preferred method of supportive psychotherapy would be productive.

5.3.8 She perhaps could have foreseen the marked deterioration in Mr Winship following the withdrawal of her supervision and support but there was little she could do to mitigate that effect.

5.3.9 She did discuss Mr Winship's aggressive feelings towards his family and it is possible that if she had read the records of earlier keyworkers she might have become concerned by the long term references to serious family problems, and to Mr Winship's sometimes malevolent expressions in respect of his father.

5.3.10 By the time of Miss Marshall's involvement in May 1994 the Care Programme Approach had been in operation for three years and its emphasis on the need to consult the patient's relatives and carers should perhaps have led her to make a more positive effort to persuade her patient that an examination of his relationships with his father, mother and sister might be helpful. Such an effort might of course have been more appropriate at a later stage of her involvement with Mr Winship if it had continued beyond its six months span.

5.4 Mr Gary Bevis

5.4.1 When he was asked by his multidisciplinary team to take over Mr Winship's supervision from Clare Marshall Mr Bevis read her notes, had a discussion with her and attended a meeting at Queen's Medical Centre to discuss Mr Winship's recent admission to hospital and the view of his case being taken by psychiatrists. He did not think it necessary to obtain and read the records of keyworkers prior to Miss Marshall.

5.4.2 He accepted the view that Mr Winship was not suffering from a major psychiatric illness but was a vulnerable young man with considerable areas of conflict in his life,

with poor social coping mechanisms and who was becoming dependent on psychiatric services.

5.4.3 He saw his role as providing supportive psychotherapy while monitoring Mr Winship's progress to ensure that no more sinister development was taking place. He saw Mr Winship regularly during the first period of supervision and tackled the principal issues being presented by Mr Winship. He instigated a referral to specialist psychotherapy services to explore areas which he felt were beyond his expertise.

5.4.4 He noted that Mr Winship was improving and this confirmed his view of the case. He never felt that his patient showed any evidence of psychosis. As a result he considered it appropriate, with Mr Winship's agreement, to terminate contact in August 1995.

5.4.5 When Mr Winship was re-referred in late March 1996 Mr Bevis felt that he should resume the supervision of Mr Winship along the previous lines. There did not seem to be any indication for a referral to a psychiatrist for an opinion.

5.4.6 At no point in either of his periods of contact did Mr Bevis ever feel that Mr Winship posed a risk to anyone.

5.4.7 It is our view that Mr Bevis, for the most part, took appropriate steps to familiarise himself with Mr Winship's case, although we repeat the concern mentioned at paragraph 5.3.9 because he did not see the earlier CPN notes and it must always be helpful to be able to consider the long term history of the patient's condition and treatment, as recorded by previous carers. He saw Mr Winship regularly, made detailed notes of the sessions, referred him for appropriate specialist help and effectively communicated his views of Mr Winship's progress to his General Practitioner. During neither period of contact with Mr Winship does Mr Bevis seem to have been given any information by Mr Winship to indicate that he was actively psychotic or was suffering from a schizophrenic illness or was a risk to others. The therapy and supervision given by Mr Bevis was therefore appropriate to the view that he and others took of Mr Winship's case.

5.4.8 It is to be noted however that Mr Bevis arranged none of the regular multidisciplinary reviews which are a recommended feature of the Care Programme Approach. That is not to say that reviews would have altered the diagnosis or the treatment but in principle the periodic multidisciplinary review of a patient's progress must permit the possibility of insights not otherwise readily obtainable.

5.5 Dr Ahmad

5.5.1 Dr Ahmad was responsible for Mr Winship's care from June 1994 until the date of the tragedy. His first contact occurred during two brief admissions in June 1994 but his major experience of Mr Winship was during his almost four week admission in November and December following the obviously important assessment made in the A & E Department by Dr Amin, SHO, during which suspicions of psychosis were again raised and Mr Winship made threats against his father.

5.5.2 Dr Amin clearly examined Mr Winship in detail on both issues and on his history and his presenting mental state was not convinced that true psychotic symptoms were present. If they had been they were transient. On the basis of this he did not consider that Mr Winship suffered from an enduring mental illness such as schizophrenia. As a result it was decided that Mr Winship did not present a serious risk to his father but more a risk to himself, for which, if he was insistent on taking his early discharge, he should be detained under Section 5(2) of the Mental Health Act.

5.5.3 In our view this was not an unreasonable diagnosis to make in the light of the mental state presented to Dr Ahmad, but, and it is easy to be wise with hindsight, we wonder if he should have been more aware and more impressed by the fact that this had been the second occasion that Mr Winship had presented in such a way at the A & E Department and whether he should have questioned more vigorously than he did whether undoubted personality difficulties and real social stress coupled with heavy drinking were the most likely cause of episodes of psychotic or psychotic like symptoms, one of the striking features of which was a frank statement of wanting to kill his father. Perhaps a less definite decision as to the presence or absence of an

enduring mental illness might have better reflected the complexity of Mr Winship's presentation, the duration of his problems, the occasional unusual features and the uncertain response to the treatment plan.

5.5.4 Mr Winship was reviewed at regular intervals and his medication appropriately adjusted to reflect the apparent general improvement in his mental state. Careful, considerate and well planned arrangements were made for his discharge by those involved in his care in hospital and to be involved in his care in the community. Although Mr Winship abruptly took his own discharge the planned arrangements still took place.

5.5.5 Dr Ahmad did not see Mr Winship again after he discharged himself from hospital on 22.12.94, and in view of his diagnosis it was not to be expected that he would, unless requested by his patient's keyworker. Mr Winship was not thought to be suffering from an enduring mental illness and the keyworker was Mr Bevis, a respected senior colleague. This arrangement worked satisfactorily to the extent that Mr Winship was discharged by Mr Bevis after seven months of greatly improved stability.

5.5.6 When Mr Winship was re-referred no member of the psychiatric staff saw him to conduct a mental state examination and there is the possibility, and if the pattern of Mr Winship's history was repeated a probably remote possibility, that evidence of continuing psychosis might have been revealed on questioning specifically directed to that end.

5.5.7 However in view of the view taken of Mr Winship's case by the succession of psychiatrists who saw him and his care at a level equivalent to Care Programme Approach Level 1 the fact that no psychiatrist saw him is understandable.

5.6 **Dr Bratt**

5.6.1 Dr Bratt saw Mr Winship consistently and regularly. He was impressed by Mr Winship's degree of distress and disability. He referred and re-referred Mr Winship to the psychiatric services at all appropriate points. He always prescribed medication

suggested by specialists and prescribed others of his own consistent with the views being taken of Mr Winship's case. We have no criticism of his care of his patient.

6. OVERVIEW

6.1 Mr Winship's case is a complex and difficult one. His condition proved difficult to diagnose. With the passage of time and hindsight much has become clearer partly because Mr Winship, as he has told us, was prepared to be much more frank with the forensic psychiatrists who saw him after the death of his father and who produced for the Crown Court reports in which they recorded the diagnosis referred to at paragraph 1.1.

6.2 The difficulty in coming to a diagnosis in his case was the result of a number of interrelated factors. Mr Winship comes from a dysfunctional family which experienced considerable difficulties because of his father's alcoholism and the response of other family members. With the onset of adolescence he started to question his experiences and with the simultaneous development of academic pressures he started to feel depressed. He began to drink. He left home at the earliest opportunity because of difficulties with his mother. In his early contacts with psychiatric services which included a lengthy in-patient admission and a considerable period at the Day Hospital all the interviews with him, and day to day experience of him, made it quite understandable to view his psychological and social difficulties as the result of an interaction between personality factors and life experiences in an intelligent, emotionally insecure adolescent. It was therefore appropriate to attempt to tackle his difficulties by a counselling approach augmented by antidepressants for his mood disturbance and major tranquillizers for anxiety and tension. This was the approach taken by both Dr Baruah and Professor Szabadi.

6.3 At some point, the date of which is unclear though Mr Winship insists that it happened very early on, he started to experience auditory hallucinations principally of his father's voice denigrating him and threatening him. These experiences were episodic and settled spontaneously and were usually associated with additional stress

which he attempted to cope with by increasingly heavy drinking. During interviews with junior and senior medical staff in hospital, at times when he was more settled, and during his lengthy psychotherapeutic programmes with Miss Marshall and Mr Bevis he did not reveal the entirety of his mental state, choosing to present only his feelings of depression and anxiety and his problems in relationships. Occasionally he did mention aggressive feelings towards his father but never in a style or in a context which would have led Miss Marshall or Mr Bevis to consider his experiences to be psychotic.

6.4 Only in the A & E Department and shortly after his subsequent admissions to hospital did he appear to give a clearer picture of his psychopathology and even then he described his symptoms in a partial and indistinct way leaving those who interviewed him to question whether he was actually describing clear cut psychotic experiences or was describing severe feelings of psychological distress in a quasi-metaphorical way. It was even considered that because of his knowledge of psychiatry and experience of psychiatric services he might be producing or exaggerating symptoms to achieve the end of an admission to hospital because he was so distressed and was having difficulty coping in the community. He was frequently under the influence of alcohol and this made assessment of the nature of his symptoms and his veracity all the more difficult. Following his admissions to hospital and modification of his medication it never proved possible to get him to describe in detail or in a similar manner the symptoms he had described to the SHO who had seen him in the A & E Department.

6.5 The importance of some of his earlier statements seems to have been appreciated by Dr Ahmad when he took over his case. He interviewed him in depth on a number of occasions and questioned him about significant issues, symptoms which might indicate psychosis and thoughts about killing his father. Dr Ahmad does not seem to have been presented by Mr Winship with a clear and accurate picture of what he had been experiencing and what he might still have been experiencing at a less intense level. Dr Ahmad therefore was reluctant to draw the conclusion, on the basis of the available evidence, that Mr Winship was suffering from an enduring mental illness, most probably schizophrenia. He was dealing with a young man with psychological

difficulties, considerable problems in relationships and coping with his life, who was drinking heavily in the community and occasionally whilst an in-patient in hospital. His general performance in hospital once his acute distress had settled was similar to that described earlier by colleagues with greater experience of him who did not consider Mr Winship to show features of a mental illness.

6.6 The reason why Mr Winship did not reveal the full extent of his psychopathology is probably not entirely to do with natural reluctance or embarrassment. In hospital he was no longer alone and he was getting extensive psychological support. He felt safe in hospital and enjoyed the protection which it provided, to the extent that those most involved in his care described him as becoming hospital or illness dependant. As is conventional psychiatric practice he was usually being prescribed antipsychotic drugs in small to medium doses, at least at the beginning of his admissions, not because he was thought to be psychotic but to help him with his feelings of anxiety and tension. It is highly probable that because of a combination of these features his psychotic episodes quickly settled or his more persistent experiences became much less intense.

6.7 Dr Ahmad does seem to have evaluated the risks associated with the threats that Mr Winship expressed to his father and to himself. He formed the view that the risk would be much greater and would have to be taken very seriously and managed intrusively if the threats arose from an enduring psychotic illness. Because in his view such an illness was not demonstrated the risk was transient and was insignificant once Mr Winship settled down as he invariably did after a period of time.

6.8 Periods of regular skilled counselling and supportive psychotherapy by Miss Marshall and Mr Bevis seemed to have beneficial effects in reducing Mr Winship's self injury, attendances at the A & E Department and admissions to hospital. Appropriate areas were covered during these sessions and issues of self esteem, his philosophy of life and death and his feelings about his family were all discussed. His family were not involved because Mr Winship did not want this and it was not thought to be crucial to override his wishes. At no point in his social supervision were psychotic or psychotic like phenomena elicited nor was there any indication that he might act as he did. Mr

Winship received exemplary care from his general practitioner Dr Bratt who kept in appropriate contact with the Mental Health Services

6.9 Mr Winship received a great deal of skilled multidisciplinary care both in hospital and the community.

7. CONSIDERATION OF THE MATTERS REQUIRED TO BE INVESTIGATED BY THE INQUIRY

7.1 The Inquiry has been careful to recognise that Mr Winship's treatment and care fall to be judged in the light of the information available and by reference to what represented good practice and proper professional judgement at the relevant times. The tragic outcome may lend a retrospective significance to earlier symptoms, statements or behaviour but although the killing of Mr Winship senior cannot be ignored it should not prevent an objective view as to whether his son's treatment and care was of proper quality when it was provided.

7.2 In this context the Inquiry records two general reservations.

a) Examination of the entirety of the records compiled on Mr Winship, undertaken by a senior clinician, perhaps Dr Ahmad with advice from Mr Bevis, might have identified the possible significance of scattered references to the complex family situation, to Mr Winship's feelings about his father and to episodes which partook of a psychotic nature, and might have resulted in a reappraisal of his diagnosis and in changes to his treatment plans.

b) Those elements of the CPA which recommend family consultation and regular reviews were not observed, although it must be recorded that Mr Winship was resistant to the involvement of his family. Therefore it must be questioned whether Mr Bevis could have elicited material which he could have carried back to a review meeting and which would have affected the course of his client's treatment.

The following commentary is offered in the light of these considerations.

7.3 1a

i The quality of his health, social care and risk assessments.

Health needs and risk assessments were justified on the information available to those making them. Mr Winship made no demand on Social Services

7.4 1b

i The suitability of his treatment, care and supervision in respect of his assessed health and social care needs.

Mr Winship received, in hospital and in the community, treatment and care which was never less than adequate and was for the most part of high quality. The professional assessments of his mental health problems were competent and treatment was appropriate; his care in the community was well planned and delivered. He received services of a high quality from his GP. He made little demand on Social Services. As regards risk assessment the principal concern was of self harm and it could not reasonably have been predicted that he would kill his father, or anyone else.

7.5 1b

ii The suitability of his treatment, care and supervision in respect of his assessed risk of potential harm to himself and others.

The Inquiry accepts the general conclusion of those who cared for Mr Winship that, despite various incidents of self injury, he had no genuine suicidal intention. As regards injury to others alternative diagnoses, with different potential risk elements, were considered;

assessment was a matter of professional judgement and the Inquiry cannot say that the judgements made were incorrect.

7.6 Drug misuse was not a significant factor. Relatively high alcohol intake is recorded but its effect was not significant except in that it tended to make Mr Winship less inhibited in what he was prepared to say to the doctors who examined him, usually in the A & E Department.

7.7 1c

i The extent to which Mr Winship's care was provided in accordance with statutory obligations, relevant Departmental guidance and local operational policies.

The Inquiry has already recorded its concerns about the incomplete application of the Care Programme Approach in Mr Winship's case. It is not possible to express a firm conclusion as to whether family consultation or multidisciplinary reviews would have altered the course of events. The potential benefit of family involvement was self evident but Mr Winship was resistant and his father might have been unwilling to participate. In other respects there was no evidence that relevant guidance was not followed.

7.8 1d

i to iv The extent to which prescribed care plans were appropriate and comprehensive, made known to others as necessary, complied with by Mr Winship and effectively monitored.

Care plans were well constructed and there was an effective mechanism for the keyworker to report when necessary to other members of the Mental Health Care Team. Mr Winship was not totally compliant but in the view of the Inquiry any failures on his part did not affect the course or outcome of his treatment. Monitoring, in the

community, was essentially left to Mr Winship's key worker and might have been more comprehensively provided if Team reviews had taken place from time to time.

7.9 To consider the quality of any relevant professional judgements.

None of the judgements considered by the Inquiry was such that it could not have been made by a reasonable body of practitioners in the particular specialty.

7.10 To examine the adequacy of the collaboration and the communication between the agencies involved in the care of or the provision of services to Mr Winship, and between statutory agencies and Mr Winship's family.

As already recorded Mr Winship's treatment and care fell to be provided essentially by NHS agencies and inter-agency communication was generally satisfactory. There was little need to establish contact with Mr Winship's family except for the purposes of investigating and seeking to understand the apparently complex relationships between himself and his father and himself and his mother and it was generally accepted by those caring for him that Mr Winship would not agree to family consultation.

8 FINDINGS

8.1 Subject to the minor reservations set out earlier in this report, Mr Winship received a good quality of treatment and care for his mental health problems whether in hospital, or receiving community based services or from his General Practitioner.

8.2 Mr Winship's killing of his father could not reasonably have been predicted or prevented.

8.3 The evidence received revealed a need (which may now be in course of being addressed) for a greater commitment to the principles of the Care Programme Approach.

9. RECOMMENDATIONS

9.1 It should be the practice for the records of professional staff providing care and support in the community to be passed to successive workers so that the client's long term history can be understood and taken into account.

9.2 Full compliance with the requirements of the CPA should be required with particular reference to the need for regular multidisciplinary reviews.

9.3 Changes in, and discharge from, the treatment plan should not be agreed by the keyworker alone, and in particular the responsible consultant psychiatrist should be involved.

9.4 Although the principles of patient confidentiality require to be observed, professional staff should understand that there will be cases where interpersonal relationships play so important a part in the patient's thinking and motivation that positive attempts should be made to persuade the patient to accept the participation of those concerned in the processes of diagnosis and treatment.

Appendix A

The Inquiry into the Care and Treatment of Peter Richard Winship from 1992 - 1996

Remit for Inquiry

1. To examine in detail the treatment and care of Peter Richard Winship by the health services, from 1992 until the killing of his father on 20th July 1996, and in particular:-

   a. the quality of his health, social care and risk assessments,

   b. the suitability of his treatment, care and supervision in respect of:-

      i his assessed health and social care needs and
      ii his assessed risk of potential harm to himself and others

      taking account of any previous psychiatric history, including drug and alcohol abuse,

   c. the extent to which Mr Winship's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC(90)23, Supervision Registers HSG(94)5 and Discharge Guidance HSG(94)27, and local operational policies,

   d. the extent to which his prescribed care plans were

      i appropriate and comprehensive

      ii made known to others as necessary

      iii complied with by Mr Winship and

      iv effectively monitored

2. To consider the quality of any relevant professional judgements.

3. To examine the adequacy of the collaboration and communication between:-

   a. the agencies involved in the care of Mr Winship or in the provision of the services to him and

   b. the statutory agencies and Mr Winship's family.

4. To prepare a report and make recommendations to Nottingham Health Authority.

Appendix B

PROCEDURE ADOPTED BY INQUIRY

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

   a. of the terms of reference and the procedure adopted by the Inquiry; and
   b. of the areas and matters to be covered with them; and
   c. requesting them to provide written statements to form the basis of their evidence to the Inquiry; and
   d. that when they give oral evidence they may raise any matter they wish, and which they feel might be relevant to the Inquiry: and
   e. that they may bring with them a friend or relative, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them, with the exception of another Inquiry witness; and
   f. that it is the witness who will be asked questions and who will be expected to answer; and
   g. that their evidence will be recorded and a copy sent to them afterwards for them to sign.

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

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

4. Representations will be invited from professional bodies and other interested parties as to present arrangements for persons in similar circumstances and as to any recommendations they may have for the future.

5. Those professional bodies or interested parties may be asked to give oral evidence about their views and recommendations.

6. Anyone else who feels that they may have something useful to contribute to the Inquiry may make written submissions for the Inquiry's consideration.

7. All sittings of the Inquiry will be held in private.

8. The findings of the Inquiry and any recommendations will be made public.

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

10. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments which appear within the narrative of the Report and any recommendations will be based on those findings.

Appendix C

WITNESSES

Dr S.W.A. Ahmad	Consultant Psychiatrist
Dr M.O. Aveline	Consultant Psychiatrist
Dr R.K. Baruah	Consultant Psychiatrist
Mr G.R. Bevis	Community Psychiatric Nurse
Dr K.G. Bratt	General Practitioner
Dr D.G. Kingdon	Consultant Psychiatrist
Miss C.L. Marshall	Psychologist
Professor E. Szabadi	Consultant Psychiatrist
Mrs J. Winship	Mr Winship's Mother
Miss J. Winship	Mr Winship's Sister
Mr P.W. Winship	The Patient