Report of the Independent Inquiry into the Treatment and Care of **Richard John Burton**

A report commissioned by

Leicestershire Health Authority

October 1996

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PREFACE

We were jointly commissioned in May 1996 by Leicestershire 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.

Hugh Chapman
Chairman

Malcolm Ashman
Social Services Advisor

Oluwafemi Oyebode
Medical Advisor

Brian Rogers
Nurse Advisor

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All of the witnesses of fact (and especially Mr. & Mrs. David Burton) for their frankness and willingness to co-operate in a process which was personally demanding and at times stressful.

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REPORT OF THE INQUIRY INTO THE TREATMENT AND CARE OF RICHARD JOHN BURTON

1. The Offence

1.1 At Leicester Crown Court on 31st July 1996, Richard John Burton ("Mr. Burton") 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 was returned to Rampton Hospital where he had been detained for assessment of his mental condition after having pleaded guilty on 20th March 1996 of the manslaughter of Janice Symons.

1.2 In the final medical report considered by the Court before disposing of the case, the Consultant Forensic Psychiatrist who had assessed him at Rampton, wrote that Mr. Burton was "a man of superior intelligence with a long standing severe and complex disorder of personality. He requires treatment dealing particularly with his potential loss of anger control, suicidal thoughts, poor inter-personal skills, hopelessness and negative beliefs about himself".

2. Personal History

2.1 Mr. Burton was born in Harwich on 17th February 1964 and was the youngest of three children. After three years, the family moved to Windsor and when Mr. Burton was aged eight, to Cambridge. By 1982 Mr. Burton's parents had again moved to Leicestershire, where they still live.

2.2 The Inquiry has read numerous accounts of Mr. Burton's school years as a member of a family of high academic achievement and high academic expectation. He was apparently happy at school in Windsor but in a report to the Court dated 8th December 1995, a Consultant Forensic Psychiatrist recorded that "in Secondary School in Cambridge, he felt that he was unpopular with the other children because of his different accent, tendency to be weak and unable to stand up for himself and talent for drama and music which gave him, on his own admission, an inflated view of himself".

2.3 A report to the Court from a second Consultant Forensic Psychiatrist dated 19th February 1996 states, in respect of his Secondary School at Cambridge, that "Academically .... he got on well but he said he found it hard to get on with people of his own age. He felt isolated because of his background and he said he got a lot of "stick". He was middle class and most of the other children at the school were not and he was told he was "stuck up". He was bullied ....".

2.4 In a second report to the Court dated 17th July 1996 the first of the Consultants referred to above wrote "Further investigation has revealed little new information concerning his upbringing and development other than the degree of competitiveness within the family and the expectations of success and achievement for the children".

2.5 It is clear from reports exploring this aspect of childhood that Mr. Burton felt unable to reach the same high standards as others and despite an innate talent for sport and music and drama he perceived himself a failure. He consequently developed the technique of avoiding taking responsibility for his behaviour, his dependency allowing him to blame others.

2.6 Mr. Burton's father himself, in evidence to the Inquiry, said that "Growing up in a climate of a relatively competitive group of siblings, or two siblings, where a lot of emphasis was put on actually trying, not necessarily succeeding, but trying to carry things through, Richard felt a failure and I think much of the problem arose from the fact that he felt there was little that he could take pride in, and with each attempt which was not carried through, he felt less and less pride in himself".

2.7 Dr. Alan King, Consultant Behavioural Psychotherapist, who saw Mr. Burton in May 1984, recorded a not inconsistent opinion "Intelligent young man, from a talented family, who is wrestling with the thorny problem of whether to face the hell of being at University, or the guilt of not being there."

2.8 After comprehensive school, Mr. Burton moved to a Sixth Form College in Cambridge where he appears to have been more settled. Despite self doubts he achieved A, B and D grades in his A level examinations and was accepted at Leeds University to read a degree course in international history and politics, starting in the autumn of 1982. His brother and sister had preceded him respectively to Oxford and to Cambridge Universities.

2.9 A doctor at the Leeds University Health Service recorded that Mr. Burton during his first term found it difficult to settle and on 4th March 1983 he was admitted informally to Scalebor Park Hospital at Burley in Wharfedale with symptoms of depression. He was discharged seven weeks later, to return to his parents' home in Leicester.

2.10 Mr. Burton's father gave an account of his son's career following his discharge from Scalebor Park Hospital which can be summarised as follows. He took a temporary job, gradually becoming more settled, visited Europe for four weeks and returned to resume his temporary employment. In February 1984 he went back to Leeds University but remained there for only about a month. On resuming residence with his parents, Mr. Burton obtained employment in the Medical Records Department at Leicester General Hospital and his father records that his mental state again improved gradually. In September 1986 Mr. Burton began a full time course in Business Studies at Leicester Polytechnic. The first six months of the course seemed to go well but further problems arose and Mr. Burton began to behave erratically, leaving home for varying periods of days or weeks without explanation. Eventually his parents decided that it would be better if he moved out of their home and it appears that he had already decided to look for his own accommodation. Accordingly,

in about September 1987 his father helped him to move to a bed-sit in St. Saviour's Road, Leicester.

2.11 Mr. Burton appears not to have returned to his Polytechnic course and he obtained employment at the Leicester General Hospital as a porter. Mr. Burton senior states that after the move to St. Saviour's Road, "We did not see Richard for several weeks". However, Mrs. Burton made contact and her husband's statement continues "Over the following eighteen months, Richard visited us every two weeks for a meal. He was doing well at work and at home. He had met a girl .... and seemed to get on very well with her ....and in I believe March 1988 the two of them rented a house together ...". Mr. Burton and his partner later, in 1990, purchased a house, again in Leicester.

2.12 Mr. Burton Senior records that over the next four years his son had seemed reasonably happy with his partner. He began to take an interest in amateur dramatics and an Open University Course in Computer Studies but in March 1995 he announced that he and his partner were splitting up and he moved into single room accommodation in Victoria Park Road, Leicester.

2.13 Mr. Burton's parents maintained contact over the following few weeks. Their son seemed less settled and confessed that his parting from his girl friend was affecting him more than he had expected.

2.14 On 16th April 1995 he visited the family home for lunch and announced that he intended to seek help by involving himself with the Pentecostal Church. This news worried Mr. Burton's father who "felt that things were going back to how they had been ten years earlier". He gave Mr. Burton a set of self awareness tapes and on 20th April he visited his son at 144 Victoria Park Road to give him some computer or word processor material.

2.15 Mr. Burton Senior did not see or speak to his son again although Mrs. Burton received a telephone call on 8th May. When asked how her son had sounded, she said "he seemed all right".

2.16 Mrs. Symons was killed on 11th May 1995.

3. Psychiatric History and Treatment

3.1 There is no substantial evidence that Mr. Burton suffered from mental disorder before going to Leeds and it is the period from March 1983 to May 1995 upon which the Inquiry has focused its attention.

3.2 There are, however, one or two indications of some kind of emotional disturbance before that time, for example there are references in the records to his having experienced periods of depression since the age of 11 or 12 but they cannot have been regarded as sufficiently serious to justify medical intervention.

3.3 Scalebor Park Hospital

3.3.1 Mr. Burton was referred to Dr. A.D. Clarkson, Consultant Psychiatrist at Scalebor Park Hospital by Dr. J.E. Everett (Medical Officer, University Health Service) on 4th March 1983. He was then a first year student at Leeds University studying international history and politics.

3.3.2 Mr. Burton was admitted, informally, to Scalebor Park on the same day. He gave a three week history of lowered mood, variable sleep pattern which included periods of insomnia and hypersomnia, poor appetite, loss of weight, suicidal thoughts and a lack of interest in the future. He had, in the weeks leading up to his admission, contacted the Samaritans because of suicidal ruminations. The psychiatric symptoms seemed to have been precipitated by the break up of his relationship with a girlfriend. It was also likely that he was having difficulty in coping with his academic work.

3.3.3 On admission he was noted to be unshaven and dressed in black. His mood was depressed and he expressed feelings of hopelessness. His speech was normal in form and content and there was no evidence of delusional beliefs or of hallucinatory experiences. He recognised that he was in need of psychiatric assistance and complied with treatment. Physical examination was almost entirely normal. The only abnormal result from physical investigation was the Dexamethasone Suppression Test (DST). The DST is a measure of the integrity of the hypothalamic-pituitary-adrenocortical axis which is known to be abnormal in about 50% of patients with a diagnosis of endogenous depression. However, it is a non-specific abnormality which can also be found in a number of other psychiatric and medical conditions.

3.3.4 The psychiatric diagnosis was Endogenous Depression. During this admission it also emerged that Mr. Burton had personality difficulties and it was concluded that "he is anxious, schizoid and self-critical". He was treated with Clomipramine, a tricyclic antidepressant, at a dose of 25mgs twice daily and 75 mgs at night. This is a total dose of 125 mgs daily and is within the accepted therapeutic range.

3.3.5 Mr. Burton was discharged home to his parents in Leicester on 22nd April 1983 and advised to take two terms off university with a view to starting his studies again in January 1984. There was no psychiatric follow-up arrangement, although the discharge letter sent to the Medical Officer who had referred him was sent to Mr. Burton's GP in Leicester. Mr. Burton was seen by his GP in Leicester on 5th May 1983 and his medication was reduced to Clomipramine 100 mgs daily. He was provided with 120 capsules of Clomipramine. His GP saw him on 13 occasions between June 1983 and January 1984 and his medication was gradually reduced until it was discontinued in January 1984. The GP notes describe a gradual but definite improvement in Mr. Burton's clinical condition in the period following his discharge from Scalebor Park Hospital.

3.4 The Day Hospital of the Psychiatric Department at Leicester General Hospital

3.4.1 Mr. Burton was referred informally to the Day Hospital in April 1984 by Dr. Martin Laundau-North, a clinical psychologist, who was known to the family. Dr. Landau-North had become involved at the request of the family but had found the problem of greater complexity than he had supposed and he then sought Day Hospital attendance for Mr. Burton under the "nominal" care of Dr. Alan King, Consultant Behavioural Psychotherapist. Dr. King was unwilling to be a "nominal medical officer" and a formal referral by the GP was requested. The formal referral was made by his GP on 2nd May 1984 to Dr. King who by then had already seen Mr. Burton on the previous day.

3.4.2 The initial assessment was comprehensive and detailed. Dr. King concluded that there was no evidence of a primary affective disorder but that there was evidence of an Adjustment Reaction. Mr. Burton attended the Day Hospital regularly until August 1984. He was also seen by Dr. Peter Trower, a clinical psychologist, who specialised in Rational Emotive Therapy (RET), an early form of cognitive behavioural psychotherapy. During Mr. Burton's attendance at the Day Hospital, he was seen regularly by nurses and occupational therapists. The hospital notes are detailed and indicate that a thorough assessment of his needs was conducted. He was discharged from the Day Hospital in September 1984 but continued to be followed up by Dr. King in his out patient clinic until May 1985.

3.4.3 On his discharge, Dr. King believed that Mr. Burton had made substantial improvement.

3.4.4 In July 1984, Dr. King had referred Mr. Burton to Dr. Chris Whyte (Consultant Psychotherapist) to assess his suitability for dynamic psychotherapy. Dr. Whyte saw Mr. Burton twice, on 15th and 22nd August 1984 respectively. He concluded that Mr. Burton did not have any symptoms or signs of schizophrenia or major depression. His diagnosis was Schizoid Personality Disorder. There was no evidence from these interviews to suggest any risk to others. Dr. Whyte specifically enquired into Mr. Burton's fantasy life as is routine in psychotherapy assessments. There was no account of aggressive or violent fantasies. Mr. Burton's risk of self-harm was noted but Dr. Whyte did not find any evidence at the time to suggest that Mr. Burton posed a significant risk to himself.

3.4.5 Dr. Whyte was in doubt about Mr. Burton's suitability for dynamic psychotherapy. This doubt was based on his belief that the personality disturbance "ran quite deep" and would be resistant to change. Also, Mr. Burton's capacity for constructive self-reflection was thought to be limited. However, in May 1985 when a place came up, Mr. Burton was contacted and offered the opportunity to have dynamic psychotherapy. He declined this offer, by telephone.

3.5 Ward 33 Department of Psychiatry, Leicester General Hospital

3.5.1 Mr. Burton was admitted into Ward 33 Leicester General Hospital on 27th August 1987 under the care of Dr. N.C. Low, Consultant Psychiatrist, following an overdose of 80 Paracetamol tablets. The admitting doctor was Dr. Fiona Mackenzie, Senior House Officer to Dr. Low. Mr. Burton took the overdose in the context of feelings of depression and guilt. There was also a history of poor appetite, sleep disturbance and poor concentration. The overdose was not accompanied by any "final acts" and there was no suicide note. Mr. Burton asked his father to take him to hospital later on the day of the overdose. It was notable that he was on a Business Studies course at Leicester Polytechnic which he was finding stressful at the time. The mental state examination at the time of admission revealed a withdrawn young man who was difficult to interview. There was evidence of low mood, feelings of derealisation, low self-esteem, and guilt. There was no evidence of delusional beliefs or abnormal perceptions. He was thought to be of above average intelligence and he had a good insight into the causes of his low mood state. Physical examination and investigations were all normal. The clinical diagnosis was Depressive Personality Disorder. It was thought that psychotropic medication was not indicated in his case.

3.5.2 He was discharged on 2nd September 1987. On discharge, his mood was brighter and he denied any continuing suicidal thoughts. He had started to socialise with other patients on the ward. His appetite had improved and he was able to concentrate on and to enjoy reading. He was referred to the Woodlands Day Hospital.

3.5.3 On Mr. Burton's admission to Ward 33 he was interviewed by a 2nd year student nurse, Richard Benson, whom the patient informed that he had fantasies to harm his parents. This information was communicated to the Staff Nurse who was supervising Mr. Benson's work and Mr. Benson was informed that aggressive fantasies were not uncommon in psychiatric patients. Mr. Burton's aggressive fantasies were not brought to the attention of the medical staff. During this admission to Ward 33 there was no evidence of aggressive behaviour and there was no reason to believe that Mr. Burton posed a risk to anyone.

3.6 Woodlands Day Hospital

3.6.1 Mr. Burton attended the Woodlands Day Hospital from 8th September to 21st September 1987. The initial assessment was carried out by Dr. I. Woollands, Registrar in Psychiatry. On admission to the Day Hospital, Mr. Burton appeared poorly groomed and his eye contact was reported to be poor. His mood was low and there was evidence of continuing suicidal ruminations. His speech was normal in form and content. There was no evidence of delusional beliefs or of abnormal perceptions. The clinical impression was of a longstanding personality disorder with secondary depressive symptoms.

3.6.2 During this admission to the Woodlands Day Hospital, Robert Downing, a student social worker, interviewed Mr. Burton's mother on 10th September and completed a detailed social work assessment.

His report documented Mr. Burton's previous episodes of self-harm including separate attempts to cut his throat and wrists, and overdoses of drugs. There was no account of violent behaviour directed at others.

3.6.3 Mr. Burton was referred to Dr. Agami for psychotherapy during this admission but he failed to co-operate with this arrangement. His attendance at the Day Hospital became irregular and in this period he took another overdose of 10, (or according to his father, 30) Paracetamol tablets and was admitted into the Leicester Royal Infirmary for the night of 17th and 18th September. At the Royal Infirmary he was seen by a psychiatrist who considered that there had been no genuine suicide attempt. Mr. Burton was discharged from Woodlands Day Hospital with no further follow-up arrangement on 21st September 1987. The long term prognosis was thought to be poor because of his apparent lack of motivation to comply with treatment. It is recorded that Mr. Burton's Business Studies course was due to resume on 22nd September.

3.7 **Events in April and May 1995**

3.7.1 Mr. Burton attended his GP's surgery on 25th April 1995 and was seen by Dr. N.H. Joshi. This consultation took place at the Clyde Street Surgery because he was seen as an emergency. Mr. Burton was registered with Dr. J.C. Astles but he was seen by Dr. Joshi because of the urgency of the consultation. He informed Dr. Joshi that his colleagues at work had prompted his attendance at the surgery because they thought he was withdrawn in his demeanour and had suggested that he take two weeks off work as he was not coping with his responsibilities. Mr. Burton also informed Dr. Joshi that he had broken off his relationship with his girlfriend six weeks before the consultation. Dr. Joshi established that Mr. Burton was low in mood and his appetite, concentration and sleep were impaired. Although his patient felt desperate and hopeless in relation to his recently ended relationship, he denied any suicidal thoughts. Dr. Joshi formed the opinion that Mr. Burton was suffering from "clinical depression" and gave him a prescription for Fluoxetine 20 mg daily. A supply of 30 tablets was dispensed. Fluoxetine is a selective serotonin re-uptake inhibitor (SSRI) a form of antidepressant medication. Dr. Joshi arranged to see his patient again in two weeks.

3.7.2 Dr. Joshi prescribed Fluoxetine because of its safety in overdose and also because of its good side-effect profile. Dr. Joshi was aware of the reports of Fluoxetine induced violent behaviour in some patients but regarded these reports as unconfirmed and controversial.

3.7.3 Mr. Burton was seen at Leicester Royal Infirmary on 5 May 1995 by the duty doctor, Dr. B. Lenihan, following an overdose of 10 Lemsip sachets. Dr. Lenihan interviewed him for approximately 1 hour. He informed her that

he had taken an overdose of 17 Fluoxetine tablets the previous day. These overdoses had taken place in the context of the break-up of a seven year relationship with his girlfriend.

Although Mr. Burton had wanted to die at the time he took the overdose of Lemsip sachets he had changed his mind and had presented himself in the Accident and Emergency Department of the Royal Infirmary. His mental state at the time was described as predominantly depressed in mood. His sleep was disturbed and there was evidence of poor appetite and weight loss. There was evidence of low self-esteem but there was no evidence of hallucinations or delusions. Mr. Burton denied being ill and did not regard himself as being depressed. Dr. Lenihan concluded that the overdose was impulsive in nature and that the risk of a further suicide in the immediate future was low. However, she thought that there was a possibility that her patient was suffering from "clinical depression". There was no history suggestive of a wish or urge to harm others. Indeed, Dr. Lenihan had interviewed Mr. Burton on her own and had not felt threatened by him, although she took the usual precaution of carrying an alarm. She considered, however, that he should be seen by a Consultant Psychiatrist and arranged for him to be seen in Dr. D.I. Khoosal's out-patient clinic on 24th May. Dr. Lenihan's referral letter to Dr. Khoosal was dated 11th May and was received by Dr. Khoosal on the 17th. Dr. Lenihan had already confirmed the date of the out-patient appointment by telephone before her letter was written. The probability is that if Dr. Khoosal had seen Mr. Burton, he would have been referred to the City East Community Mental Health Team. In the event Mr. Burton killed Mrs. Symons on 11th May and did not keep the appointment with Dr. Khoosal.

4. Findings and Conclusions about Individual Episodes of Mr. Burton's Treatment

4.1 Scalebor Park (1983)

4.1.1 Mr. Burton's admission into Scalebor Park Hospital was his first psychiatric hospital admission. The medical and nursing notes are comprehensive and detailed. The risk of suicide was well recognised and had receded by the end of this admission. There was no mention of risk to others nor was there any behaviour which indicated the existence of such risk.

4.1.2 Mr. Burton's parents did not visit in the early part of the admission because he specifically requested that they should not do so. There is an entry in the medical notes by Dr. Clarkson's Senior House Officer, documenting this and also documenting the fact that the SHO had spoken to Mr. Burton's mother to explain his condition and treatment. Mr. Burton spent Easter 1983 at home and was taken back to Scalebor Park by his parents at the end of that holiday break. There is no entry in the notes indicating whether his parents were seen on this occasion or whether they indicated a wish to be seen.

4.2 Day Hospital (1984)

4.2.1 Mr. Burton's contact with the team at the Day Hospital lasted for four months but in the last month his attendance was poor. He was seen regularly by Dr. King and Dr. Trower. He was followed up for a further period of nine months by Dr. King after his discharge from the Day Hospital.

4.2.2 The assessment of his condition was made by two senior medical clinicians and two clinical psychologists. His management followed a plan of action determined by these assessments. There was never any evidence that Mr. Burton could pose a risk to others. Risk to himself was also judged to be low at the time.

4.3 Ward 33 Leicester General Hospital and Day Hospital (1987)

4.3.1 The details of Mr. Burton's admission into Ward 33 and subsequent attendance at Woodlands Day Hospital which were available for scrutiny, were comprehensive. However, a significant proportion of the nursing notes from Ward 33 were missing. This made it difficult to assess in detail the nursing aspects of his care during this admission.

4.3.2 A multidisciplinary assessment was conducted at the Day Hospital and a treatment plan was devised.

4.3.3 The account of violent fantasies of harming his parents given to Mr. Benson on 27th August, 1987 and briefly recorded by him under the heading of "Thought Disturbance" as "fantasises about killing his parents and others" was the only entry in the entirety of the medical records between 1983 and 1995 examined by the Inquiry which gave any intimation of any tendency to fantasise about causing harm to others. The report by Mr. Benson was incidental and there is no evidence that it accorded with what was known about Mr. Burton at the time. There was no past or recent history of threats or actual harm directed at others. The concern of all the clinicians involved in his care then and later was to diminish the risk of harm to himself. Indeed, even if the report of his violent fantasies had been brought to the attention of medical staff, the members of the Inquiry Panel considered it unlikely that it would have led to any different course of action.

4.4 GP and Hospital Care (1995)

4.4.1 Dr. Joshi's assessment of Mr. Burton's clinical condition was appropriate. His choice of Fluoxetine was well founded.

4.4.2 There have been reports of Fluoxetine induced violent behaviour in children and adolescents treated with this medication (King et al, 1991) and in patients having a learning disability with a history of epilepsy and previous aggressive behaviour (Troisi et al, 1995).

4.4.3 However, there are also reports of the effectiveness of Fluoxetine in the treatment of impulsivity and depression in patients with a diagnosis of Borderline Personality Disorder (Cornelius et al, 1991). The current state of knowledge is summarised by the Drugs and Therapeutics Bulletin (1992) as follows: "The relation of Fluoxetine to irritability, hostility and aggression remains unsettled".

4.4.4 Mr. Burton's own account of his urges to harm his landlady (communicated to the psychiatrists who interviewed him after the offence but not to Dr. Lenihan) suggested that these urges had been present for three weeks before the incident. This could be read as showing that these urges were co-incident with the use of Fluoxetine and therefore causally related to Fluoxetine.

4.4.5 However, it is unlikely that Fluoxetine had a role in his case. In 1983 whilst at Scalebor Park Hospital he received Clomipramine which he took for several months. Clomipramine is also a serotonin re-uptake inhibitor, although it is not as selective in its action as Fluoxetine. It does not appear to have provoked in Mr. Burton homicidal ruminations or urges. Furthermore, he took an overdose of Fluoxetine on 4th May 1995 and this appears to have exhausted his supply. On this basis he would not have taken Fluoxetine between 5th and 11th May 1995.

4.4.6 The offence was committed on 11th May 1995 and is unlikely to have been induced by this medication.

4.4.7 Dr. Lenihan's assessment of Mr. Burton's condition was thorough. She acted appropriately in the circumstances. She was conscientious in her duty in arranging out-patient follow-up for Mr. Burton and in informing the GP of her actions. There was no indication of risk to others and the risk of suicide was judged to be minimal.

5. Overall Conclusions about the Assessment and Treatment of Mr. Burton's Mental Health Problems

5.1 Mr. Burton's assessment and management on the four occasions on which he had contact with psychiatric services at Scalebor Park Hospital and in Leicester were thorough and adequate to his needs.

5.2 There was no evidence of his potential risk to others. The predominant feature of his condition was of his risk to himself. This risk was judged not to be particularly high but was responded to appropriately on each occasion when he presented to the services.

5.3 The views of Drs. King and Whyte were that Mr. Burton's risk to others was not apparent during their contacts with him and his subsequent violent behaviour could not have been predicted on the basis of what was known to them in 1984-1985. There was no history of repeated violent threats or

behaviour. Indeed, there was no history of violent behaviour directed even at inanimate objects.

5.4 The forensic psychiatric reports presented to the Crown Court by Dr. I.D. Wilson, Dr. J. Anderson and others, suggest that Mr. Burton had been engaging in violent fantasies since early adult life and furthermore that the violent attack on his landlady had been on his mind for at least three weeks before the incident. There were also references to previous urges to harm his ex-girlfriend and reports of his shaking her during rows.

In Dr. Anderson's report, Mr. Burton is said to have been violent and disparaging to his girlfriend on at least three occasions; on one occasion he lost his temper in an uncontrollable frenzy and repeatedly stabbed a chopping board with a knife; on another occasion he punched and kicked her and on the final occasion he tipped margarine over her when she accused him of treating her with contempt. Mr. Burton's mother gave evidence to the Inquiry that in 1987 she had returned home on one occasion to find him holding a knife out towards her. It had not occurred to her at the time that she might have been at risk. None of this evidence was known to the clinicians involved in Mr. Burton's care at any time in the period 1983-1995 and the only reference to the possibility of violence to others was the solitary entry about his fantasies of harming his parents made in the nursing notes in 1987. It was therefore not possible to predict Mr. Burton's potential for violence. The incidents of violence described in the forensic psychiatric reports did not occur in the context of any demonstrable mental illness. All the forensic reports concur on the absence of symptoms or signs of mental illness. This underlines the complexity of this case.

5.5 The Inquiry team in the Kim Kirkman case expressed the view that the following factors each play a part in making a judgement about risk to others; the past history of the patient; self-report by the patient at interview; observation by trained staff of both the behaviour and mental state of the patient; discrepancies between what is reported and what is observed; statistics derived from studies of related cases; and prediction indicators derived from research. In Mr. Burton's case none of these factors pointed towards the likelihood of risk to others. The Kirkman Inquiry concluded that "nothing predicts behaviour like behaviour". There had been nothing in Mr. Burton's previous behaviour to highlight his potential risk to others. The Report of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People (RCPsych, 1996) demonstrated that 66% of individuals involved in homicide had been involved in earlier episodes of violent or aggressive behaviour and 26% had received criminal convictions for offences involving violence. Neither of these factors was present in Mr. Burton's case.

5.6 In summary, on the basis of what was known to those who were concerned with Mr. Burton's treatment and care between 1983 and 1995, there is no reason to believe that anyone could have predicted his violent behaviour nor could they have acted in any way to prevent the tragedy which occurred.

5.7 Mr. Burton's long term partner in her statement to the police dated 11th May 1995 said that she had met him on 5th May 1995 and he had told her that he was going to watch "Reservoir Dogs", a film reputed to be violent in nature. In Mr. Burton's own handwritten account of his life and the circumstances surrounding the offence he describes how he was influenced by the words of songs such as "Paint it black" by the Rolling Stones and Pilate's and Judas's songs in the musical "Jesus Christ Superstar" by Lloyd Webber. Any effect of the film "Reservoir Dogs" on Mr. Burton's violent behaviour is hard to judge. In general, it is unclear whether watching violent films makes a significant contribution to the perpetration of violent acts.

The research literature is divided on the issue (Cumberlatch & Howitt, 1989) but there is an emerging opinion that a small group of vulnerable viewers who are probably more impressionable may be susceptible to the influence of violent films (Lande 1993). In Mr. Burton's case, all that can be said is that he put considerable emphasis on the words of songs and may also have placed a similar emphasis on the content of films. There is no positive indication that the film "Reservoir Dogs" was anything other than incidental in the chronology of events.

6. The Interaction of Health and Social Services

6.1 The General Organisational Context

6.1.1 As already stated, the essential focus of this Inquiry spans the years between 1983 and 1995. It was through this period that Mr. Burton's mental ill health became manifest and resulted in significant contacts with the specialist mental health services, as a user of psychiatric and psychological in-patient and day services.

6.1.2 The events which are the subject of the Inquiry took place against a backcloth of very considerable changes in the organisation and operation of the health and social services. These were prompted by new legislation and guidance and affected all those involved with the psychiatric services. The progressive run-down of long-term hospital care facilities and the shift from large all-purpose treatment and care facilities, to a more complex pattern of provision concerned with multi-disciplinary and multi-agency work, resulted in both the separation and the continuing interdependence of treatment and supportive care functions.

6.1.3 Another significant factor was the organisational change resulting from the creation of purchaser/provider relationships in the National Health Service and the emergence of fundholders in general medical practice. These changes required underpinning by interactive systems and interactive behaviour on the part of all concerned and necessitated joint planning, sometimes joint commissioning, and joint training. Evaluation and audit arrangements also needed to be developed.

6.1.4 The following paragraphs trace the development and implementation of these changes for the principal agencies involved in Leicestershire.

6.1.5 Leicestershire Health Authority serves a resident population of 926,000 and in 1995/96 had an annual budget of £375 million. It is the purchaser of a range of psychiatric in-patient and out-patient services as well as supporting community services. The Leicestershire Mental Health Service NHS Trust, which was created in 1994, is the main provider of psychiatric services, and the Inquiry was told that in the year 1995/96 £52 million was allocated to those services. To support and integrate in-patient services, seven locality based community mental health teams have been established. The Family Health Services Authority merged with Leicestershire Health Authority by statute in April 1996.

6.1.6 The Social Services Department of Leicestershire County Council serves a population of 926,000 people of whom about a third live in Leicester. In 1995/96 approximately £7.4 million (7.4%) of its annual revenue budget was allocated to mental health services. The County Council was created out of the local government reforms in 1974. It too has experienced significant legislative change, most notably from the Mental Health Act 1983, The Children Act 1989, and the National Health Service and Community Care Act 1990, which established its role as a planner and purchaser of nursing and residential home placements and non-NHS day services, but without the organisational imperative to separate purchasing and providing activities. However, Leicestershire County Council has made such arrangements at operational level.

6.1.7 The Department is organised on a headquarters based, strategic and operational co-ordination model. In addition, there is a county wide services division delivering a number of specialist and county wide services including notably the out of hours and emergency services, and forensic social work, substance misuse and deliberate self harm provision.

6.1.8 All other services are based on four divisional offices which have generic and specialist teams. These undertake assessment and provision of services for adults and children.

6.1.9 There is express recognition of the need to engage service users and carers as far as possible in the planning and delivery of care and after care, with particular emphasis on these matters at the point of assessment of need, care planning, discharge from care and follow-up support thereafter.

6.2 **Mental Health Services**

6.2.1 The significance of these services is reflected in both authorities' staffing arrangements. In Social Services a divisional manager (a third tier level post) is the lead officer for planning mental health services; a headquarters based

planning and policy development officer supports this work and with the lead officer has a work focus based on interagency planning and operational matters.

6.2.2 The Health Authority has a purchasing director at second tier level, concerned with this area of work and a mental health and learning disability purchasing team which includes social services membership.

6.2.3 The Social Services Department has an establishment of seventy specialist Approved Social Workers. Since 1991, these have been progressively deployed across divisional social work teams, in specialist mental health social work teams based on the seven health localities, and in the emergency duty team. Prior to 1991 social work support for psychiatric care in hospitals was provided by hospital based social workers. The revised arrangements were created to reflect the shift to increasing amounts of care at home for those suffering the effects of psychiatric illness. However, strong operational liaison and other links are maintained between the locality based teams and the hospitals and the hospital wards they serve across the county.

6.2.4 Line management of Approved Social Workers is provided by team managers (mental health) who are Social Service Department based whilst Approved Social Workers for day to day purposes are attached to the community mental health teams which are headed by a health service Locality Manager. The teams are multi-disciplinary and multi-agency in function and provide the basis of assessment and care planning of clinical and social care needs. The teams have good links with housing, benefits and other key agencies as well as with community support groups. Not all mental health social work is attended to by specialist Approved Social Workers. It has proved appropriate to allocate referrals which indicate low dependency to generic teams.

6.2.5 Other specialist work support for psychiatric services is provided through the emergency duty team, the substance misuse team, and the forensic social work arrangements at Arnold Lodge, a medium secure unit, which is situated within the grounds of the Towers Hospital.

6.2.6 There is also specialist social work support to the deliberate self-harm team which is based at the Leicester General Hospital Psychiatric Department and provides a service to the Leicester Royal Infirmary. This team has medical, nursing and social work input. Its function is primarily to deal with the immediate consequences of incidents involving attempted self-harm. It is therefore involved in assessing the need for immediate action or for the referral to other services or into the mainstream psychiatric services. Where appropriate short-term follow up work is carried out.

6.2.7 The events involving Mr. Burton occurred in the Social Services Department's City East division which is coterminous with a health locality. This area is served by two community mental health teams which were established in 1993, serving the south-east and the north-east of the city.

6.2.8 The inner city areas served by these teams (a population of about 70,000 people per team) have high levels of deprivation, a mobile population, and a significant number of ethnic minority groups amounting to over 40% of the population served. This is a very busy area for health and social services teams and the needs presented to them are frequently complex in nature.

6.3 Joint Working

6.3.1 A good level of collaborative activity between health and social services and others is now required at strategic, operational and practice levels in the planning, purchasing, provision and monitoring of services.

6.3.2 Co-operation between health and social services is essential to access central government specific grants for funding nursing, residential and home care services and for special funds for the development of services to support those suffering from severe and enduring psychiatric illness, i.e. the Mental Illness Specific Grant. Other forms of special funding, e.g. for substance misuse services, also require evidence based joint submissions between health and social services and frequently with other agencies to achieve success.

6.3.3 A recent requirement of Social Services Departments is concerned with the publication of local Community Care Charters, preceded by extensive consultation with key agencies, service users and carers. The Community Care Charter is progressing the development of service standards and user involvement in a way not dissimilar to that already enshrined in the Patient's Charter.

6.3.4 All the above developments are buttressed by specific statutory requirements and by good practice guidance which is issued from time to time by the Department of Health. There is particular concern with care and after-care especially with regard to discharge arrangements and the involvement of patients and service users in the determination of care plans. Most recently, this guidance has been enshrined in Circular HSG(94)27, which is built on an earlier circular HC(90)23, in the Health of the Nation publication "The Key Area Handbook on Mental Illness Services" and in "Building Bridges". While promoting the active involvement of all those concerned in these matters, the patient's right to confidentiality is recognised.

6.4 Joint Working in Leicestershire

6.4.1 Examination of documents and the information given by witnesses to the Inquiry confirm that there are established and sound procedures in place to promote co-operation between the health and social services and other agencies in Leicestershire.

6.4.2 There exists a Joint Consultative Committee of the health and social services, and a Chief Officer, Joint Care Planning Team and below it an all agency Joint

Strategy Group which involves virtually all those concerned with the operation of mental health services.

6.4.3 The Joint Strategy Group is currently led by the Social Services Department. Its remit is to take an overall view of services and to establish sub or task groups which look in more depth at certain aspects of service delivery and performance. Currently there are nine such task groups in existence looking at issues ranging from information and advocacy to services for mentally disordered offenders.

6.4.4 There also exists a "Business Meeting" which is led by the Leicestershire Mental Health Service NHS Trust. The work of this group is to monitor the working of operational arrangements and to identify areas which require attention, or perhaps which need addressing at other levels or by other organisations, whether at policy or operational level.

6.4.5. The level of co-operation has resulted in an organisational capacity to produce joint community care plans for the past four years. An inaugural joint community care plan was produced in the year before it was statutorily required, as a means of learning about the processes involved.

6.4.6 Joint procedures exist for the operation of the Care Programme Approach. These have been kept under review since their inception in 1991 and have been updated as appropriate.

Since 1995 joint procedures have been written to integrate the Care Programme Approach and the care management processes for assessment in Social Services.

6.4.7 Work is in progress on risk assessment strategies and procedures to assist those involved in assessment, particularly in the areas where self-neglect or self-harm or dangerousness to others may be present.

6.4.8 Generally a structure and a system for the operation of community mental health teams is now established and the working arrangements as they apply to the City East team appeared to work smoothly and well. Arrangements for the provision of specialist social workers in mental health, i.e. Approved Social Workers, appear to be adequate, even under pressure, to meet the needs of community mental health teams during the day and to provide an adequate response for out of hours and emergency work. Five Approved Social Workers were assigned to the City East Community Mental Health Team which would have dealt with Mr. Burton's care, had the arrangements which Dr. Khoosal might have been expected to make (mentioned in paragraph 3.7.3) come to fruition.

6.4.9 Successful joint commissioning has taken place which has enabled the accessing of central government grants for community care.

6.4.10 The mental illness specific grant has been utilised to the full for the creation of a range of services for those suffering from severe and enduring psychiatric illness.

6.4.11 Joint commissioning with Social Services as the lead agency has also been achieved to integrate and co-ordinate the provision of all learning disability services.

6.4.12 Training strategies and programmes are necessary to support all these developments and currently attention is being given by a number of working groups to ways of giving greater importance and resources to this sphere of work.

6.5 **Contact with the Social Services**

6.5.1 Neither Mr. Burton nor his family had any involvement with the Social Services, (other than with a student social worker who compiled a social history with Mrs. Burton in September 1987), because they had not sought any and no referral from any other service was thought to be necessary. In the immediate aftermath of the homicide, Social Services staff were involved in statutory functions concerned with the operation of the Mental Health Act and to provide support during the police and criminal evidence interviews which took place. Subsequently, a forensic Social Worker was considerably involved in the period up to Mr. Burton's transfer to Rampton. During this period the Social Worker concerned saw Mr. Burton on five occasions, his family on two occasions and his former partner once. In addition there were numerous telephone contacts. Mr. Burton's parents expressed satisfaction to the Inquiry concerning the level of co-operation between the health and social care agencies and about the support they received subsequent to the 11th May, 1995.

6.5.2 In relation to the contacts with the specialist psychiatric services previously described, the relevant witnesses were asked about their knowledge of how to access social work support and their expectations of it. They were also asked to identify reasons why there had been no referral to Social Services for Mr. Burton and his family.

6.5.3 In response the witnesses explained that at the point of contact with the specialist psychiatric services there had not appeared to be reasons to suggest a referral to Social Services. Mr. Burton did not have accommodation problems, he was in employment for much of the period and also studying and since 1988 had been in an apparently long-term and stable relationship with a partner. They also had in mind indications from Mr. Burton that he did not wish his family to be involved.

6.5.4 It is also the case that any help which Mr. Burton needed was not of the kind provided by Social Services. The principal features of the interventions which were appropriate (and which were arranged by others) were to provide for him

more specialised psychological therapy with the objective of improving his self-esteem and social functioning. He did not present as having immediate needs and broadly accepted the services which were offered to him with some evidence of a positive motivation, except for his eventual refusal of the dynamic psychotherapeutic help which was arranged for him in 1985. His discharges from care were to home or to his partner and he was in employment or studying for much of the period.

6.5.5 It is also the case that during the 1980s there were no national practice guidelines surrounding the processes of assessment, care planning, discharge and after-care of the kind which have become enshrined in procedures since 1990.

6.5.6 It is clear that social work support was available in the hospitals and from other sources but in the case of Mr. Burton it was not perceived to be relevant or necessary.

6.6 **The Substance of Witness Statements to the Inquiry**

6.6.1 All witnesses were invited to comment on their view or actual experience of the matters under consideration, and the arrangements described above.

6.6.2 Mr. Burton, interviewed at Rampton Hospital by two members of the Inquiry Panel, felt that the services had been responsive and appropriate to the needs that he presented to various clinicians at different stages in his illness.

6.6.3 His parents expressed in their statement to the Inquiry Panel their disappointment with the lack of initial involvement with them when their son first became ill in 1983. However, they balanced this view with an appreciation of the dilemma that Richard as an adult was entitled to make choices about whether to involve them or others. They were aware that in 1983 and thereafter he had been explicit to those concerned in treating him, about his wishes that his parents should not be involved.

It is clear in all guidance to the relevant agencies that such wishes, so clearly expressed, must be respected, even though those concerned should point out to patients the possible benefits of the involvement of close relatives and carers.

6.6.4 The clinicians and nurses who assisted the Inquiry were questioned about the availability and responsiveness of social work support during the day and out of hours and how it could and should be accessed. All knew how to access it if referral was necessary and expressed confidence that a request would be positively responded to.

6.6.5 Mr. Burton's General Practitioner, Dr. Joshi, expressed similar views. He was particularly complimentary about the Social Service Department's divisionally based direct access teams, which allowed him easy entry into the services and a quick response.

6.6.6 Dr. Joshi did comment that information and literature about contact points provided by the Community Mental Health Teams and social services divisions could at times be unco-ordinated and as such a potential inhibitor to seeking help for low dependency needs. He drew attention to the tendency of different teams to produce information in different ways, to different forms of request for information and to different contact points. He felt that this was a particular problem for his practice because it spanned more than one of the city area teams' boundaries.

6.6.7 Social work staff, both managers and practitioners, who were interviewed felt that in the City East area co-operation with the health services was good and worked well and that they had ready access to clinical support when required. They also felt that there was every opportunity to be fully involved in key decisions about patients whether in hospital or in the community.

The arrangements described to the Inquiry for the involvement of patients and relatives seem generally to be sound and welcoming and very frequently used. They did, however, not appear to be formalised in a way which would ensure uniformity of approach across a large number of teams.

6.7 Conclusions

6.7.1 After examining the procedures and hearing the evidence from witnesses to the Inquiry it is possible to conclude that had Mr. Burton taken up his out-patient appointment on 24th May 1995 which was made for him by Dr. Lenihan on 9th May in the City East area he might have benefited from the system of care in terms of in-patient and community services which was by then available and which appeared competent to assess his needs and meet them appropriately as well as involving him in decisions about planning for his care. It is also likely that he would have been encouraged to involve his family and any other significant people in his life to assist in that process.

6.7.2 At the same time his low self-esteem and his history of failure to persist with treatment plans formulated for him, make it difficult to express a confident view as to the benefit which he might have obtained from hospital based and community services. It is doubtful whether he could have been detained for any length of time (if at all) under the Mental Health Act. It is also to be noted that final decisions about his mental illness and its treatability were only reached after examination by numerous psychiatric experts and an intensive assessment at Rampton Hospital over a period of some three and a half months.

6.7.3 It is very significant that none of the witnesses who assisted the Inquiry considered Mr. Burton to be a danger to others. All felt that he presented a degree of risk to himself in terms of self-harm and that he also presented himself to the specialist services in a way which suggested that he would seek help when he needed it, but only in a manner which was acceptable to him.

7. Consideration of the Matters Required to be Investigated by the Inquiry, under its Terms of Reference in the Light of the Evidence Received

7.1 1. (i) The quality of health, social care and risk assessments

On each occasion when Mr. Burton presented for diagnosis or treatment, the assessment of his health requirements was of good quality. He made no demand on social services and in terms of risk assessment the concern was about self-harm. On the evidence it could not reasonably have been predicted that Mr. Burton would act violently to others.

7.2 1. (ii)
(a) The appropriateness of treatment, care and supervision in respect of his assessed health care and social care needs.

The Inquiry is satisfied that in terms of health care requirements, Mr. Burton's treatment, care and supervision were of good quality on each occasion when he presented with mental health problems. The Inquiry is also satisfied that those examining and treating Mr. Burton in a health service context saw no need for social care.

7.3 1. (ii)
(b) The assessment of the risk of potential harm to himself or others.

The Inquiry has concluded that none of the reported episodes of self-injury represented a genuine and determined attempt at suicide and it is satisfied that each such episode (if it resulted in contact with health services) was dealt with appropriately.

As regards harm to others, the Inquiry records that there was no evidence to indicate that Mr. Burton was a risk to persons other than himself.

7.4 In coming to the conclusions set out under the three preceding heads, the Inquiry has taken account, as required, of previous psychiatric history, drug and alcohol abuse and previous convictions. It records that there was no evidence of drug or alcohol abuse (as distinct from occasional use) or of any previous convictions.

7.5 1. (iii) The extent to which Mr. Burton's care complied with statutory obligations and national and local policies.

The Inquiry is satisfied that the care provided for Mr. Burton was consistent with relevant requirements at the material times.

7.6 1. (iv) The extent to which prescribed care plans were effectively compiled, delivered and complied with.

The Inquiry has principally been concerned with diagnosis, treatment and care in the 1980s, prior to the emergence of the emphasis which is now placed on the Care Programme Approach and Community Services. Until 1995, Mr. Burton's care was of a quality consistent with requirements and expectations current at the time. His referral to Dr. Khoosal in May 1995 might, as already mentioned, have made him the subject of a wider concept of assessment and care but it must be questioned whether involvement of that kind would have been accepted.

7.7 2. To consider the appropriateness of the professional and in-service training of those involved in Mr. Burton's care.

As already stated, Mr. Burton made little demand on Social Services personnel prior to the date of his offence but the Inquiry heard nothing to suggest that the qualifications and in-service training of social workers were not of good quality. The medical assessments and treatment provided by health service staff, which were considered in detail, were competent and in some instances (in the cases for example of the work of Dr. Mackenzie and Dr. Lenihan) of excellent quality. The records compiled at Scalebor Park Hospital are also commended.

7.8 3. (i) To examine the adequacy of collaboration and communication between the agencies involved in the care of, or the provision of services for, Mr. Burton.

On the facts of the present case, little co-ordination of hospital based and other services was necessary. As was the practice at the material times (until the events of 1995), the assessment of overall patient need was undertaken by hospital staff and although social worker input was available if required, none was thought necessary in Mr. Burton's case. The Inquiry offers no criticism of that state of affairs.

Mr. Burton's GPs were kept advised of assessments, treatments and outcomes. They responded when necessary to his needs but the services of general practitioners were and are normally provided on the initiative of the patient. There is no evidence of any failure by the GPs concerned to provide appropriate advice and treatment to Mr. Burton when their help was requested.

7.9 3. (ii) To examine the adequacy of collaboration and communication between the statutory agencies and Mr. Burton's family.

Mr. Burton's parents have expressed disappointment about what they perceived to have been a lack of opportunity to discuss their son's problems with, or contribute information to, those in the health or social services who were undertaking his care. It must however be remembered that Mr. Burton was aged 19 (and therefore an adult) when he was admitted to Scalebor Park Hospital. There are references at various times to his reluctance to allow his parents to be involved and Mrs. Burton did discuss her son with carers on more than one occasion. Hospital ward staff gave evidence that a near relative's request to see the treating doctor would always be agreed and there is a note in the records compiled at the Day Hospital at Leicester General Hospital dated 7th June 1984 reading "Dr. King says that if Richard's mother phones or contacts us due to worries about Richard, then he is prepared to give her an apt (appointment) if she wishes".

The Inquiry is thus left with the belief that (subject to Mr. Burton's right to insist on confidentiality) hospital staff, if approached, would have been willing to meet the parents. The distress of Mr. and Mrs. Burton is well understood but the Inquiry does not consider that their complaint of failure of communication or co-operation is justified.

8. Findings

8.1 Mr. Burton received adequate treatment and care for his mental health problems on each occasion that he required the provision of hospital services between 1983 and 1995.

8.2 Mr. Burton's killing of Mrs. Symons could not reasonably have been predicted or prevented.

8.3 At all material times, Social Services were organised in such a manner that social care could have been provided if required. Such services were not, however, perceived to be relevant to Mr. Burton's needs, whether by the patient himself or by the treating hospital staff or by his parents.

8.4 Current arrangements in Leicestershire for co-ordinated health and social services generally accord with good practice and appear to be in the process of constructive development. Some recommendations in respect of relatively minor matters are, however, set out in Appendix A.

APPENDIX A

1. Although the absence of some medical and nursing records was not significant for the purposes of the Inquiry, it raised a question about present practices concerning the storage, security, retention, and disposal of such records. It is, therefore, recommended that the Health and Social Services Authorities should review their arrangements.

2. Users and Carers. Systems and procedures for involving patients and carers in the assessment, planning and delivery of services particularly around discharge and after care should be formalised and published for the guidance of all concerned.

3. The Health Authority, the Trusts and the Social Services Department should review the information they produce to promote inter-agency working and communication so that it is standardised as far as possible and is clear about team boundaries and contact points.

4. There also appears to be a need for a directory of support agencies to be available to GPs, clinicians, community team workers and others which will provide a source of referral for a range of mental health needs.

APPENDIX B

LEICESTERSHIRE HEALTH AUTHORITY

The Inquiry into the Care and Treatment of Richard John Burton 1983 - 1995

Remit for Inquiry

1. To examine all the circumstances surrounding the treatment and care of Mr Richard John Burton by the mental health services, including primary care, from 1983 until the murder of Mrs Janice Symons, in particular:

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

   b. the appropriateness 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 and the number and nature of any previous court convictions,

   c. the extent to which Mr Burton's care was provided in accordance with statutory obligations, relevant guidance from the Department of Health, including the Care Programme Approach HC(90)23, LASSL(90)11, 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. effectively drawn up

      ii. delivered and

      iii. complied with by Mr Burton

2. To consider the appropriateness of the professional and in-service training of those involved in the care of Mr Burton, or in the provision of services to him.

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

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

   b. the statutory agencies and Mr Burton's family

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

5. To consider such other matters as the public interest may require.

APPENDIX C

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 final 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 D

LETTER TO WITNESSES

Independent Inquiry into the Care and Treatment of Richard John Burton

Chairman of the Inquiry
Mr R H D Chapman

Committee Secretariat
Leicestershire Health HQ
Gwendolen Road
Leicester LE5 4QF
Tel: 0116 258 8610

PERSONAL AND IN STRICT CONFIDENCE

Name

Dear

I am writing to invite you to meet with the Independent Inquiry which has been set up to look into the care and treatment of Richard John Burton by the mental health services, including primary care, from 1983 until the murder of Mrs Janice Symons in May 1995. A copy of the Inquiry's Terms of Reference is enclosed and a copy of the Procedure adopted by the Inquiry for your information.

Although the Inquiry is not a legal inquiry, it is to be chaired by myself, Hugh Chapman. I am a Solicitor, former legal Advisor to Yorkshire Regional Health Authority, and a Mental Health Act Commissioner. The membership consists of Mr Brian Rogers, RMN, currently Professional Development Officer of the Community Psychiatric Nursing Association, Mr Malcolm Ashman, ex-Director of Social Services for Lincolnshire, and Dr O A Oyebode, MRC Psych., Consultant Psychiatrist, Queen Elizabeth Psychiatric Hospital, Birmingham. The Inquiry will sit in private.

From the initial examination of all the records relating to Richard John Burton, the Inquiry Panel considers that you may have relevant evidence to give to the Inquiry. The Inquiry Panel would therefore like to meet you on in Conference Room 1 at Leicestershire Health Headquarters, Gwendolen Road, Leicester. A map showing the location is enclosed. Arrangements have been made for you to meet with the Inquiry Panel at on that date. It is anticipated that the meeting will last 45 - 60 minutes. When you arrive at the Reception Desk please register with the Receptionist and you will be escorted to a room where you will be asked to wait until the time of your appointment.

You may, if you wish, be accompanied when you meet the Inquiry Panel. This may be by a friend, who may be a representative from your Union or Defence Organisation, a lawyer, or by some other representative with the exception of another Inquiry witness. However, it is to you that questions will be directed and from whom replies will be sought. Your oral evidence will be recorded and a copy will be sent to you afterwards, which you will be asked to sign and return.. It would be helpful if you could confirm that you will attending and whether or not you will be accompanied.

In order to shorten the time on oral evidence, and to help clarify issues before the Panel meeting, we would ask you to provide a written statement setting out and providing a commentary upon your involvement with Richard John Burton. You will, however, have full opportunity at the Panel meeting to raise any matter you wish, and which you feel might be relevant to the Inquiry. We would be grateful if your statement could define the reasons for your contact with Richard John Burton, and, in particular, describe your involvement in his treatment and care. I would be grateful if your written statement could reach me by

Copies of the medical records will be available at the Panel meeting should you wish to consult them to refresh your memory or a copy could be made available to you in advance by contacting the above office.

Reasonable travelling expenses incurred in attending the Inquiry will be paid at NHS rates by the Health Authority.

It is intended that the setting up of the Inquiry Panel by the Health Authority will not be made public until Richard John Burton is sentenced and this is not likely to happen until towards the end of July, 1996 when a press release will be issued.

We would like to thank you for your co-operation and assistance.

Yours sincerely

Hugh Chapman
Chairman of the Inquiry

APPENDIX E

LIST OF WITNESSES CALLED

Name	Position
Benson, Mr R	Student Nurse
Birtwisle, Mr T	Social Services Manager
Burton, Mr & Mrs D	Parents
Burton, Mr R J	
Edgeley, Mr S	Nurse
Gallagher, Miss K	Nurse
Hopcroft, Mrs S	Nurse
Joshi, Dr N H	General Practitioner
King, Dr A	Consultant Behavioural Psychotherapist
Lenihan, Dr B	Senior House Officer in Psychiatry
Mackenzie, Dr F	Senior House Officer in Psychiatry
McKay, Mr G	Hospital Trust Manager
Murray, Ms R	Approved Social Worker
Sherriff, Miss L	Nurse
Stanley, Mr A	Social Services Manager
Warrington, Dr J	Consultant Psychiatrist
Whyte, Dr C	Consultant Psychotherapist
Wilson, Dr I D	Consultant Forensic Psychiatrist

APPENDIX F

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