The Report of the Independent Inquiry into the Care and Treatment of Mr William Scott whilst a Patient in the Weller Wing, Bedford and Shires Health & Care NHS Trust

Chaired by: Clare Price

Dr Donald Dick

Ian Milne

Jane Mackay

Bedfordshire Health Authority

Charter House Alma Street Luton Bedfordshire LU1 2PL
Telephone: 01582 744800 Facsimile: 01582 451718

Bedfordshire Health Authority

CONTENTS

CHAPTER 1 - THE INQUIRY

1.0 We were invited by the Bedfordshire Health Authority to conduct an independent Inquiry into the treatment and care of William Monaghan Scott.

1.1 Our terms of reference were as follows:-

Firstly, to investigate all the circumstances relating to the treatment and care of Mr Scott by local mental health services and in particular:

1.1.1 The quality and scope of health and social care and risk management;

1.1.2 The quality and appropriateness of his hospital treatment and subsequent support, supervision and after care in the community in respect of:

(a) his assessed health and social care needs;
(b) his assessed risk of potential harm to himself or others;
(c) his previous psychiatric history;
(d) the number and nature of his previous convictions.

1.1.3 The extent to which Mr Scott's care and treatment reflected the relevant statutory obligations, relevant guidance from the Department of Health (including the Care Programme Approach and discharge guidance) and local operational policies.

1.1.4 The extent to which Mr Scott's prescribed care and treatment plans were appropriate and were:

(a) effectively communicated and delivered; and

(b) complied with.

1.1.5 The history of Mr Scott's medication and compliance with treatment regimes.

1.1.6 Any other factors relevant to the delivery of care and treatment of Mr Scott, including the skills and competencies of staff involved in his care, the appropriateness of the local policies and procedures and any other relevant matters;

1.1.7 To consider the adequacy and effectiveness of the collaboration and communication between the various agencies (Bedford and Shires Health and Care Trust, Bedfordshire GP services, Bedfordshire Social Services and the police) who were or should have been involved in Mr Scott's care and between the statutory agencies and Mr Scott's family;

1.2 Secondly, we were invited to prepare a Report to Bedfordshire Health Authority and Bedfordshire Social Services and to make recommendations which will have implications for the future provision of mental health services.

1.3 **The Inquiry procedure**

1.3.1 We began by obtaining William Scott's written consent to our seeing records that related to him. We obtained copies of those records which seemed relevant to our Inquiry, including medical and nursing records, social services records and police records.

1.3.2 We identified those witnesses who we believed to be able to offer relevant

information to our Inquiry and each such witness was invited to give evidence to the Inquiry.

1.3.3 No witness refused to attend the Inquiry.

1.3.4 In advance of each witness coming to give evidence, he or she received a letter from the Secretary to the Inquiry stating that we would not require the witness to affirm his or her evidence and that he or she could bring a friend, relative, legal adviser or trade union representative to the Inquiry. Further, each witness was given an outline of the issues about which we wished to hear evidence.

1.4.5 Before any witness gave evidence to us, the members of the Inquiry Panel were introduced. In addition, we explained that the interview was being recorded and that a note was also being made of it. Each witness was told that he or she would receive a copy of the transcript of his or her evidence and could make amendments, corrections or additions to it. The witness was asked to sign that transcript and to return it to the Secretary to the Inquiry. We explained that, whilst the transcript of evidence was confidential to the Inquiry, we might choose to reflect a part or parts of a witness' evidence in our Report.

1.4.6 We further explained that, if we concluded that a witness might be the subject of criticism, then a copy of that part of the Report containing such potential criticism would be sent to that witness in order that he or she might have an opportunity to respond to it.

1.4.7 All sittings of the Inquiry were held in private.

1.4.8 We received evidence from the witnesses who are listed at Appendix 1 to this Report. This included all of the witness statements obtained by the police in preparation for the prosecution of William Scott.

1.4.9 We read and considered the documents listed at Appendix 2.

1.4.10 We have made findings of fact on the basis of the written and oral evidence which we received, including the various records relating to William Scott which we have considered. Our conclusions and recommendations are based upon those findings of fact.

1.4.11 Throughout this Report, we refer to the Bedfordshire Health Authority as "the Health Authority" and to the Bedford and Shires Health and Care NHS Trust as "the Trust".

CHAPTER 2 - DENISE PALMACCI

2.0 Both Doris Hurrell (Denise Palmacci's mother) and Donald Palmacci (her son) came to talk to us about Denise Palmacci and her relationship with William Scott. We learned a large amount about this relationship from them and were very much impressed by the calm and dignified manner in which they gave their evidence.

2.1 Denise Palmacci was born on 27th December 1956. She was the only child of George Alexander Hurrell and Doris Winifred Hurrell. Her father died on 1st December 1968 when she was almost 12 years old.

2.2 Her only child, Donald, was born on 3rd June 1980. He is the son of a man who Denise Palmacci met whilst she was in the United States of America.

2.3 On 23rd April 1983, Denise Palmacci married Stephen Palmacci, and Donald was readily accepted as his son. In January of 1987, the relationship between Denise and Stephen Palmacci broke down and they were subsequently divorced. In 1993, Stephen Palmacci moved to live in the United States of America. Notwithstanding the breakdown of the relationship between his mother and stepfather, Donald maintained a very good relationship with Stephen Palmacci and has remained in regular contact with him.

2.4 Denise Palmacci started working in the "Next" clothes store in Bedford during the 1980's, initially doing a Saturday job. She was good at her job and gradually increased her hours and responsibilities until she was working full-time as the manageress of the menswear department of that store.

2.5 In 1988, Denise Palmacci met William Scott. Donald Palmacci told us that their relationship became a difficult one within a year or so. He described how

William Scott had been very aggressive and argumentative and jealous of everything which his mother did to make herself happy. Mrs. Hurrell told us that it was "a very unusual relationship" and said that her daughter was always trying to help William Scott. She described how her daughter had gone with him to meetings for alcoholics and had similarly supported him in his desire at one time to become a Born Again Christian because she thought that that would help him. She said that it was unbelievable how her daughter had put herself out for him and done so much to help him.

2.6 Although William Scott spent many nights at Denise Palmacci's house, he always maintained his own address. At her request, the relationship was not a sexual one. Mrs. Hurrell did not think that they had ever become engaged although Donald Palmacci had some vague recollection of their talking about an engagement a long time ago. Nothing ever came of this.

2.7 Donald Palmacci said that William Scott had drunk a lot on occasions but that he thought that his drinking had decreased in recent years. William Scott was very interested in bodybuilding and took anabolic steroids which he got through contacts at a gymnasium where he worked out. He said that his mother used to argue with William Scott about his misuse of steroids and that there was a noticeable change in his character when he was taking them. He was noticeably more aggressive and irritable. According to Mrs. Hurrell, he had terrible mood swings

2.8 Donald Palmacci had never seen William Scott hit his mother but she had told him that William Scott had grabbed her throat on one occasion. He believes that a neighbour had to intervene during an argument when William Scott was becoming violent towards her. He said that the relationship always seemed to flare up when he was not around and that there was still a dent in a wall in his home where William Scott had punched the wall.

2.9 Mrs. Hurrell and Donald described 4 separate instances when William Scott had been cruel towards a Yorkshire Terrier which Denise Palmacci owned. They knew of occasions when he had been violent, which apparently included two fights with a neighbour of Denise Palmacci and one with the driver of a car in Bedford. He spoiled Christmas holidays which they spent together and regularly indulged in attention-seeking behaviour.

2.10 In about May 1996, the relationship between Denise Palmacci and William Scott came to an end. Mrs. Hurrell told us that William Scott was not prepared to accept that the relationship was over.

2.11 We were told that Denise Palmacci had not ended the relationship earlier because she feared William Scott. He was said to be a frightening man.

2.12 Towards the end of June 1996, Denise Palmacci started a relationship with another man, Michael Barton. Donald Palmacci told us that his mother really liked him and that they had got on very well. He was very pleased about this friendship.

Comment

As will become apparent later in this Report, we can appreciate that there were reasons why the nature of the relationship between Denise Palmacci and William Scott may have been open to misinterpretation by those who treated William Scott when it ended. Notwithstanding this, we were impressed by the clear and detailed account of it which Mrs. Hurrell and Donald Palmacci gave.

From other accounts in the police statements we have read, it seems that there were many heated arguments between William Scott and Denise Palmacci. As Donald Palmacci told us, William Scott had grabbed

Denise Palmacci around the throat on one occasion and it appears that she was scared of him. It is particularly noticeable that there is evidence that she was extremely frightened as to what William Scott would do to her if he saw her with another man.

We have come to the view that there was much to be learned about William Scott and his relationship with Denise Palmacci other than by talking merely to him.

CHAPTER 3 - WILLIAM SCOTT'S LIFE IN SCOTLAND

3.0 William Scott's family

William Monaghan Scott was born on 22nd November 1956 in Bangree, Fife. He was the fourth of seven children and taken into the care of the local authority at times because of his mother's confinements. We understand that his mother left the family in about October 1960 at which time William Scott was again taken into the care of the local authority.

3.1 From a very early age, William Scott suffered from frequent attacks of asthma which necessitated admissions to hospital. In particular, in December 1960, he was admitted to Cameron Hospital, East Fife suffering from pneumonia and an asthmatic condition. He was discharged some nine months later in September 1961 and placed in a children's home in Glenrothes. It appears that two of his sisters were also at the home. From 6th September 1963, William Scott was fostered with a Mr and Mrs Baxter and lived in Denbeath, Methil together with two sisters. There is no mention of his having any contact with his father during his childhood. If there were any contact, we suspect that it was limited to the very early years of his childhood.

3.2 William Scott's behaviour whilst with his foster family

By the age of nine years, William Scott's progress at school and behaviour were such that he had been referred to an educational psychologist. He was demanding attention at school and was described as disturbing and annoying the other children both in and out of school. During 1966, his behaviour was considered to be disturbed and was causing considerable distress to his foster mother. His name was placed on the waiting list for admission to the Ovenstone Children's Psychiatric Unit, although his foster mother subsequently chose to continue his placement with her rather than taking up the offer of a place at the Unit when one became available. Thereafter, William Scott's behavioural problems appeared to improve for a while.

3.3 In February 1969, William Scott was seen at Cameron Hospital, Fife having been referred again by the local authority because of behavioural problems, stealing, unhappiness at school and concern about his foster mother. He was seen by Dr Evan Jones, senior registrar, who formed the impression that William Scott had trouble in his relationships with other people. There was an indication of personality difficulty with a suggestion of some loss of contact with reality but Dr Jones did not consider there to be any illness of a serious psychotic nature evident at the time. By 5th August 1969, William Scott was described as having "settled quite well at Braehead School" and was thought to be functioning as well as could be expected.

3.4 From the records we have seen, it appears that William Scott became quite anxious to trace his natural parents when he was aged about 13 years. A reunion was apparently arranged through Social Services at which only his siblings attended, although we have not seen the Social Services records which would confirm this. William Scott left his foster home when he was aged about 15 years and had very little contact with members of his family after that.

3.5 He does not seem to have had any relevant contact with the medical services between 1969 and 1976 when he was admitted to hospital on a large number of occasions.

3.6 **Admissions to hospital during 1976**

On 29th March 1976, William Scott was admitted to the Victoria Hospital, Kirkcaldy with an acute attack of asthma.

3.7 On 14th April 1976, he was re-admitted to that hospital having collapsed whilst out walking. He was diagnosed as suffering from asthma and acute hysteria.

3.8 On 6th May 1976, a further admission to the Victoria Hospital followed when William Scott had taken an overdose of 23 Dalmane tablets. Upon admission, he said that he had been in a fight over a girl and had won the fight but that the girl did not want to know him afterwards. He said that he had taken the tablets to get a good sleep after the fight. He was discharged on 7th May 1976, having been seen by Dr Thrower, clinical assistant, who said that the impression of him was "of a boy who through emotional deprivation suffers from a grossly inadequate personality with overlying hysterical features".

3.9 On 8th May 1976, William Scott went again to the Casualty Department of the Victoria Hospital having taken an overdose of 20 Diazepam tablets. On 10th May 1976, William Scott was seen by Dr Ross, a clinical assistant in psychiatry. Dr Ross described him as "inadequate, emotionally insecure, hysterical and of well below average intelligence" and said that there was an added depressive element at that time. William Scott was transferred to Stratheden Hospital, Cupar. We have no information for how long he was a patient at Stratheden Hospital.

3.10 On 31st May 1976, he was admitted to the Victoria Hospital for a night after an overdose of 14 Valium tablets. It appears that he was hoping to be re-admitted to Stratheden Hospital but that the psychiatrist considered that such an admission should not take place since there was no treatment which was likely to be of any help to him. He was therefore discharged on lst June 1976.

3.11 On 6th June 1976, he was taken to the Victoria Hospital by the police and admitted as an emergency. He had taken 4 Mogadon tablets. In addition, his breathing had worsened about an hour prior to admission and he was therefore treated as a case of acute bronchial asthma. He was discharged on 30th June 1976 once a place had been found for him to live.

3.12 On 6th July 1976, there was a further admission because of another attack of asthma although William Scott was said to be "hysterical and hyperventilating". He was described as being "intent on causing trouble and making a nuisance of himself". Although he suffered from asthma, it was thought that it could be difficult to distinguish true asthma from an hysterical reaction.

3.13 On 9th July 1976, William Scott was admitted to Stratheden Hospital He was described by Dr McWalter, assistant psychiatrist, as being "a man of vulnerable personality and limited intelligence who suffers from asthma and has led a very unsettled life". On this admission, William Scott claimed to be suffering from marked trembling in his hands. The tremor soon cleared up when he was treated with Ascorbic Acid 50 mgm t.i.d. and Mogadon 10 mgm. *nocte*. It was decided that he had been malingering and seeking admission to hospital to avoid living in the lodgings which had been found for him. He was discharged from Stratheden Hospital on 13th July 1976.

3.14 On 30th July 1976, William Scott was transferred from Milesmark Hospital, Dunfermline to Cameron Hospital after developing breathlessness in the Milesmark out-patient department. He was seen by a Dr Frazer who felt that he was hyperventilating and had "minimum of wheeze". However, he was admitted to the Milesmark Hospital overnight and then transferred to the Cameron Hospital. He was considered to be fit for discharge on 31st July 1976 although it transpired that he had nowhere to go. Finally, a decision was made that he should be discharged and then go to the Social Services Department where arrangements would be made for him.

3.15 It seems that a further admission to the Victoria Hospital may have subsequently followed an overdose by William Scott of beer and Aspirins. There is no record of this admission, simply a reference to it in a letter.

3.16 **Admissions to hospital during 1977**

On 5th July 1977, William Scott was admitted to the Victoria Hospital. He had collapsed after smoking some Moroccan dope cigarettes and drinking to excess. He was again seen by Dr Ross who described him as "inadequate, emotionally insecure, vulnerable to stress and of low average intelligence". He was also thought probably to be an alcoholic. He had been taking drugs including LSD during 1976. Arrangements were made for him to attend the Psychiatric Day Unit at the Victoria Hospital. Dr Ross expressed a hope that they would be able to help although he felt that the long term prognosis for William Scott was "pretty poor".

3.17 On 25th July 1977, William Scott was admitted to Cameron Hospital with asthmatic symptoms. He was discharged on 4th August 1977. He was however re-admitted at midnight on the same day because he had been to the police station in Leven at which time he was described as being "very depressed" and threatening to commit suicide. He was discharged from Cameron Hospital on 10th August 1977.

3.18 **Admissions to hospital during 1978**

On 15th February 1978, William Scott was seen at Cameron Hospital "with a supposed story of excessive intake of Amoxyl and Ventylin inhaler". He was reported as having been "in and out of hospital with frequent complaints of asthmatic wheeze in a very inadequate personality". He was discharged on 16th February 1978.

3.19 In mid-March 1978, William Scott started to attend at the Day Psychiatric Unit.

3.20 On 29th May 1978, William Scott was admitted to the Victoria Hospital, Kirkcaldy after taking 12 Tryptizol tablets and drinking 3 pints of beer. He had felt depressed recently because his girlfriend had left him and he could not accept it. His General Practitioner had prescribed the Tryptizol that morning and he had decided to commit suicide. It was not thought to be a serious attempt at suicide because he went out

to look for help after he had taken the tablets. He was transferred to Stratheden Hospital for further management of his psychiatric state. He told a Dr Barua, psychiatrist, that he had been "feeling quite depressed since his girlfriend left him about eight weeks ago". He had been back and forth to her home "to patch things up without any success". William Scott was discharged from Stratheden Hospital on 2nd August 1978.

3.21 On 8th August 1978, he was re-admitted to Stratheden Hospital following a further overdose of drugs. He was described as being "a man who fails to learn from experience" with "a tendency to act impulsively". A decision was taken to transfer him to one of the longer term wards at Stratheden Hospital at the beginning of October 1978. He in fact absconded on 6th October 1978 with one of the female patients from the hospital. At that time, it was thought doubtful whether he was capable of supporting himself for any length of time in the community.

3.22 On 9th October 1978, William Scott was admitted to the Milesmark Hospital after an episode of vomiting which contained a trace of blood. He was said to be drinking excessively at weekends "usually managing 7 to 8 pints of beer and 7 to 8 spirits per night" and this was almost always followed by severe vomiting. He was discharged from the Milesmark Hospital on 10th October 1978 and advised about reducing his alcohol intake.

3.23 On 27th October 1978, William Scott was admitted to Milesmark after an overdose of approximately 14 Distalgesic tablets and a considerable amount of alcohol. An attempt was made to persuade him to stay for further psychiatric assessment but he refused this advice and took his own discharge on 28th October 1978. He had made a full and uneventful recovery from the overdose.

3.24 On 5th November 1978, William Scott was admitted to the Royal Edinburgh Hospital in delirium tremens. On the night before the admission, he had

hallucinations of "elephants and things". He said he had been drinking all the time since his earlier discharge from Stratheden Hospital and drank 1 bottle of rum a day. He claimed to have started drinking at the age of 13 years. In the discharge summary prepared by a Dr Elizabeth Parry, senior house officer, the diagnosis was of alcoholism and of personality disorder with a poor prognosis. He was discharged on 30th November 1978. In this discharge summary, there is reference to William Scott having been previously married with a child; it is said that the marriage broke up because of his drinking. Although there is a later reference to an intended marriage, we have had no other evidence in the course of our Inquiry that William Scott was in fact married or had a child.

3.25 **Admissions to hospital during 1979**

On 22nd March 1979, William Scott was admitted to the Royal Edinburgh Hospital. He claimed to have drunk 1_ bottles of rum on the day prior to admission and one can of beer on the day of admission. He said that "he was feeling terrible" and that "he had been seeing things climbing up the walls and was really frightened". He also said that he was using LSD and "hash". On admission, he was dishevelled and tremulous. It was noted that his tremor increased markedly when he was being observed and disappeared completely when he thought that he was unobserved. He complained of seeing people under the bed and of seeing pink elephants although it was thought to be doubtful that he was genuinely hallucinating. His insight into his condition appeared limited and it was thought unlikely that he would abstain from alcohol in the future. He was discharged on 24th March 1979.

3.26 On 12th April 1979, William Scott was admitted to the Royal Infirmary of Edinburgh with "typical features of delirium tremens with gross visual hallucinations". He was described by a Dr. Brown, registrar, as having "a long history of alcohol, marijuana and LSD abuse". He was living in a YMCA and was in the habit of drinking 1_ bottles of rum a day. He was described as obviously finding "hospital care to his

liking". He persisted in the week of his admission "with gross tremor and amazing visual hallucinations. During ward rounds he sought attention by banging his head against the sides of his chair". When William Scott was told that he could no longer smoke in the ward, he took his own discharge on 19th April 1979. His long term prognosis was described as being "obviously poor".

3.27 On 26th April 1979, William Scott was seen in the out-patient department of the Royal Edinburgh Hospital as an emergency. He said that "he felt he was "going out of his mind", things seemed strange, he saw faces that were not there. Images went racing through his mind of his mother, his girlfriend and his father who died in November. He wondered whether he was going to do "daft things"". He said that he had been drinking at least a bottle of rum a day and always had to be drunk and that "his present problems started because his American girlfriend left Inverness and he began drinking very heavily again". He was thought to have a personality disorder associated with excessive abuse of alcohol.

3.28 On 9th July 1979, William Scott was admitted to the Royal Infirmary as a transfer from Roodlands Hospital. There was "a vague history of having fallen whilst playing football and possibly striking the right parietal region and injuring his left hand". In the discharge summary, it is said that: "The impression was gained that this might have been an hysterical episode". He was discharged on 12th July 1979.

3.29 On 6th September 1979, William Scott was admitted to hospital (which one is not immediately apparent from the records) suffering from delirium tremens. He had been drinking excessively for some weeks. He was described as having "had one or two girlfriends" and said that "falling out with the recent girlfriend led to this excessive bout of drinking". He was described as being a "young man with a rather dependent personality, especially so dependent upon drink". There was no evidence of psychotic behaviour. The diagnosis was given in the discharge summary by Dr W.E. Dickson,

senior house officer, as:-

> "(a) alcohol dependence
> "(b) Formulation, this young man seems to have a number of features suggestive of psychopathic personality disorder. He is unemployed and has very little family roots. He spends a large amount of his time drinking and because of his personality at times this drinking is extremely excessive, leading to acute alcoholic hallucinosis".

3.30 The prognosis was again described as being "extremely poor". Dr Dickson said that he seemed not "to be very motivated to stop drinking". He was discharged on 12th September 1979.

3.31 On 8th October 1979, William Scott saw Dr. Dickson at the out-patient department of the Royal Edinburgh Hospital. On this occasion, he denied any alcohol excess and Dr. Dickson found no evidence of it. He said that "he did not want to be with people at all and that he couldn't stand them and he was going to go crazy. He did not know when but maybe it was going to happen any time". Dr. Dickson's opinion was that "he was not suffering from any new psychiatric illness and that his behaviour was manipulative and as a result of his personality".

3.32 **Admissions to hospital during 1980**

On 23rd January 1980, William Scott was admitted to the Bangour General Hospital in the early hours as he had been found wandering and cold by the police. He was discharged later that morning.

3.33 On 28th May 1980, William Scott was reviewed in the out-patient department of the Royal Infirmary. He had been referred to that department from the Accident & Emergency department where he had been seen on 6th May 1980 having "presented with a tremor of the hands present over a few days" which "was particularly

bad on the night of admission". When questioned by a Dr. Campbell, senior house officer, about his presentation to Accident & Emergency on 6th May 1980, he "looked rather sheepish and admitted that he was really seeking attention at that time, as well as an excuse to stay off work for a few days". He told Dr. Campbell that he had not touched alcohol for about 5 months and that this was no longer a problem. He said that the need for alcohol had been replaced by "a fairly deep religious experience". He was described as being "prone to occasional episodes of attention-seeking, such as that which occurred on 6.5.80". Before being discharged from the clinic, William Scott apologised for having caused more trouble by going to the Accident & Emergency department.

3.34 On 3rd October 1980, William Scott was admitted to the Leith Hospital in Edinburgh. The police had found him in a collapsed state. Whilst in Casualty, he shook his arm and banged his head on the wall and it was initially thought that he might have delirium tremens. Despite receiving oral doses of Chlormethiazole and Diazepam, he did not quieten down and was admitted to the ward for drying out. Whilst on the ward, there were "several displays of attention seeking in which he accentuated tremor, pointed to things on the ceiling without tremor in his hands, and banged his head against the bars of the bed". It was noted that William Scott requested to leave on several occasions but could not in fact "rise from his bed". He discharged himself from the Leith Hospital on the 9th October 1980 having been "essentially admitted with acute alcohol intoxication".

3.35 **Admissions to hospital during 1981**

On 16th November 1981, William Scott was admitted as an emergency to the Royal Infirmary with a "presumptive diagnosis of drug induced hallucinatory state". He was admitted for overnight observation but consistently denied the abuse of "any legal, proprietary or therapeutic drugs" and was discharged home on 17th November 1981. It was recorded that the most likely diagnosis remained "an altered state of consciousness induced by drugs". It was thought that his presentation may well have been related to the fact that he was due in Court on 16th November 1981 because of "non

payment of a club membership fee". Dr. I. MacLeod, psychiatric registrar, gave the following information under the heading "Impression":-

> "(1) Psychopathic personality disorder.
> "(2) Past history of multiple drug abuse and alcoholism.
> "(3) It is possible that this presentation relates to an LSD flashback, but I think it is more likely related to his impending court appearance."

3.36 Dr. MacLeod said that he feared that there was little to benefit from William Scott having further contact with psychiatrists and he was discharged on 17th November 1981.

3.37 **Admissions to hospital during 1982**

On 6th August 1982, William Scott was admitted to Raigmore Hospital, Inverness. He had been working in a dusty atmosphere and did not have his Salbutamol inhaler with him. On 7th August 1982, he complained of an episode of central chest pain. He was "hyperventilating with little objective evidence of bronchospasm and his pulse was 80 per minute". He later admitted that he had exaggerated the symptoms to attract attention. He was discharged on 8th August 1982.

3.38 **Admissions to hospital during 1983**

On 2nd August 1983, William Scott was admitted to the Western General Hospital in Edinburgh with a history of "two weeks heavy cold increasing shortness of breath over the last few days with sudden deterioration". He was described as having "a past history of alcoholism". He was discharged on 5th August 1983 with a diagnosis of acute asthma. The discharge letter which was written by Dr. Wilkinson said that William Scott was due to be married in October.

Comment

The information summarised above is drawn from William Scott's GP records. We did not consider that it was necessary for us to hear oral evidence about his childhood and early adulthood in Scotland beyond that which he chose to tell us. From the records, we formed the view that William Scott had in many respects a difficult childhood. It appears that he had little, if any, meaningful contact with his mother from the age of four onwards. There is no mention of his father's involvement with the family throughout his childhood. Save for having been fostered with two sisters and for the reunion arranged through Social Services when he was 13 years old, he seems to have had no contact with any other member of his family. He possibly lost contact with the two sisters with whom he lived after he left his foster home. He does, however, seem to have had some form of stability in his life in that he lived with the same foster parents for approximately nine years and his foster mother opted to keep him with her rather than to place him in the Ovenstone Children's Psychiatric Unit when he was offered a place there.

Despite having had some stability, he began to abuse alcohol possibly when he was as young as 13 years old and became dependent upon it. He also misused other illegal drugs.

He took a large number of overdoses. He indulged in attention-seeking and manipulative behaviour.

He often had nowhere to live and no job.

From early adulthood, William Scott was diagnosed as suffering from a personality disorder. The prognosis for him was described as being poor. That diagnosis of a personality disorder has persisted throughout his

adult years.

CHAPTER 4 - WILLIAM SCOTT'S MOVE TO BEDFORD

4.0 Between August 1983 and May 1984, William Scott moved to live in Bedford.

4.1 Admissions to hospital during 1984

His first contact with the medical services in Bedford was on 27th May 1984 when he was admitted to the Bedford General Hospital (Weller Wing) at 1.50am after the police had picked him up whilst he was drunk He said that he was upset because his girlfriend had left him. He discharged himself at 8.00pm having been prescribed Largactil. Upon admission, he was said to be verbally and physically aggressive and he apparently needed three police officers to hold him down.

4.2 Admissions to hospital during 1985

On 20th January 1985, William Scott was informally admitted to Weller Wing for drying out from alcohol. He was accompanied by a friend from the Christian Church Society who had known him for the past year. He said that his girlfriend had left him seven days earlier which had upset him and, as a result, he went on a drinking spree. He was described as having "no money, no will to live, sees no future and is feeling low and depressed and suicidal". On 29th January 1985, he was discharged without medication. No follow up arrangements were made.

4.3 On 7th February 1985, William Scott was re-admitted after an overdose of distalgesic, Actifed and alcohol. Upon arrival, he was unconscious and responded to pain by flexion only. A psychiatric appraisal was carried out by a Dr. Garg, locum registrar, on 8th February 1985 who found William Scott to be "thoroughly unco-operative and verbally aggressive". Dr. Garg considered his mental state and decided

that, despite the fact that he was aggressive, he was neither suicidal nor depressed. Dr. Garg was "convinced that he is exhibiting psychopathic flavour in his make up" and said that "it is my view that he could be discharged if physically fit". William Scott was discharged on 9th February 1985.

4.4 At that time, William Scott had had what was described as a "residential social job" although he apparently lost it. At the time of this admission, he had no money but did have somewhere to live.

4.5 On 3rd July 1985, William Scott was seen by a Dr. R.W. Barker with a suspected foreign body in his right eye.

4.6 **Admissions to hospital during 1986**

On 3rd February 1986, William Scott was admitted to Weller Wing. This was a referral by his General Practitioner and he was in delirium tremens. The consultant psychiatrist in charge of his care was Dr Treves Brown. A history was taken which included the following information:-

4.6.1 He had been drinking whisky and lager. On some days, he drank a lot and he would go without drinking for a few days.

4.6.2 He worked for NACRO, cutting down trees etc.

4.6.3 He had a past medical history of a suicide attempt twelve months previously when he was admitted to Weller Wing. After his discharge, he had managed up until recently.

4.6.4 He was single. Both of his parents were said to be alive. He said that his father was 55 and living in Dundee. His mother was separated

and also living in Dundee. He described her as an alcoholic. He claimed to have seven brothers and sisters. All of them were said to be living in Scotland but he had no real contact with them saying that "they don't want to know me" although he referred to having made contact with his parents three years earlier. He had been with foster parents between the age of 6 and 14 and had been thrown out by them because of his drinking. He said that he had been in and out of prison ever since begging, hustling and sleeping rough.

4.6.5 He was described as being unable to give a coherent account of himself. He had tremors in both hands. He had no delusions but claimed to have auditory hallucinations saying that he kept hearing music and voices.

4.7 Upon examination, he appeared physically unsteady, drowsy and incoherent.

4.8 On 17th February 1986, William Scott was described as "keeping dry on the ward" but it was thought that he would go out drinking if discharged. At a ward round on 24th February 1986, he was said still not to be settled. Consideration was given to his admission to Stratheden Hospital or to the St. Bernard's Wing of Ealing Hospital. He apparently expressed a preference that he should go to Stratheden Hospital. He was discharged from Weller Wing on 27th February 1986. He was prescribed Chlorpromazine 50mg twice daily.

4.9 William Scott was referred to the St. Bernard's Wing of Ealing Hospital although it seems that there was doubt as to his likely prognosis. On 23rd May 1986, he was admitted for a five week group therapy programme after he had been through

detoxification. He was discharged from St. Bernard's on 27th June 1986.

4.10 In the discharge summary from St. Bernard's which is dated 10th July 1986, Dr. M. Dickinson, registrar, described William Scott as having "an extremely disturbed background". He had abused all sorts of drugs in the past, including LSD, and had become addicted to alcohol. The discharge summary contained the following information:-

> "He coped reasonably well with the 5 week course, although he found the first and last weeks rather difficult, becoming particularly paranoid during the first few days of the last week. This may have been precipitated by him attempting to split up with his girl-friend over the previous week-end and also the feeling of loss accompanying the conclusion of the programme. In spite of the paranoid ideas, it should be pointed out, that he was an active and quite useful group member".

4.11 William Scott was prescribed one tablet daily of Abstem together with Stelazine 2mgs t.d.s and Procyclidine 5mgs in the morning. Dr. Dickinson said that he "would guess he will need psychiatric care in the foreseeable future and might benefit from referral to the local psychiatric services".

4.12 William Scott told us that he believes that St Bernard's cured him of his addiction to alcohol. He learned that he could hold down a job and that he could have a sense of pride in himself and self respect. He kept himself cleaner and "had a far better outlook on life". He realised that, if he did not stop drinking, the alcohol could kill him.

> *Comment*
>
> *We do not know what became of the suggestion that William Scott might be admitted to Stratheden Hospital but we believe that he gained a lot from his admission to St. Bernard's.*

We are not aware of any referral being made for him at this time to any local psychiatric services.

4.12 **Admissions to hospital during 1987**

On 10th March 1987, William Scott's then General Practitioner (a Dr. Hamilton) wrote asking for William Scott to be admitted to Weller Wing "to forget the fact that his girl friend has left him". He was talking about suicide and felt that he could not cope. On the same day, he was referred to the Albany Road Psychiatric Day Hospital for an urgent first contact/attendance (i.e. within 48 hours). The reason for referral was given as follows:-

> "Over the past 3-4 weeks has had relationship problems. Breaking up with girlfriend ... (daughter of woman he stays with). He has apparently been too demanding and too possessive, also conflicts about sexual aspects. Girlfriend wants to break it off. This has caused Willy to feel confused, very tense and feels he's "going to go berserk". Also feels he will be driven back to drinking. His behaviour has been quite unpredictable and destructive at times. ... Felt admission was inappropriate, but he could well benefit from Day Hospital attendance with the opportunity to discuss his situation and come to a more realistic and responsible perspective on things."

4.13 In fact, before any admission was arranged, it seems that William Scott was admitted to Bedford General Hospital via the Accident & Emergency department at 9.30pm on 12th March 1987. He claimed to have taken some Dothiapin tablets. The relationship which had ended was described as being "apparently rather pathological i.e. intense +++". William Scott was described as being subjectively suicidal and was thus thought to be a possible suicidal risk. He said that he felt "like exploding, lashing out and throwing things, but he has so far managed to control himself". He left hospital on 14th March 1987 against medical advice.

4.14 The diagnosis on discharge was given as "personality disorder" and "alcohol dependence". No drugs were prescribed for him.

Comment

Surprisingly there is no evidence in any of the records which we have seen about subsequent follow-up at the Albany Road Day Hospital but we believe that William Scott probably did attend the hospital since he said that he had been there when he was admitted to Weller Wing in 1996.

4.15 **Further admissions to hospital between 1988 and 1996**

On 11th May 1988, William Scott was admitted to the Bedford General Hospital. He had fallen on his left ankle; no fracture was seen.

4.16 On 3rd March 1989, William Scott was admitted there for an emergency appendicectomy. It was noted in his medical records that he was using anabolic steroids for bodybuilding.

4.17 On either 21st or 22nd April 1989 at 3.15am, William Scott was admitted via the Accident & Emergency Department to the Bedford General Hospital complaining of a head injury and back injury. He had slipped and fallen downstairs whilst going to get a cup of tea and claimed to have lost consciousness although it was unclear for how long. No fracture had been sustained. He was discharged on 23rd April 1989. By this time, it is apparent from the medical records that William Scott was describing Denise Palmacci as his fiancee.

4.18 By early January 1990, William Scott had been suffering from sciatica which had led to his being away from work for a number of months. He was offered a discectomy but was reluctant to have an operation.

4.19 On 6th January 1992, William Scott was admitted to the Bedford General Hospital via the Accident & Emergency Department with abdominal pain. This was thought to have been caused by constipation with abdominal colic. He was discharged on 9th January 1992.

4.20. In March 1994, William Scott was referred to a Mr. C.B.G. Adams, Consultant Neurosurgeon at the Radcliffe Infirmary, Oxford, for further investigation of his back pain. An MRI scan showed a bulging L5/S1 disc but no nerve root compression. William Scott said that he did not wish to have any form of surgery and he was discharged.

4.20 On 12th August 1994, William Scott joined the list of Dr. Basra (General Practitioner). He informed Dr. Basra that he was drinking eight units of alcohol a week. He did not mention he had taken a number of overdoses in the past nor did he mention he was taking anabolic steroids. When he joined Dr. Basra's list, he was not perceived as being a patient with a psychiatric history.

4.21 In October 1994, William Scott was referred to the Pain Relief Clinic at the Bedford General Hospital. He was seen by Dr. D.A. Dutton on 13th March 1995 who advised him to do some general exercises by way of swimming and cycling. In addition, Dr. Dutton discussed facet joint blocks with William Scott although he was not keen on injection therapy if that could be avoided.

4.22 On 17th March 1995, Dr. Dutton wrote to Dr. Basra about his treatment of William Scott and referred to his living with his partner in what is described as having been "a fairly stable relationship". We understand that this is a reference to Denise Palmacci since William Scott's partner is described as being an assistant manageress in one of the local stores in Bedford.

4.23 On 10th May 1995, William Scott attended at the Accident & Emergency department of the Milton Keynes General Hospital complaining of an injury to his back. He was diagnosed as suffering from back pain but left the department without treatment.

4.24. William Scott failed to attend a follow-up appointment at the Pain Relief Clinic at Bedford General Hospital on 11th September 1995.

4.25 From about October 1994 until about 31st March 1996, he appears to have been in receipt of medical certificates, presumably related to his back pain.

4.26 On 5th February 1996, he was admitted to the Milton Keynes General Hospital when he suffered a "sudden onset of severe gripping right-sided upper abdominal pain whilst at work" which was "associated with vomiting and followed by a black-out". He discharged himself from the hospital on 14th February 1996 before all investigations had been carried out. Dr. T. Samuel, medical registrar, said in a letter to Dr. Basra dated 26th March 1996 that one possible explanation for William Scott's abdominal pain was "steroid induced, hepatic or myocardial necrosis" and that he had been strongly advised to stop taking anabolic steroids. Dr. Basra told us he would have discussed the misuse of anabolic steroids with William Scott if he had raised the issue first but he did no more than to ask him whether he was taking or had taken steroids. Dr. Basra told us that he chose not to confront William Scott about his misuse of steroids because he had an "odd personality". At no time, did William Scott seek help from him for the misuse of anabolic steroids.

4.27 **William Scott's consultation with Dr Basra - 11th May 1996**

On 11th May 1996, William Scott went to see Dr. Basra saying he was "unhappy" and told him that this was because he had split up with his girlfriend. We

understand that this is a reference to the relationship with Denise Palmacci coming to an end.

4.28 This was a short consultation with Dr. Basra (it lasted no more than 5-7 minutes). Dr. Basra formed the impression that William Scott was "getting on all right" despite the breakdown of his relationship. He said that he was "very pleasant to talk to at the time" but that he told Dr. Basra no more than that the relationship had come to an end. Dr. Basra told William Scott he could talk to him if he chose but he wanted to see somebody else so Dr. Basra suggested that he should contact Relate. Dr. Basra said that William Scott could come back to him if he did not get any help. He did not know whether or not William Scott did contact Relate.

4.29 William Scott told us that he went to see a counsellor called Barbara at the "Beds Counselling Service" when his relationship with Denise Palmacci ended. He said that it helped him a lot to have somebody to talk to but the counselling sessions cost him £20.00 an hour which he could not really afford so he stopped going to them. He talked to the counsellor about his early life which he found "painful" to do at times and told her that he was finding it hard to cope without Denise Palmacci. William Scott also told us he and Denise Palmacci talked about going to Relate but that they just never seemed to get around to going. From what he told us, it seemed that, for him at least, a large part of the problem in their relationship was the lack of sexual intercourse.

4.30 Dr. Basra noted in his records of the consultation on 11th May 1996: "Advised to review in a few days". It was Dr. Basra's intention that William Scott should continue to attend counselling with Relate if he were happy with that. If he wanted further help from Dr. Basra, then he could contact him. Dr. Basra told us William Scott did not return to him seeking further treatment until 12th June 1996. The consultation which took place on that date was concerned with dizziness which William Scott had suffered at work. It had nothing to do with his problems in his relationship

with Denise Palmacci.

4.31 There were no convictions for offences of violence recorded against William Monaghan Scott at any time.

Comment

From the evidence, we consider that William Scott has suffered from a borderline personality disorder throughout his adult years. This has been recognised by many of those members of the medical profession who have had contact with him.

From 1976 to 1987, William Scott took numerous overdoses, none of which was particularly serious and, indeed, he told us and others that he had done things to gain attention at times. However, there was no attempt at suicide during his relationship with Denise Palmacci.

It is also clear that, whilst William Scott has a history of alcohol abuse which had led to his being admitted to hospital on a considerable number of occasions, he has had no alcohol-related admission following his discharge from the St. Bernard's Wing of the Ealing Hospital in May 1986. From the accounts given to us by Donald Palmacci, Mrs. Doris Hurrell and William Scott himself, we know he continued to drink from 1986 onwards but this does not seem to have been to such an extent that it necessitated medical intervention.

Similarly, whilst William Scott has a long history of the misuse of illegal drugs, it is noticeable that this was not a reason for his being admitted to hospital at any time during his relationship with Denise Palmacci.

As will become more apparent from this Report, the use of anabolic steroids featured in William Scott's life from probably about 1988/1989 with a significant increase in the quantity which he took in the two years leading up to mid-1996. It may be that this misuse of anabolic steroids replaced the abuse of other substances. Whether this is right or not, it is particularly noticeable that William Scott had no contact with mental health services throughout the whole period of his relationship with Denise Palmacci. We believe that Denise Palmacci tried very hard for a long time to be a supportive friend and stabilising influence for William Scott as Donald Palmacci and Mrs. Hurrell described to us, and that she achieved that aim.

CHAPTER 5 - THE FIRST ADMISSION TO WELLER WING IN 1996

5.0 22nd June 1996 - 25th June 1996

5.1 At 3.15am on 22nd June 1996, William Scott was admitted to Keats Ward of Weller Wing with a history of having raped his girlfriend of 8 years (i.e. Denise Palmacci) that evening. We wish to emphasise that William Scott has at no time been prosecuted for this alleged incident. Our record about it in this Report is taken from the evidence which we have heard and read during our Inquiry. In his medical records, it was noted they had split up 6 weeks earlier, that William Scott had gone to her house that night, threatened her with a knife and raped her. During the incident, Denise Palmacci is said to have cut her finger accidentally. When we spoke to William Scott, he told us that Denise Palmacci had in fact taken the knife away from him and hidden it, and that they then made love. It is recorded in his medical records that William Scott had asked her to call the police but she had refused and had telephoned his General Practitioner instead. He was described as now being very remorseful and not wanting to live and was said to have taken an overdose of Paracetamol. His General Practitioner was reported as having said that he would drive off a bridge.

5.2 We had hoped to interview the General Practitioner who saw William Scott as part of our Inquiry. Unfortunately, Dr. Basra knew nothing of the events of 21st/22nd June 1996 when he came to speak to us and was unable to tell us the name of the doctor who would have been covering his practice that night. Despite our asking him to make enquiries, he has not returned to us with the name of the doctor who arranged for William Scott to be admitted to Keats Ward. There is no record of the doctor's name in any of the medical notes which we have seen.

5.3 Upon admission, William Scott was described as being in low mood and suicidal. He said: "I can't believe what I've done" and "I do not know why I did what I

did. Not in my right frame of mind". He was described as being very depressed so that the plan was to admit him and to maintain discrete observations.

5.4 **William Scott's admission interview with Mr Toyloco**

Mr. Toyloco admitted William Scott to Keats Ward. On the assessment form which Mr. Toyloco completed, he recorded the next of kin and main carer as being a John Denyer (a friend of William Scott). Mr. Toyloco noted that William Scott had been treated twelve years previously for alcoholism. The relevant life change identified was "break up with girlfriend". The stated reason for the patient's admission was described as "totally depressed and unable to cope". His feelings and expectation relating to his present illness were "to get better".

5.5 Under the heading "Prevention of hazard to human life", William Scott was described as verbally abusive and physically aggressive towards his girlfriend. Mr. Toyloco told us William Scott said that he was angry and abusive when he went to Denise Palmacci's house that night and the reference to physical aggression towards her was a reference to his having used a knife to threaten her. He did not mention any incident of violence other than that. There was no indication of destructive behaviour noted towards himself, others or property. The patient was described as not being homicidal. As far as suicide was concerned, it was said that he "wanted to die because of split with girlfriend".

5.6 Mr. Toyloco told us William Scott was tearful and very remorseful during the admission interview. He was angry at what he had done to Denise Palmacci but that anger was directed towards himself. He was given PRN Temazepam 20mg at 4.00am and then went to bed and slept well.

5.7 On two occasions on 22nd June 1996, William Scott demanded to leave

Keats Ward. On the first occasion, he said that he had to go to work. He had a job making car exhaust systems. He was told that he needed to be seen by Dr Rao (a Consultant Psychiatrist) and his team and that it would be to his good to stay on the ward until then. William Scott then agreed to stay until the following Monday (i.e. 25th June 1996).

5.8 On the second occasion (at 5.45pm), he again said he had to go to his job. He was described as "aggressive and shouting" but unwillingly agreed to remain on Keats Ward. A note was made that, if he wanted to go again, his situation would have to be discussed with the consultant on call and detention under section 5(2) of the Mental Health Act 1983 would have to be considered.

5.9 On 25th June 1996, Dr. Thomas noted in the records that William Scott had been "told this morning that he lost his job". He is recorded as saying "I'm worse than ever", "I have no respect" and "I'm going crazy". He was said to be "not planning to go back to GF [girlfriend]".

5.10 At 8.30pm on 25th June 1996, William Scott was complaining of severe pain in the abdomen and nausea. He was noted to have "dropped himself on the floor in the corridor, curled up his body and would refuse to move saying it increases the pain". He was put into a wheelchair and taken to bed. He would not allow an abdominal examination.

5.11 There was a review by the surgical senior house officer at 9.30pm who noted that there had been a "sudden onset of severe epigastric pain one half hour after Thioridamine 25mg. Was smoking at the time. Pain resolved spontaneously. Denies any previous indigestion. No alcohol intake (??)". There was no localised pain upon examination and the plan for treatment was described as being "If recurs will review again".

5.12 **Contact with Social Services**

On 27th June 1996, Keats Ward contacted Social Services saying William Scott was requesting a social worker's support. The reason for contact was given on the Social Service's file as being:-

> "1st admission for depression.
> "No discharge date arranged yet.
> "The above requesting social work support.
> "More information available but can not be given over the telephone."

5.13 This is the first contact which the Social Services department had in relation to William Scott.

5.14 On 28th June 1996, there is a note on the Social Service's file which recorded further information obtained from Keats Ward. This reads as follows:-

> "Mr. Scott is requesting social worker involvement. The referrer feels that a male social worker would be more appropriate as Mr. Scott raped his girlfriend. Mr. Scott very depressed since the incident, ashamed and wants to be punished.
> "Girlfriend not pressing charges - says that six weeks ago Mr. Scott stopped taking anabolic steroids and became violent, not his normal self. Rape occurred when girlfriend ended relationship."

5.15 **William Scott's behaviour and demeanour on Keats Ward**

Comment

We asked the nursing staff who gave evidence to us to describe William Scott's behaviour and demeanour on Keats Ward during his first admission in 1996. We found some members of the nursing staff had great difficulty at times recalling specific incidents and details when questioned

by us. This may result from the fact that the events with which we are concerned took place a little over a year before our interviews and that memories have faded in the meantime. It may also be that there was some concern, and possibly reluctance, at having to talk to us about the care and treatment of Mr. Scott. Notwithstanding this, we believe the following account represents an accurate view of Mr. Scott's behaviour and demeanour as it was perceived by the nursing staff. We are, however, conscious that, when we sought specific details of matters which we considered to be important, they could not always be given.

5.16 During the admission which started on 22nd June 1996, Mr Bowers was William Scott's primary nurse and Mrs Tommy was his associate nurse.

5.17 Although a number of models were being piloted in mid-1996, Mr. Bowers described the role of the primary nurse as including "offering structured time [to a patient] but the time would be his to verbalise his feelings and anxieties at that time". He told us that William Scott had been admitted to Keats Ward "feeling depressed, anxious and reporting that he had raped his girlfriend, and this was causing him to have considerable feelings of guilt and anxiety". He could recall him being "argumentative and abusive on occasions" although he was unable to recall any specific reasons for that behaviour.

5.18 Mrs. Tommy told us that, when William Scott first came to the ward, he did not want to talk to anybody and he was angry although he did not say why. Mrs. Tommy told us she believes that both the nursing and medical staff involved with the care and treatment of William Scott knew that he was angry and, on 28th June 1996, she agreed with him that she or his named nurse would spend _ hour per day with him. She said he made many telephone calls from the ward to Denise Palmacci when he was heard shouting down the telephone and he was angry when he made the calls.

5.19 No member of the nursing staff to whom we spoke was able to give us any indication as to what was said during these telephone calls. Nobody appears to have discussed them in any detail with William Scott.

Comment

We find it surprising that the qualified nursing staff did not act in a more proactive way to manage William Scott's anger. We consider that anger management should have been one feature of his nursing care plan.

5.20 Mrs. Robson told us she had little contact with William Scott but she had felt that "he was a bit hostile" when he attended her occupational therapy class on the morning of 27th June 1996. She told us she attended the multi-disciplinary team meeting on 1st July 1996 and that William Scott then "seemed quite approachable in as much as he was not over-anxious, agitated, his body posture was quite good, his eye contact seemed OK".

5.21 Mr. Toyloco said he would describe William Scott as "somebody who was feeling quite rejected" and he explained that he meant by this comment that he felt rejected by Denise Palmacci. Although he was very tearful when admitted, he became happier and quite relaxed during the period of his first admission.

5.22 Wendy Miller told us William Scott "was in tears and very distressed and could not understand why he should have done such a thing" [i.e. raped Denise Palmacci].

5.23 Ms. Miller also said that she showed somebody who she understood from William Scott to be Denise Palmacci to his room on Keats Ward on one occasion and she later saw them kissing and the woman lying on top of William Scott on his bed. Ms.

Miller was unable to recall precisely when this happened but said she had not told any senior member of nursing staff about it since "many patients have their spouses in to visit them and I would not go and say "Oh so-and-so is kissing so-and-so".

Comment

We think that visits to the ward by Denise Palmacci were highly significant. It was the ending by her of her and William Scott's relationship which had precipitated this psychiatric incident and a visit by her was relevant to understanding William Scott's psychiatric condition. All of the nursing staff were or should have been aware of the facts leading to his admission and therefore of the significance of Denise Palmacci's visit to the ward. This was an opportunity to invite her to talk (with William Scott's permission) about their relationship We consider that there should be some guidance given to nursing staff about reporting and documenting visits to a patient by a person who is of direct relevance in a psychiatric incident.

5.24 **Dr. Wagle's Review on 28th June 1996**

On 28th June 1996, Dr. Wagle reviewed Mr. Scott's case. She told us "he was a bit anxious". He talked continuously and anxiously about the rape. He was "otherwise OK". He told Dr. Wagle he felt confused about the whole episode because he had loved Denise Palmacci but at the same time he had raped her. He felt guilty about it and said that he should not have done it but now it had happened he did not know what to do next.

5.25 When Dr Wagle and William Scott talked about the rape, William Scott said that it might help if he could talk to somebody about it and so they considered whether he should receive some sort of counselling. William Scott told Dr. Wagle he had been to the Albany Road Day Hospital many years before and he would like to go

back there. Dr. Wagle therefore arranged a referral to the Albany Road Day Hospital and gave it to the ward staff to post. A copy of the referral is not contained in the medical records.

5.26 William Scott told Dr. Wagle that he felt "safe on the ward". When she asked what he meant by that, he said there were people around him but did not elaborate further.

5.27 William Scott told Dr. Wagle he had been in touch with Denise Palmacci. Dr. Wagle said to us that she understood that Denise Palmacci had visited him on the ward but that they were just friends now. She said she was unaware of any telephone calls that he might have made to Denise Palmacci from the ward and she had no recollection of nursing staff telling her about any such telephone calls.

Comment

This seems to us to be an instance of the need for there to be clear communication between nursing and medical staff. Dr. Wagle seems to have formed the view that there was little to fear in the relationship between William Scott and Denise Palmacci since he told her they were just friends. Had she been aware of the angry telephone calls which he was making to her, we believe she may have formed a different impression.

5.28 **1st July 1996 - The multi-disciplinary team meeting**

A multi-disciplinary team meeting took place on the morning of 1st July 1996. Dr. Balasubramaniam was amongst those present, as was Mr. Frampton. Mr. Frampton told us that he left the meeting with the impression that this case was not a high priority and that William Scott was really only looking for assistance with welfare benefits as far as Social Services were concerned. He told us there "was no hint of

concern over this particular case at the time. There was no discussion about the issues of rape and the possible implications".

5.29 **1st July 1996 - The ward round**

Dr. Balasubramaniam did a ward round on the afternoon of 1st July 1996. He told us that, at that ward round, he knew that William Scott "had apparently claimed that he had raped his girlfriend at knife point. He was very remorseful, guilty and suicidal although Dr. Balasubramaniam commented that he was not happy with the history initially taken from William Scott. He told us this was "a very abnormal presentation for somebody to come like this after doing an act like that, suddenly becoming suicidal and in depression". He also told us that "my fear was that he would go and do it again" and explained that this was a fear that William Scott would threaten Denise Palmacci again, not be violent towards her. Dr. Balasubramaniam said he did not think that he could do anything to deal with that risk. He could only set up some sort of mechanism to help William Scott over the longer term. He envisaged that long-term help as meaning "going to the Day Hospital where he would be assessed. He would have a psychologist and they would offer an appropriate level of care to go with that".

5.30 Dr. Wagle accompanied Dr. Balasubramaniam on the ward round and she recalled that William Scott talked about feeling guilty about the rape. She said that Dr. Balasubramaniam told that it was probably going to be on his mind for a very long time and that the best way to deal with it would be to go for counselling, to discuss it with his counsellor and to learn different coping skills to deal with it. She told William Scott that staying on the ward may not be of much benefit to him since "this admission was more of a crisis". She said he seemed to be doing fairly well and he had settled enough so that he was not going to benefit from continuing to be an in-patient.

5.31 Lorna Day was also present at the ward round. She is a social worker and her role was to liaise with the ward. She told us that Social Services' input in respect of

William Scott seemed to be limited to the provision of financial advice.

5.32 **The plan for care in the community**

William Scott's plan for care in the community showed Vanda Harrow as having been his primary nurse during this admission (nobody has been able to explain to us why this should be so when Mr. Bowers was his primary nurse nor to tell us who in fact wrote out the plan). His key worker was Dr. Balasubramaniam.

5.33 Dr. Balasubramaniam told us that discussion about discharge for William Scott was to the effect that he would have "the minimum care programme based on the diagnosis and also that he would be referred to the day ward. He was allocated a social worker by the social worker colleague who was at the meeting and out-patients referral". Dr. Balasubramaniam believed that William Scott had been allocated a Mr. Bulwant Mann as his social worker. In fact, although Mr. Mann had been identified at the appropriate social worker, he was not allocated to William Scott's case at that time and had had no contact with him.

5.44 Dr. Balasubramaniam told us he did not feel that William Scott's misuse of anabolic steroids needed further investigation.

5.35 The care plan read as follows:-

"2/7/96 Discharge today.

Refer to Albany Road for Counselling.

O.P.D. 3/52 to review need for meds.

"Recognition of relapse

Feeling low in mood.

? Heavy drinking

Inability to cope.

"Planned date for discharge *

"Review date *

"Social work needs assessment completed yes/no *

"Social work needs assessment attached yes/no *"

Those parts of the plan marked with an * were not completed.

5.36 William Scott's discharge summary stated that the reason for admission was "suicidal ideation" and the diagnosis at discharge was:-

"No major mental illness.

"Adjustment disorder".

5.37 He was discharged on 2nd July 1996. No medication was prescribed for him.

5.38 It is apparent from William Scott's General Practitioner records that his appointment for an initial assessment at the Albany Road Hospital was only sent out by the Hospital on 11th July 1996 and it was scheduled for 30th September 1996.

5.39 Dr. Balasubramaniam told us he expected William Scott to be sent an appointment for an initial assessment at the Albany Road Day Hospital within a week or two of his discharge and that it was the responsibility of the primary nurse to ensure that there was an appointment made quickly. Mr. Torn (adult services manager) said it was the key worker's responsibility to co-ordinate the care of a patient, including ensuring that speedy appointments were obtained where appropriate.

CHAPTER 6 - OUR CONCLUSIONS ABOUT THE FIRST ADMISSION IN 1996

6.0 The assessment of risk

6.1 William Scott's presenting problems arising out of the breakdown of his relationship with Denise Palmacci were poorly assessed, misunderstood and misdiagnosed during this first admission to Keats Ward in 1996 such that the effect on him of this breakdown was not adequately explored. We are concerned that Dr. Balasubramaniam was not satisfied with the medical case history which he was given but did not follow this up and consider that junior doctors should be supervised in the performance of all aspects of their duties, particularly where information which is obtained by them may affect the assessment of risks which may arise in the management of a patient. The responsible medical officer should oversee the work carried out on his behalf.

6.2 Although William Scott was clinically assessed for suicidal risk, there appears to have been little, if any, detailed assessment of the risk of violence to others even though Dr. Balasubramaniam was concerned that there was a very real risk of a further threat being made to Denise Palmacci by William Scott. We gained the impression that the fact that Denise Palmacci chose not to tell the police about the alleged rape at the outset but instead contacted William Scott's General Practitioner may have led the clinical team to minimise its reaction to this apparently serious and violent incident. We also feel it may have underestimated the risk of potential violence to her because she remained in contact with him.

6.3 We consider two features should have caused more concern amongst the clinical team during this first admission than appears to have been the case and should have triggered an assessment of whether William Scott posed a risk of violence to

others:-

6.3.1 William Scott's own admission at the time that he had raped Denise Palmacci at knifepoint;

6.3.2 William Scott's history of misusing anabolic steroids over a number of years.

6.4 We feel that a decision as to whether it was appropriate to discharge William Scott given these circumstances ought only to have been taken after such an assessment had been carried out and fully documented. It was particularly noticeable that, when William Scott became disturbed in his earlier years, this often followed the ending of a relationship. However, this admission stands out from earlier ones because it was precipitated by William Scott reacting violently to the breakdown of the relationship. This was something he had not done before and the diagnosis made was of an adjustment disorder resulting from this breakdown. The nature of the relationship with Denise Palmacci therefore needed careful and detailed consideration in our view.

6.5 We fully appreciate that we have found out a lot about William Scott in the course of our Inquiry and we are therefore looking at his treatment and care with the benefit of hindsight; however, we have come to the view that William Scott should not have been discharged from hospital without an investigation of his home and personal circumstances being carried out. WE feel that insufficient consideration was given to asking Denise Palmacci about his recent behaviour, history or any threats to her even though she probably came to the ward on at least one occasion. We understand that Dr. Balasubramaniam was anxious not to encourage any desire which William Scott may have had to involve Denise Palmacci in his care when she had ended the relationship. Yet given she had visited the ward and he telephoned her regularly, we think it was foreseeable that there would be contact between the two of them and any risks inherent in that contact needed to be assessed. By failing to talk to her, the clinical team may have

missed the opportunity to gather important information about William Scott's past behaviour towards her and other people.

6.6 We are aware there were concerns amongst the clinical team that it would be a breach of patient confidentiality to discuss a patient with an ex-girlfriend. However, nobody asked William Scott to give his consent for there to be contact with Denise Palmacci. In our view, this consent should have been sought.

6.7 We cannot of course be certain that Denise Palmacci would have been prepared to be involved in William Scott's care but we have come to the view that it is probable that she would have been willing to give some information to the medical team in the light of her past history of trying to help him and the evidence which we have heard and read which shows that she discussed their relationship with other people.

6.8 Similarly, nobody spoke to John Denyer about William Scott to ascertain whether he could provide any relevant information nor to any of the people with whom he shared a house. We appreciate that it may not have seemed easy to identify a main person from whom information about him could be obtained but, as was highlighted in "The Report of The Inquiry into the Care and Treatment of Christopher Clunis", there should not be an assumption made that a patient has no roots or contacts in the community.

6.9 We accept that it may have been very difficult to predict the tragic event which ultimately occurred but have come to the view that this does not mean that there did not need to be any attempt to predict it: this is the very essence of risk assessment.

6.10 **The misuse of steroids**

We have concluded that the clinical team failed to investigate the possible impact which the misuse of anabolic steroids may have on a patient diagnosed as suffering from a personality disorder and to assess the possible implications of this for

that patient's care and treatment. As appears later from this Report (at paragraph 12.5), it is possible that long-term and regular misuse of anabolic steroids may have contributed to abnormal personality traits and abnormal behaviour exhibited by William Scott. A detailed history of his drug misuse should have been taken which recorded the types of drug used, the doses taken and the routes of administration. Whilst we would not have expected the clinical team itself to have expert knowledge of anabolic steroid misuse, appropriate advice could and should have been sought once it knew more about which drugs were being used by William Scott.

6.11 Had there been an assessment of the risks to his own health and safety and to others, it may be that William Scott could have been persuaded himself to seek the help of the substance misuse services.

6.12 Once these assessments had been made, a decision could be made as to whether it was appropriate to discharge William Scott or not. If it were appropriate for him to remain on Keats Ward, consideration could have been given as to whether detention under the Mental Health Act 1983 was indicated if he was not prepared to remain on an informal basis. We do not say that it necessarily was but believe that these matters should have been thought about.

6.13 **Post-discharge care**

If an assessment of the risk of violence had been done and if William Scott's misuse of anabolic steroids considered in greater detail, then it may be that the same decision would have been reached, i.e. that his discharge was appropriate. We concluded that, if a decision was taken that this was the appropriate course of action, there should have been an early assessment of his needs by the Albany Road Day Hospital. If at all possible, this should have been done before discharge. Similarly, there should have been contact with the substance misuse service to see what assistance (if any) it could offer.

6.14 Admission to an acute unit is intended to provide stability and structure to a patient's life when it is needed. It is important that these are available when a patient returns to the community. William Scott was distressed, remorseful and asking for help when he was admitted on 22nd June 1996. He improved quickly but then showed rapid changes of mood including anxiety, verbal aggression and the expression of guilt and depression. We consider that he left hospital after ten days still in a fairly distressed state of mind and with none of his problems resolved. In an attempt to address his problems, fairly immediate community support in the form of an early appointment for an assessment at Albany Road Day Hospital and the allocation of a social worker was apparently envisaged for him by the clinical team. In fact, neither of these materialised.

6.15 Dr. Balasubramaniam told us counselling was envisaged as a package of psychotherapy designed to help William Scott with "expressing emotion, coming to terms with whatever he was worrying about, his girlfriend, whether he was guilty, remorseful". Nonetheless, we were left with the impression that none of the doctors to whom we spoke nor William Scott himself seemed to have a clear view what "counselling" was being offered. It seems to have been seen as an alternative to taking immediate action on his problems but we felt none of the problems for which counselling might be appropriate were adequately identified nor was a named therapist identified who might take him on after assessment.

6.16 Given that a decision was taken to discharge William Scott, there had to be compliance with "The Bedfordshire Health and Social Services Discharge Policy for People with Mental Health Problems" (which is dated 4th February 1994 and was then in operation). This stated that there should be a detailed aftercare plan for, amongst others, those patients who are considered vulnerable. At the least, we think that William Scott fell into this category in June/July 1996. The policy provided that all plans had to be recorded in writing and were to include:-

"The person's needs
"How the needs will be met
"Which agencies will be involved and named people in those agencies
"Who will undertake each part of the plan and their commitment to fulfil this
"Review dates
"Who has overall responsibility for the care plan and that they have accepted responsibility
"Record of unmet needs and completed Service Deficiency Form
"Clearly identifies when the person is under section 117 [of the Mental Health Act 1983]".

6.17 These requirements were not satisfied in practice in William Scott's case. There was no assessment of what his counselling needs were nor how they were to be met. There was no named therapist who had indicated a commitment to undertake the counselling.

6.18 It is apparent Social Services were being guided by the multi-disciplinary team on Keats Ward and expected it to perform any assessment of risk and to pass on any concerns it might have about a patient. Lorna Day and Mr. Frampton were both under the impression that Social Services' input was to be confined to providing advice about finances to William Scott. Lorna Day's role was limited to providing liaison between Social Services and the ward. If more were expected of Social Services (whether in relation to its participation in the multi-disciplinary meeting or the ward round or subsequently), that should have been made clear. We consider that, in the case of each patient with which it deals, a multi-disciplinary team should ensure that each agency's respective roles and responsibilities are well defined and understood so as to avoid any potential for misunderstanding.

6.19 We are of the view there was a failure at this time to appreciate the need to ensure that the community support which was envisaged for William Scott was in fact

in place. The management of those living in their own homes must be taken seriously. There had to be a speedy referral to the day hospital and assessment of him, if that was the appropriate course to be followed. We consider an urgent appointment should have been obtained for him.

6.20 We also believe it is important all members of the multi-disciplinary team have instructions as to what they must do to implement a care plan in order to eliminate any potential for misunderstanding between the team. There should be guidance and instruction given by the responsible medical officer where this needed.

CHAPTER 7 - 2ND TO 4TH JULY 1996

7.0 Edinburgh

7.1 On 2nd July 1996, William Scott was discharged from Weller Wing. He drove to Edinburgh and stayed with a friend, Lawrence Marshall. He stayed in Edinburgh until 4th July 1996 when he drove back to Bedford.

7.2 William Scott's return to Bedford

Whilst he was driving back to Bedford, William Scott took an overdose. He told us this was an overdose of Paracetamol and of anabolic steroids, of which the steroids were Dianabol (this is Methandrostenolone - a synthetic anabolic steroid).

7.3 He then went to Denise Palmacci's house and waited in the garden for her to return. Donald Palmacci told us that, at about 5.15pm, he saw William Scott there and asked him what he was doing. William Scott replied that he was waiting for Donald's mother and he just wanted to say "a last good bye".

7.4 Donald Palmacci telephoned his mother at work and told her William Scott was sitting in the garden. Mrs. Hurrell said her daughter was "absolutely petrified" when she got this telephone call and it appears the manager of "Next" called the police to take her home. The police did not take her to the door of the house but dropped her a little distance from her home so she walked down the road to the house. Donald Palmacci said his mother asked him to check William Scott's pockets which he did. He said words to Denise Palmacci to the effect of "give me one last hug and I'll go". The two of them spent about half an hour standing outside Denise Palmacci's home during which time the police telephoned Donald Palmacci and asked if everything was all right. He said it seemed to be because he had not heard any arguing. His mother came into the house and said she would call a taxi for William Scott. Donald in fact called the taxi and William

Scott left in it.

7.5 According to the statement of PC J.A. Carter (which is dated 12th July 1996), Denise Palmacci told him that William Scott had raped her on 22nd June 1996 when she travelled back with him to her house on 4th July 1996.

7.6 At 9.50pm on 4th July 1996, William Scott was admitted to Pilgrim Ward at the Bedford General Hospital having taken an overdose of some 20 Paracetamol tablets and some anabolic steroids. He arrived in an ambulance which had been called by one of the people with whom he shared a house. The senior house officer in the Accident and Emergency department contacted the Guy's Hospital Poisons Unit who advised that he should be treated with Parvolex IVI. He was described on admission as being "sleepy and lethargic" and refusing to be examined. He remained on Pilgrim Ward until 6th July 1996.

CHAPTER 8 - THE SECOND ADMISSION TO WELLER WING IN 1996

8.0 On 6th July 1996, William Scott was transferred to Keats Ward. He was re-admitted to Keats Ward by Dr. Prendergast who told us he was quite tearful when she admitted him. He was very distressed at his behaviour towards Denise Palmacci which had led to the previous admission and he gave Dr. Prendergast the impression that he could not cope with the guilt which he felt at his behaviour towards her. He described it as being "totally out of character and said that he could not forgive himself". He said "he "couldn't cope" when he was discharged 4 days ago, but didn't say so to the doctor".

8.1 Dr. Prendergast noted that William Scott "still has suicidal thoughts. Suicide attempt not planned in advance, but no regrets". He said he still felt like killing himself and he wanted help to be able to cope with what he had done and how he was feeling because of it. She described William Scott as being "keen for any treatment and help at that time".

8.2 Dr. Prendergast made a clear note that William Scott had a history of abusing anabolic steroids. She told us William Scott's misuse of anabolic steroids was not something he wanted to talk to her about in any detail but she expected that it was something "which might or might not be gone into in detail later".

8.3 Dr. Prendergast admitted William Scott to Keats Ward on an informal basis. She noted that the team were to review him and he was possibly to be assessed for psychologist/counsellor input at Albany Road.

Comment

We consider that Dr. Prendergast's assessment of William Scott for the purpose of this second admission was comprehensive and competently

performed. She assessed the immediate risk of self-harm and properly recorded that William Scott had a history of abusing anabolic steroids in order that there could be further consideration of this issue if that was considered to be appropriate.

8.4 **The admitting nurse**

Mrs. Vanda Harrow was the admitting nurse on this occasion. She was also allocated as William Scott's primary nurse for this admission. Although his main carer was given as his friend, John Denyer, he said that his next of kin was Denise Palmacci. Mrs. Harrow told us William Scott "was full of remorse from the rape of his girlfriend" and he "was generally very low and depressed". She noted he had been verbally abusive towards staff and physically aggressive towards his girlfriend having raped her at knifepoint. He was described as being suicidal but denied destructive behaviour towards others or property. In her admission note, Mrs. Harrow referred to William Scott having gone to say "goodbye" to Denise Palmacci. She recorded that he had a history of abusing anabolic steroids and alcohol.

8.5 Mrs. Harrow prepared a nursing care plan for William Scott. She noted, amongst other matters, that he had been depressed since the break up of his relationship. He felt guilty about the rape and had asked for counselling help to enable him to come to terms with what he had done to Denise Palmacci and also to talk through his childhood and related problems. She noted that he had stated he would still like to "end it all". The goals stated in the nursing plan included the following:-

> "For Will to state that he no longer has any wish to kill or harm himself or anyone else.
>
> For Will to state that he has come to terms with what he did and that he is ready to take advantage of any counselling offered in order to understand himself better and to learn safe ways of coping with his feelings in the future."

8.6 Mrs. Harrow noted in the nursing care plan that the nursing staff were to be aware of William Scott's whereabouts at all times and to observe and report on, amongst other things, his behaviour, mood and social interaction. She stated that the nursing care team and primary nurse were "to offer Will time to talk through his feelings and to offer him support". The primary nurse was to liaise with the multi-disciplinary team "to ensure appropriate support is in place when Will is returned to the community".

8.7 Mrs. Harrow told us that she intended the instruction that nursing staff were to be aware of William Scott's whereabouts at all times to cover any risk that he might be suicidal and that he might attack others.

Comment

We thought that Mrs. Harrow prepared a good care plan for William Scott. We formed the view that she realised that there was at least potentially a risk of harm to others from William Scott.

When we asked Mrs. Harrow about her views as to how the risk of a patient harming others should be assessed, she told us that "[t]he aggression is implicit in the fact that he raped his girl-friend and there is that tension".

It will be apparent from what we have already said in this Report that we consider this assertion to be correct. We do not criticise Mrs. Harrow's assessment of William Scott but would suggest that the Trust consider giving some guidance to nursing staff about recording the possible need for a formal assessment of a patient's risk of harm to others in his or her notes so that it can then be drawn to the attention of the medical team caring for that patient.

8.8 Although Mrs. Harrow admitted William Scott to Keats Ward and was to be his primary nurse, she was not on duty on 7th July 1996 and went on a five day study course which started on 8th July 1996. She therefore had no further contact with William Scott but told us she expected the senior nurse on the ward to liaise with the multi-disciplinary team in her absence. She expected the senior nurse to read the nursing notes, to be aware of what was written in them and to pass on anything of relevance to the multi-disciplinary team.

8.9 At 10.30pm on 6th July 1996, Dr. Prendergast again saw William Scott when he was complaining of pain in his back and his groin. There were no specific physical findings although he was trembling. Dr. Prendergast attributed this to "? anxiety". She noted that William Scott had been on the phone to his "ex-girlfriend just now, & keen to phone her back?". She discussed this backache with the medical senior house officer (Dr. Briggs) who apparently did not think it resulted from the overdose which William Scott had taken. He felt it may be related to anxiety or manipulative behaviour. Dr. Prendergast formed the view there was some backache. It subsequently settled.

8.10 She was again called to see William Scott on 7th July 1996 when he was insisting on going home "to get on with my life". There was a change from his tearful behaviour on the preceding day. He was now quite abusive, angry and unco-operative, and was insisting on going home. He told Dr. Prendergast that his girlfriend "doesn't care about him" and so he "doesn't care about her either". He was not voicing any suicidal ideas and showed no suicidal intent at that time. Mrs. Tommy was present when Dr. Prendergast saw William Scott. Dr. Prendergast was told he had made numerous phone calls to Denise Palmacci, had been arguing and shouting during those calls and was argumentative and shouting with the nursing staff also. In the nursing records, Mrs. Tommy had recorded that William Scott:-

"was very angry and abusive towards his ex-girlfriend on the phone this *mane*".

8.11 Dr. Prendergast was also informed (probably by Mrs. Tommy) that Denise Palmacci had telephoned Keats Ward that day and spoken to Mrs. Tommy who had made the following note about the call in the nursing records:-

"Girlfriend (ex) rang concerned that Will might come for her as they had had a heated argument over the 'phone."

8.12 Mrs. Tommy told us that Denise Palmacci had rung the ward saying that she was concerned about William Scott and asking if the ward could keep him. She said she was frightened of him because he was emotionally abusive. She did not say that he was physically abusive. Mrs. Tommy told us Denise Palmacci was quietly spoken and not crying or sounding distressed and that she advised her she should contact the police if she was frightened of him.

8.13 Dr. Prendergast told us that she was told by one of the nursing staff that Denise Palmacci was afraid of what would happen, presumably because William Scott had told her that he was going home, and that she did not want him to be discharged.

8.14 Dr. Prendergast was concerned that William Scott wanted to go home. She told us she was not sure what to do and she wanted his consultant's advice. She therefore telephoned Dr. Balasubramaniam. Dr. Balasubramaniam told her the diagnosis for William Scott was that he had a personality disorder and his behaviour was not treatable at that time in the psychiatric ward. She said she told Dr. Balasubramaniam about Denise Palmacci's fear of William Scott and her wish that he should not be discharged. Dr. Balasubramaniam advised Dr. Prendergast that William Scott could go home but should sign a form indicating his refusal to accept medical advice if he was

unwilling to stay. He was not sectionable at that time. Dr. Prendergast said that Dr. Balasubramaniam felt that as William Scott "did not have a treatable psychiatric disorder at that time, then it was a police matter". Dr. Balasubramaniam agreed this was what had happened except that he told us that he was not made aware at any time during William Scott's admission that Denise Palmacci was asking for a delay in his discharge. He said that, had he known of this request, he would have delayed his discharge.

Comment

William Scott had been diagnosed as suffering from an adjustment disorder following the breakdown of his longlasting relationship (which is quite separate from a personality disorder) on discharge on 2nd July 1996, yet Dr. Prendergast does not seem to have been told this during this telephone call. We consider that it is important that diagnoses are accurately recorded and communicated between all members of a multi-disciplinary team and to General Practitioners on discharge so they are fully informed as to diagnosis when they discuss the care and treatment of a patient or take over responsibility for the patient.

8.15 William Scott then made another telephone call, apparently to Denise Palmacci and came back to Dr. Prendergast. He was tearful and wanted to stay in Weller Wing. She advised him that the staff would not put up with aggressive, abusive or manipulative behaviour. He agreed to comply with the ward regulations and said he would speak with staff rather than getting into a temper or storming off. He said he wanted help and wanted to get better. Dr. Prendergast advised him not to keep telephoning or harassing Denise Palmacci. She arranged for the team doctor to review him on the following day.

8.16 Dr. Prendergast considered that, were William Scott not prepared to remain on the ward as an informal patient, then the other option was to do an assessment

pursuant to the Mental Health Act 1983 to determine whether he ought to be detained.

Comment

Again, we consider Dr. Prendergast acted appropriately when she reviewed William Scott. She considered that it might be necessary to detain William Scott under the provisions of the Mental Health Act 1983 if he were not prepared to remain as an informal patient and, since she was not sure what to do initially, she properly sought the advice of Dr. Balasubramaniam.

8.17 **8th July 1996 - The ward round**

On 8th July 1996, Dr. Balasubramaniam held a ward round. In the nursing records, it is simply recorded that William Scott was seen by "Dr. Balasubramaniam & Team". It has been difficult to ascertain precisely who was present since no list has been kept but those present included Dr. Balasubramaniam, Dr. Wagle, Mr. Bowers and Mrs. Robson. Nobody from Social Services was present.

8.18 Dr. Balasubramaniam spent approximately 15 minutes dealing with William Scott. This included the presentation of his case by junior medical staff and nursing staff. He was informed William Scott had gone to Scotland soon after discharge, had come back and gone to see Denise Palmacci. On the way, he had taken some Paracetamol and steroids. Dr. Balasubramaniam understood that William Scott had spoken to Denise Palmacci and told her that he had taken an overdose and that she had then taken him to Accident & Emergency (in fact, as we note in chapter 6, William Scott arrived in an ambulance which had been called by one of his house mates). He knew William Scott had been admitted to Pilgrim Ward, had stayed there for two days and was then transferred to Keats Ward. He had wanted to leave the ward but had been persuaded to stay until Dr. Balasubramaniam told him he could go. Dr. Balasubramaniam discussed discharge with William Scott and said that he wanted to be

discharged.

8.19 Dr. Balasubramaniam said that he was also given information about William Scott's previous convictions twenty years ago. There was no conviction for violence. He was told he had undergone alcohol detoxification several times in the past which had not always been successful and had led to repeated admissions. He formed the impression that William Scott was abusing alcohol in late June/early July 1996.

8.20 As far as William Scott's behaviour on the ward was concerned, Dr. Balasubramaniam described it as "abnormal, aggressive and seriously irresponsible behaviour on the Ward, throwing things, shouting at people, aggressive outbursts and telephoning his girlfriend". He said that "it fitted in very well with psychopathic disorder under the Mental Health Act 1983".

8.21 Dr. Wagle also told us about the ward round. She said the multi-disciplinary team had discussed what had happened since William Scott's discharge, what he was doing and his guilt about his girlfriend. Dr. Balasubramaniam went over his behaviour on the ward on the preceding two or three days and his previous admission when he was "demanding and argumentative" and "appeared manipulative to staff". Dr. Wagle told us that Dr. Balasubramaniam said William Scott did not have any symptoms or signs of any major mental illness and the mental health unit might not be the best possible option for him.

8.22 William Scott told us that he said to Dr. Balasubramaniam that he should not be discharged and that he wanted to be in "a safe environment". Dr. Wagle agreed that William Scott said that he wanted to be in "a safe environment" but none of the witnesses who spoke to us recall William Scott specifically asking to stay on the ward save for William Scott himself.

8.23 A number of points have arisen from the evidence which we have heard about this ward round.

8.23.1 The telephone call which Denise Palmacci had made to the ward on 7th July 1996 was not discussed. Mr. Bowers told us he could not be certain that information about it was passed to the ward round. Dr. Balasubramaniam told us he knew about the telephone call following his discussion with Dr. Prendergast but that it was not discussed at the ward round. Dr. Wagle also told us it was not discussed.

8.23.2 When he was asked about contact with Denise Palmacci, William Scott denied being in touch her. Even though staff were aware telephone calls had been made by him to Denise Palmacci in the course of which he sounded angry and that she had been to the ward on at least one occasion during the course of the two admissions, nobody challenged him about this denial.

8.23.3 Although the medical and nursing staff were aware William Scott had a history of misusing anabolic steroids, as with the first admission, nobody asked William Scott what steroids he was taking nor considered in any detail the effect which they could have on his personality.

8.23.4 There was no discussion about whether Denise Palmacci, John Denyer or any other person ought to be contacted to find out if they could give the medical team any further information about William Scott which might be relevant to his treatment.

In relation to contact with friends/carers, Dr. Balasubramaniam told us:-

(a) He did not understand anybody to be the main carer for William Scott even though John Denyer was listed as such. By referring to a "carer" in this context, we intend to refer to aperson with whom contact could be made if appropriate for information about a patient. He told us no address was given for John Denyer. Although there was a telephone number for him, he was not contacted because, whilst that would be done for the Care Programme Approach 2 and 3, it was not done for the minimum Care Programme which was deemed suitable for William Scott.

(b) Dr. Balasubramaniam told us that it was not his responsibility as William Scott's key worker to give instructions that somebody should go and talk to Denise Palmacci. The social worker allocated would have contacted her. Dr. Balasubramaniam also said that, in any event, staff could not become involved with ex-girlfriends because of patient confidentiality and the risks involved in any potential breach of it.

8.24 The decision of the multi-disciplinary team was that William Scott was to be discharged that same day.

8.25 **The plan for care in the community**

William Scott was again perceived as low priority within the definitions in "The Bedfordshire Health and Social Services Discharge Policy for People with Mental Health Problems" (dated 4th February 1994). The priorities were jointly agreed between Bedfordshire County Council and Bedfordshire Health Authority to "inform decision making about priorities both in terms of the assessment process and the allocation of resources".

A "high priority" patient was defined in the following terms:-

> "Carer loss/withdrawal or breakdown. Serious physical/mental deterioration.

"Complex care plans.

"Dangerous/unsafe physical environment.

"Abuse - from other, to self or others.

"Very dependent individuals/total care.

"Functional deterioration.

"Evidence of poor and reducing quality of life."

A "medium priority" patient was defined in the following terms:-

"Increased stress/distress to clients/carer. Gradual physical/mental deterioration.

"Complex care plans.

"Potentially unsafe physical environment.

"Some functional deterioration.

"Without intervention, a moderate quality of life."

A "low priority" patient was defined in the following terms:-

"Potential stress/ distress to client and/or the carer/ Evidence of some physical/mental deterioration which requires regular support. Concerns about physical environment.

"Some risk to self or exploitation.

"Potential functional deterioration and loss of quality of life."

8.26 William Scott's care plan read as follows:-

"(a) Discharge summary c/o GP

(b) Referred to Social Services awaiting appointment

(c) OPC 3/52 (last made on the last discharge 25.7.96).

"Recognition of relapse *

"Planned date for discharge *

"Review date *

"Social works needs assessment completed yes/no *

"Social work needs assessment attached yes/no *"

Those parts of the care plan marked with an * were not completed. Dr. Balasubramaniam remained his key worker.

8.27 As with the first care plan, nobody has been able to tell us who completed this care plan although the writing looks the same on each plan.

8.28 It remained the intention of the multi-disciplinary team that William Scott should receive counselling at Albany Road Day Hospital although there was still no date known for his assessment there.

8.29 Dr Balasubramaniam informed us that the ward round was told that a social worker had been allocated to William Scott. However, no one from Social Services had in fact made any contact with William Scott. It was known that he did not yet have an appointment arranged with a social worker.

8.30 William Scott was discharged on 8th July 1996. There was no entry made in the nursing records about his discharge. Mr Bowers told us that the practice on the ward would have been to advise him of Care Programme Approach involvement, to ask

him to sign the Community Care Plan, to ensure he knew who his key worker was and how to contact that person and to advise the patient to contact either his General Practitioner or the Accident & Emergency department if he needed further support. William Scott told us that he was not given any advice when he left the ward, although he told Dr. Basra that he had been told that he could contact the hospital at any time he wanted and go in so that we accept it is likely that he received some advice on discharge. Since there is no entry in the nursing records about his discharge, we do not have a note of precisely what he was told.

Comment

Our analysis of William Scott's condition at the time of his admissions is that some of the criteria for a high priority categorisation may have been satisfied (eg carer loss/withdrawal or breakdown - a category into which we think that Denise Palmacci fitted, serious mental deterioration, abuse to self or others, functional deterioration). We accept that his longstanding personality disorder would not of itself put him into this category, but we believe that it was his diagnosed adjustment disorder which needed treatment at this time and could potentially have qualified him for a high priority categorisation. At the least, we think that he should have been considered to be a medium priority patient. Had he been classed as medium priority at least, we think that his vulnerability at the time may have been better identified.

8.32 A letter dated 12th July 1996 was sent on Dr. Balasubramaniam's behalf to Dr. Basra. In this, it was said that the diagnosis was "personality disorder with adjustment reaction". On 16th July 1996. Dr. Wagle sent a discharge letter to Dr. Basra in which she said that the diagnosis at discharge was "dis-social personality disorder".

Comment

The diagnosis on discharge on 2nd July 1996 was "no major mental illness - adjustment disorder".

The diagnosis in Dr. Balasubramaniam's letter of 12th July 1996 was "personality disorder with adjustment reaction".

The diagnosis in Dr. Wagle's letter of 16th July was "dis-social personality disorder".

These are different diagnoses and we believe that it is important that, where information as to diagnosis is transferred from one doctor to another, the communication of that diagnosis is accurate and precise.

CHAPTER 9 - OUR CONCLUSIONS ABOUT THE SECOND ADMISSION IN 1996

9.0 We are of the view that William Scott's overdose on 4th July 1996 may have been born of a desire to return to hospital. He had indulged in attention-seeking behaviour of that sort in the past.

9.1 By the time of the ward round on 8th July 1996, there had been further incidents which, together with the history of the rape of Denise Palmacci at knifepoint and of William Scott's anabolic steroid misuse, should have triggered further evaluation of his immediate care. These were:-

9.1.1 Denise Palmacci's telephone call to the ward on 7th July 1996 expressing concern that William Scott "might come for her" if he were discharged. We believe this shows that she was frightened of him. We think her visit or visits to the ward could possibly have suggested otherwise but may be explained by the attempts which she had made in the past to help William Scott. By 7th July 1996, she was sufficiently concerned about him to telephone the ward and we have come to the conclusion that this call should have triggered an invitation to her to talk to a medical officer or a visit to her home by a social worker. Instructions to do this should have come from Dr. Balasubramaniam, the responsible medical officer and key worker.

9.1.2 William Scott's denial of any contact with Denise Palmacci. We think this was odd and this again ought to have led to consideration of whether she should be contacted since both nursing and medical staff knew (or ought to have known) that he had in fact made numerous telephone calls to her when he sounded angry and that she had been to the ward.

9.2 Had somebody spoken to Denise Palmacci, she may have told that person that the police had accompanied her home on 4th July 1996 because she was frightened when she heard that William Scott was waiting in her garden or of any other concerns about him which she may have had.

9.3 As with the first admission to Keats Ward in 1996, we feel a decision as to whether it was appropriate to discharge William Scott given these circumstances ought only to have been taken after there had been further evaluation of his care and consideration given as to whether detention under the Mental Health Act 1983 was indicated or not. We do not consider that it necessarily was and, indeed, believe that William Scott could probably have been persuaded to remain on a voluntary basis if it were thought appropriate that he remain on the ward. We believe these matters should have been considered.

9.4 **Post-discharge care**

We have come to the view that too little attention was again paid during this admission to William Scott's post-discharge care. It is the key worker's role to ensure before discharge that elements of the plan necessary for discharge are carried out. "This will include the patient's needs for medication, therapy, supervision and accommodation. In particular, those taking decisions on discharge have a duty to consider both the safety of the patient and the protection of other people" ("The Health of the Nation - Building Bridges" para. 3.1.15).

9.5 As we have already concluded in chapter 6 of this Report, William Scott's assessment at the Albany Road Day Hospital was needed as a matter of urgency if he were to be discharged. The nature and purpose of any counselling should have been clearly identified, together with a named therapist who would work with William Scott. This would have been in line with the Trust's existing Care Programme Approach policy which stated that "The care plan should be completed and *implemented* before the person leaves hospital" (para 3.8 - emphasis added). It is our view that it is insufficient that a care plan should simply have been made before a patient's discharge from hospital - those steps necessary to implement it must also have been taken.

9.6 The role of Social Services needed clarifying if any involvement in William Scott's treatment beyond the provision of financial advice was expected of Social Services. If any further input was expected of Social Services after the ward round on 8th July 1996 (or if the extent of its involvement was unclear), then this should have been communicated to that department.

9.7 We do not know the precise nature of the advice which William Scott was given on discharge but we have been left with the impression that he had little by way of an immediate form of support on discharge save the knowledge he had an out-patient appointment arranged for 25th July (i.e. 2_ weeks later). If he was told that he could contact Weller Wing at any time, then this ought to have provided some support for him. If he showed any reluctance to contact the ward from which he was about to be discharged, that should have been discussed with him before he left on 8th July 1996.

9.8 **The Care plans on discharge**

The care plan is supposed to be constructed to meet the assessed needs of a patient on discharge. It is essential that the completion of a care plan is not treated simply as a form-filling exercise but that it fulfils the spirit of continuing and considerate care for a patient seeking help from the psychiatric services of the Trust.

9.9 We have set out our views as to the care plan prepared on William Scott's first admission in chapter 6. Again, we consider the second care plan was inadequately completed and failed to address any of the issues which required action at the time. It did not comply with guidance in "The Bedfordshire Health and Social Services Discharge Policy for People with Mental Health Problems". When we asked Mr. McKie (Director of Mental Health and Learning Disability Services) for his views as to the quality of the care plans, he candidly described them as "awful" and "dreadful".

9.10 We are, however, pleased that improvements have been made to the Trust's Care Programme Approach policy since the events with which we are concerned. In about late 1996, the Trust introduced its "Care Programme Approach Policy" which incorporates guidance on the assessment of the risk of violence to others (which was lacking from the policy in force in June/July 1996) and as to the information which is to be recorded in care plans. A Care Programme Approach co-ordinator, Paul Rix, has been appointed to audit the Trust's Care Programme Approach systems. We hope that those improvements will be reflected in clinical practice, where needed.

9.11 Mr. McKie told us the Community Mental Health Teams had only come back into the Mental Health Services on 7th May 1996 and, as a result, he thought that there may have been a tendency at the time of William Scott's admissions for all members of multi-disciplinary teams to view the in-patient services and the Community Mental Health Teams very much as separate entities. He expressed the hope that the integration of the teams under one manager had led to improvements in working relationships and communications, where needed, and this is a hope which we share.

9.12 We also heard from the representatives from Social Services who came to talk to us that there were matters within their department at the time of William Scott's admissions which were of concern. These included a large number of high priority cases being on social workers' caseloads, insufficient numbers of social workers being

available to meet their workloads, there being a number of temporary staff in the department and the absence through temporary sickness of the senior social worker. It was also felt the management structure of the Community Mental Health Team was not as well developed as it should have been. Although we do not feel these are of direct relevance in this case, we were pleased to hear that these concerns have been largely resolved since mid-1996 by a re-distribution of high priority cases between social services and the community psychiatric nurses, the appointment of more permanent social workers and the development of the Trust management structure. It was also felt improvements have been made in Social Services' approach to risk assessment.

CHAPTER 10 - 9th July 1996

10.0 William Scott told us that, following his discharge on 8th July 1996, he still believed that he needed help and he went to the Samaritans on 9th July 1996 who advised him to go and see his General Practitioner.

10.1 He went to see Dr. Basra and asked to be put in "a safe environment" saying he did not feel safe. He told us Dr. Basra said that "Weller Wing do not want you back. It's best if you go yourself and see the doctor in Weller Wing" but that he asked for a referral. According to William Scott, Dr. Basra would not do a referral for him but gave him a prescription for Buspirone.

10.2 Dr. Basra told us that William Scott came to his surgery asking to go back into hospital and saying he was "feeling restless". Dr. Basra said he asked William Scott whether he needed to go to the hospital again and he said he had been told that he could contact the hospital at any time he wanted and go in. Dr. Basra said that if he needed to be admitted, that would not be a problem. However, he suggested he should try some medication first before he was sent back to the hospital. William Scott seemed calm and quiet to him. He appeared happy with the reassurance that he was able to ring the hospital direct. He was not suicidal nor "critically aggressive". If he had appeared to be suicidal or in need of help, Dr. Basra told us he would have arranged for him to be admitted to Weller Wing.

10.3 At 9.24pm, William Scott was taken to the Accident & Emergency Department of the Bedford General Hospital having apparently taken an overdose of steroids and Panadol and Paracetamol tablets at 2pm and vomited three times. He was seen at 10.50pm when it was noted he had taken a Paracetamol and anabolic steroid overdose the preceding week, and he had been treated by both medical and psychiatric staff. His old notes were not available. He was described as "depressed - wife left

him". It was noted that he had taken 30 Paracetamol tablets and many anabolic steroids. Apparently, William Scott subsequently decided to leave the Accident & Emergency Department without receiving any treatment. He was said to feel well and was advised to return if he felt unwell.

10.4 On 10th July 1996 at 8.40am, there is a note in the Accident & Emergency records that he rang asking "How para levels could be negative - told if he feels unwell to see GP or return".

Comment

We fully understand why Dr. Basra did not arrange a re-admission to hospital on his perception of William Scott's condition on 9th July 1996, particularly as he had no indication from the hospital that his condition might give rise to concern. Dr. Basra told us that it would be useful if a GP had some advice from the ward as to what to do if a patient came to see him after discharge: it seems to us that this may be an area where thought could be given to some immediate information being transmitted to the GP by "fax" on a patient's discharge.

Again, this overdose may have been intended to lead to his re-admission to hospital. Unfortunately, William Scott did not wait for treatment and a chance of averting the tragedy which followed may therefore have passed.

CHAPTER 11 - THE DEATH OF DENISE PALMACCI

11.0 On the evening of 11th July 1996, Denise Palmacci went out with Michael Barton. At about 9.30pm, William Scott telephoned Donald Palmacci asking where his mother was. Donald told him she had gone out with a friend from "Next". After he made that call, William Scott drove to Denise Palmacci's home, parked his car out of sight and went into her garden. He saw Denise Palmacci and Michael Barton drive back to her home and watched them kissing in the car. After a while, they drove off again and William Scott believed they were going to have sexual intercourse.

11.1 It seems he then returned to his own home and collected a kitchen knife. He returned to Denise Palmacci's home and waited for her to come back. At about 2.00am on 12th July 1996, Denise Palmacci and Michael Barton returned to the house. As Mr. Barton drove away, Denise Palmacci walked towards her house. William Scott attacked Denise Palmacci stabbing her a total of nine times. Mr. Barton heard her screams and returned to her house whereupon William Scott chased him down the road with the knife still in his hands. Denise Palmacci's screams wakened many of her neighbours and William Scott was heard to shout out words to the effect of "You've been fucking sleeping with him".

11.2 At least two 999 calls were made to the police about this incident and one for an ambulance. William Scott ran from the scene of the crime to the house of somebody he knew, a Mr. Horwood, where he said he had killed Denise Palmacci. Mr. Horwood telephoned 999 and the police subsequently arrested William Scott in the rear garden of his house. He was then taken to Greyfriars Police Station in Bedford.

11.3 At 3.30am on 12th July 1996, Police Surgeon P.D. Hart certified that Denise Palmacci was dead.

11.4 A Post Mortem examination was performed at Bedford Hospital Mortuary on 12th July 1996 by Dr. Vesna Djurovic, Senior Lecturer and Honorary Consultant in Forensic Medicine. There were eight stab wounds to the front of Denise Palmacci's chest which were grouped mainly over her central chest. In addition, bruising was found on Denise Palmacci's arms, trunk and legs which could, in Dr. Djurovic's opinion, have occurred in the course of a struggle and subsequent collapse together with a ninth stab wound on the front of her mid-left forearm. Six of the stab wounds penetrated the chest cavity and five caused injuries to the lungs and heart and its great vessels with resultant bleeding into both pleural spaces and death. The Pathologist gave as the cause of death "1a) stab wounds to the chest".

11.5 **Greyfriars Police Station, Bedford**

At 5.48am on 12th July 1996, Dr. Mary Blackshaw attended the custody suite of Greyfriars Police Station as Deputy Police Surgeon. She was asked to interview and examine William Scott and to determine whether he was fit to be detained, fit to be interviewed and to take blood samples. William Scott was sitting on a chair shaking violently. He appeared agitated but was orientated in time and place. He told Dr. Blackshaw he had previously taken sleeping tablets and tablets prescribed for the state of his mind. He said he had recently taken an overdose of Paracetamol and anabolic steroids and had been admitted to Bedford Hospital, where he had been prescribed further medication. He said he had been told to re-attend at the hospital but had not done so. Dr. Blackshaw examined William Scott and noticed sweat on his face and a staring appearance to his eyes which were wide open and looking straight ahead. He was given sugar at her request whereupon he said that he felt better and was able to answer questions. Normal eye contact was made and he started sobbing. He recovered and agreed to be interviewed. Dr. Blackshaw was of the opinion that he was fit to be interviewed. Swabs and blood samples were taken. She instructed the officers in the custody suite to review William Scott frequently.

11.6 At 9.00am on 12th July 1996 Dr. Blackshaw was called by a Sergeant Tysoe and asked to see William Scott again to re-assess whether he was still fit to be detained and to be questioned. He had previously been found by a Sergeant Canfield standing and shouting "No, no" very loudly, and appeared to be disorientated. Dr. Blackshaw attended at 9.20am and was taken to the cells. William Scott was sitting staring, unblinking into space in an apparently catatonic state. He did not respond to speech or to external stimuli. On review at 10.05am, he was walking in straight lines in the cell, staring ahead and hitting the walls with his fists. Dr. Blackshaw formed the opinion that he was not fit for interview.

11.7 She contacted Dr. Basra who told her that, following his discharge from hospital, counselling had been arranged for William Scott at the Albany Road Hospital and that he had prescribed Buspirone tablets for him on 9th July 1996. Dr. Blackshaw contacted the duty consultant psychiatrist, Dr. Rao, and the duty social worker and asked them to attend at Greyfriars Police Station for the purposes of assessing the mental state of William Scott. She instructed the custody officers to supervise him constantly. She left at 10.15am.

11.8 William Scott subsequently collapsed and was taken by ambulance to Bedford General Hospital. At about 11.45am, he was seen by Dr. Rao. There was no evidence of any disturbance in his mental state save that he was very distressed and crying. He was given some Diazepam and was said to be fit to be detained at the police station and to be interviewed when his distress had settled down. Dr. Blackshaw also attended at the Accident & Emergency Department at this time.

11.9 Dr. Rao saw William Scott again at 8.10am on 13th July 1996 at the request of the police. He was described as being "in a much more natural and calmer state of mind". There was no evidence of any psychotic disorder and no evidence of disturbed thought process. He was correctly orientated in time, place and person. He

was fit to be interviewed.

11.10 Dr. Blackshaw examined William Scott again at 5.20pm on 13th July 1996 and found him fit to be detained. Dr. Blackshaw said it was her impression that William Scott was disturbed and he did not exhibit any definite feature of psychosis. It was not appropriate for her to make a formal mental state assessment in her capacity as deputy police surgeon but she did consider it was appropriate for William Scott to be assessed by a consultant psychiatrist as she arranged.

11.11 William Scott was interviewed between 7.46am and 8.07am on 12th July 1996 by Acting Detective Sergeant Andy McKay and Detective Constable Gordon Marsh.

11.12 He was interviewed between 8.30am and 9.59am on 13th July 1996 by Acting Detective Sergeant McKay and Detective Constable Marsh.

11.13 There were further interviews by these two officers between the hours of 2.01pm and 2.45pm and 3.10pm and 3.45pm on 13th July 1996.

11.14 At 4.30pm on 13th July 1996, William Scott was charged with the murder of Denise Palmacci. After being charged, he made no reply.

CHAPTER 12 - WILLIAM SCOTT'S TRIAL: 15TH APRIL 1997

12.0 Dr. Pinto's report

Dr. Pinto saw William Scott on several occasions in his capacity as visiting psychiatrist at Bedford Prison and also at Woodhill Prison. In his report dated 30th January 1997 which was prepared for William Scott's trial, he concluded that William Scott had an extensive medical and psychiatric history which included repeated overdoses, unstable relationships and volatility of mood which are representative of a significant personality disorder fulfilling the diagnostic criteria for a borderline personality disorder 301.83 in the DSM-IV classification. There also appeared to be evidence that he was clinically depressed in view of repeated statements of guilt, unworthiness and feelings of self-destruction and para-suicidal behaviour. Feelings of depression continued after William Scott's remand into custody and had not responded effectively to anti-depressant and tranquillising medication. Dr. Pinto said: "A further compounding factor was his chronic intake of anabolic steroids which are likely to have increased his feelings of irritability and poor impulse control". He was of the view that William Scott was suffering from an abnormality of mind which substantially impaired his mental responsibility at the time of the offence.

12.1 Dr. Balasubramaniam's report

Dr. Balasubramaniam prepared a report dated 6th February 1997. He concluded that William Scott was suffering from a borderline personality disorder evidenced by the following symptoms: impulsiveness that could lead to self-harm, substance misuse, shifts in mood, inappropriate and intense anger, lack of control of anger and recurrent suicidal threats. At the time of Denise Palmacci's death, he appeared to be suffering from depressed mood and to be under the effects of anabolic steroids which had been taken as an overdose on 4th July 1996. Dr. Balasubramaniam said, when William Scott committed the offence on 12th July 1996, he was suffering from an abnormality of mind which substantially impaired his mental responsibility.

12.2 **Dr. Kanakaratnam's report**

Dr. Kanakaratnam interviewed William Scott at H.M. Prison Woodhill on 11th March 1997. He concluded that emotional instability, anti-social behaviour and alcoholism were the main features of William Scott's borderline personality disorder from which he had suffered since his teenage years. All of these had become less of a problem between 1985 and 1996 although risk factors remained throughout. Emotional instability had persisted and it was Dr. Kanakaratnam's view that the illegal use of steroids must have been a significant factor.

12.3 **Dr. Powrie's report**

Dr. Powrie is a consultant physician specialising in endocrinology. In his report, he said that athletes and bodybuilders usually take anabolic agents in dosages which are vastly in excess of those used for therapeutic purposes. The abuse of the agents "is associated with many complications including increased or reduced libido, aggression, disturbances of mood and occasionally frank psychiatric illness. Formal studies have shown that those who abuse these substances are more likely to suffer mood disturbances, increased irritability and aggression, anger and depression. Psychiatric disturbance such as mania, hypomania and major depression may also occur. Users show more aggression towards wives and partners than those who do not take these substances".

12.4 Dr. Powrie was of the view that the quantity of anabolic and androgenic agents apparently consumed by William Scott were "very large indeed and would certainly be sufficient to induce the mood disorders with which they have been associated". He had taken oral and parenteral anabolic steroids although Dr. Powrie could not be sure as to precisely what he had taken. He believed the intake included Dianabol (a synthetic anabolic steroid), hCG (human chorionic gonadotrophin), Sustanon

250 (a long acting preparation of testosterone esters) and Deca-durabolin (another synthetic anabolic steroid). He said that, without knowing the exact type of drug taken, the timing of administration and the level of dosage, it was difficult to say how long the steroids would take to clear from his system. However, the frequent multiple dosage of testosterone which he understood William Scott to have taken could take considerably longer than several weeks to dissipate and Deca-durabolin can take up to a year to clear from the system although any significant clinical effects would probably have worn off long before this.

12.5 Dr. Powrie's conclusion was that the regular and long-term abuse of high dose anabolic steroids which he believed William Scott to have participated in, "may have contributed to the abnormal personality traits, labile mood and abnormal behaviour" exhibited by him in recent years and at the time of his offence on 12th July 1996.

12.6 **15th April 1997**

William Scott pleaded not guilty to murder but guilty to manslaughter at Luton Crown Court on 15th April 1997. This plea was accepted by the prosecution, and the trial judge, His Honour Judge Rodwell Q.C, agreed that it was an appropriate plea. In passing sentence, His Honour Judge Rodwell said that he had concluded "that notwithstanding that I have misgivings, the proper course is to make a hospital order that you be detained in a secure hospital and that there be the restriction order under section 41 of the Mental Health Act 1983 without limit of time because no one can tell us precisely how long it may take to treat your psychiatric illness". Further, His Honour Judge Rodwell said that he wished "to make it clear for the benefit of future mental health review tribunals that it would be very very risky for you to be released before two conditions are satisfied. Firstly, that they are sure that your personality disorder has been treated to the extent that it has been substantially improved and secondly that they are sure that you would not start taking steroids again on release". He made an Order under section 37 of the Mental Health Act 1983 with a Restriction Order under section

41.

12.7 **HMP Woodhill**

William Scott has been assessed by Dr. J. Dent, senior registrar, for hospital admission to the Three Bridges Regional Secure Unit. Dr. Dent said that William Scott was handicapped by a severe personality disorder but that he considered his personality difficulties would not be significantly ameliorated by specific in-patient psychiatric treatment at the Three Bridges Regional Secure Unit. He suggested that an approach could be made to Ashworth Special Hospital for an assessment. The outcome of this assessment was not known to us when we spoke to William Scott for the purpose of this Inquiry although we understand that a decision was made at some point that he was not treatable. It is understandable that William Scott expressed concern to us about the uncertainty which existed in respect of where he would be detained in the future and the treatment which he would receive. He was in fact sentenced again at the Luton Crown Court on 29th August

12.8 We saw William Scott at Woodhill Prison on 23rd July 1997. We found him to be willing to talk to us - he was prepared to answer every question that we asked him which we appreciated greatly. We realized that it was not always easy for him to talk to us. He was articulate and open in his account of events although his recollection and description did not always coincide with the accounts of other witnesses from whom we heard evidence.

12.9 William Scott told us he was shocked that he had killed Denise Palmacci and volunteered to us that it was a "terrible thing" that he did.

12.10 He told us he started taking anabolic steroids in about 1988 or 1989 but that his use of them increased heavily in the two years leading up to the offence. He told us that he took Dianabol orally and injected Sustanon 250 and Deca-durabolin. He

would have two injections a week, one of Sustanon 250 and one of Deca-durabolin. He would take about 10 Dianabol a day building up his in-take for the first two weeks and then decreasing it for two weeks. In between, he took hCG. He told us his mood changed when he was taking steroids although he was not aware of it. Other people had told him that he was different. He told us he would get paranoid and think people were laughing at him. He described two fights in which he was involved but said that he was not aware that he was changing. He and Denise Palmacci used to argue and he would storm out of the house and "he would be aggressive and things like that". He suffered from palpitations and severe cramps. However, he told us that, although the anabolic steroids made him bad tempered, he never hit Denise Palmacci.

12.11 William Scott told us he was "not thinking straight" at the time of the breakdown in his relationship with Denise Palmacci and his subsequent admissions to Weller Wing. He felt he went everywhere for help and knew he wanted to be in a safe environment at that time. He knew he wanted to be off the streets. He did not feel that he was helped on Weller Wing, he did not find the referral to Albany Road of any assistance since that was "months down the road" and he could not understand why Dr. Basra gave him another prescription on 9th July 1996 when he had already taken a number of overdoses.

CHAPTER 13 - THE RESPONSE TO DENISE PALMACCI'S DEATH

13.0 Donald Palmacci and Mrs. Hurrell told us that the Victim Support team contacted them after Denise Palmacci's death to find out whether they needed any support. Save for that, nobody contacted them to talk about her death nor to explain what had happened. When they talked to us, they still did not know some of the facts surrounding her death and they had many questions which remained unanswered.

Comment

We consider that it is important that a bereaved family and friends should be treated with dignity and respect. Where there has been a homicide, it is extremely important for the family and friends of the victim to know what happened to their relative if they choose to know. We think that there should have been contact with Mrs. Hurrell and Donald Palmacci at a far earlier stage than that of our Inquiry. We hope the investigations we have conducted will provide some further information for them about this tragic incident although we do not claim to have all of the answers.

We are pleased to see that the Trust implemented "Practice Guidelines for the Involvement of the Police" in April 1997 which are intended to provide guidance to its staff after a suspected criminal act. These guidelines include provision for there to be support for individuals involved in a serious incident. It is our hope that this is intended to extend to bereaved families should the need ever arise.

13.1 We were told that staff who had been involved in the care of William Scott had been offered counselling on an informal basis to enable them to come to terms with the incident. In particular, Miss Michel (the senior nurse for the acute unit) offered

support and advice to some members of staff. The nursing staff also discussed it amongst themselves on an informal basis.

Comment

We consider that it is important that staff should be able to discuss a serious incident should they wish to do so and we are pleased that Miss Michel was able to offer support to those members of staff who wanted it. We are also pleased the nursing staff were able to provide support to each other on an informal basis. During our Inquiry, we heard that information about the counselling available to staff should a serious incident occur is circulated to them and we believe that this is to be commended.

We also believe that it is important that staff are supported through the internal and external Inquiry process which can be daunting and give rise to considerable anxiety. Again, we are pleased to report that Mr. Torn and Miss Michel were involved in the internal Inquiry which was conducted by the Trust and were available to offer support if needed and that the Trust made the services of a solicitor readily available for any member of its staff who came to speak to us. This is to be commended.

13.2 In the week following Denise Palmacci's death, Senga Mitchell (then the Business Manager for Learning Disabilities) conducted interviews with five members of staff (Dr. Balasubramaniam, Dr. Prendergast, Dr. Wagle, Mr. Bowers and Mrs. Tommy) in order to gather details of William Scott's care and treatment whilst he was a patient on Weller Wing. She told us that her role was to present the facts as she saw them and to highlight any discrepancies. She did not have a written brief. She prepared a report which was given to the then Chief Executive of the Trust. A decision was then taken that no subsequent internal inquiry needed to be conducted.

Comment

It is not our intention to be critical of Senga Mitchell who followed the instructions which she was given, however, we feel that this was an inadequate response to a serious incident. It is important that the factual background and implications of a serious incident are considered in depth soon after the incident occurs so that, if a particular course of action or change in practice is identified as necessary, any modifications can be implemented as soon as reasonably possible. We consider that there should have been a clinical audit of William Scott's care and treatment after Denise Palmacci's death and more detailed consideration of this incident by the management of the Trust itself than seems to have occurred.

We believe that the "Serious Incident Policy" issued by the Directorate of Mental Health and Learning Disability in November 1996 should lead to improved investigation of serious incidents in the future should the need arise.

CHAPTER 14 - RECOMMENDATIONS

14.0 We do not claim that William Scott's case was an easy one to manage and we are conscious that those caring for him were keen not to encourage any dependence by him on in-patient care. We think this is a proper view for a clinical team to take. We are also conscious that Dr. Balasubramaniam has only 10 acute beds on Weller Wing for a population of 60,000 people and is himself key worker for some 400 patients (each of which presumably imposes considerable pressures and demands on his professional life) and that support for those discharged from hospital is not always immediately available in the community. Notwithstanding this, we identified issues which concerned us in the course of our Inquiry as to the treatment and care which William Scott received. We have already set those out in this Report and give in this chapter our recommendations arising out of our Inquiry. We have been left wondering whether, if more had been known about him, his management might not have been very different.

14.1 We hope that the recommendations which we make will assist in the provision of mental health services but stress, as we did at the outset of this Report, that they are based on our findings of fact on the evidence which we have heard. To that extent, our Recommendations are inevitably limited in their scope.

14.2 **The Care Programme Approach**

If the Care Programme Approach is to be applied effectively and efficiently for the benefit of patients, their relatives and carers and the public, the professionals whose job it is to implement the Care Programme Approach must appreciate fully the criteria upon which it is based, i.e.:-

14.2.1 there must be systematic arrangements for assessing the health and social needs of people accepted by the specialist psychiatric services;

14.2.2 there must be the formulation of a care plan which addresses the identified

health and social care needs;

14.2.3 there must be the appointment of a key worker to keep in close touch with the patient and monitor care;

14.2.4 there must be regular review, and if need be, agreed changes to the care plan (para 1.3.5 - "Building Bridges").

14.3 **The assessment of the risk of violence**

The assessment of the risk of harm posed to others by a patient must in appropriate cases be included within the system applied for assessing the health and social needs of a patient. This should not be based only on the patient's account of events and must never be the result of a view as to his or her existing mental state formed after only one or two brief interviews with him. We consider that all members of multi-disciplinary teams who take on patients for psychiatric assessment should be made aware of the indications which should trigger a formal and exhaustive assessment of the risk of violence to others. We include within the ambit of this not only the medical staff but also nursing staff, social workers and any others involved in the provision of psychiatric care to a patient.

14..4 Doctors should be aware that an incomplete assessment of the risk of violence to others may either provide false reassurance to colleagues, family and friends or unfairly label the patient as violent to the detriment of his or her treatment programme. If the responsible medical officer has any doubts about the quality of the information with which he has been provided, he should say so and cause further investigations to be made.

14.5 **Recommendations:-**

14.5.1 Clinical teams involved in the psychiatric assessment of patients should investigate the range of published assessment documents and checklists, relating to the assessment of the risk of violence. These should be

compared with any existing policy for the assessment of dangerousness in use and the practices judged best suited to the clinical team should be adopted for regular use.

14.5.2 All those involved in the provision of psychiatric services should be trained in the use of such assessment documents and checklists and should be given regular opportunities to refresh their knowledge and ability to use these.

14.5.3 All members of psychiatric teams, of whatever discipline, should constantly remind themselves and be reminded that the proper assessment of the risk of harm to others must:-

- be **exhaustive** to the point of tedium;
- record a **very thorough exploration of the mental state** of a patient over a period of time;
- always include a **detailed independent account** of the patient's mental state and behaviour from a member of his family or friends (it should never be assumed that there is no person from whom such an account can be obtained);
- embody the **observations of nursing staff**;
- study the documents describing past **personal and psychiatric history**, noting **any** report of violence;
- study **social work and probation records** where such records are available;
- obtain records of **criminal convictions** if this is possible.

14.6 **Confidentiality**

The issue of the confidentiality of a patient's medical history presents many problems which are not for us to resolve. It is inevitable that information about a

patient has to be collated and it may well have to be shared amongst a number of agencies caring for that patient. The information-gathering process is likely to have to involve family and/or friends. A failure to appreciate how the issue of confidentiality should be approached could lead to serious errors in the management of a patient's care if relevant information is not obtained because of a misplaced belief that to do so would involve a breach of confidentiality.

14.7 **Recommendation:-**

Guidance should be given to all members of multi-disciplinary teams as to how they should approach the issue of the confidentiality of a patient's medical history.

14.8 **Communication**

Communication of information is inevitably required in the assessment of the health and social needs of a patient and the transfer of information between professionals involved in his or her care must be of good quality. The Trust has formulated a "Transfer of Care Procedure" providing for the transfer of a patient's care to a large number of services.

14.9 **Recommendation:-**

The Trust should ensure that this Procedure is fully implemented and monitored and, further, that consideration is given as to how the effective and efficient transfer of information to General Practitioners can best be achieved.

14.10 In William Scott's case, it seems likely that most members of the nursing and medical staff knew about Denise Palmacci's telephone call to Keats Ward on 7th July 1996 even though it was not discussed at the ward round on the following day.

Nevertheless, we wish to emphasise that any communication from somebody which relates to possible violence by a patient should be treated seriously.

14.11 **Recommendations:-**

14.11.1 The Trust should consider giving some guidance and advice to nursing staff about recording the possible need for a formal assessment of the risk of a patient harming him or herself or others in the nursing notes if they are of the view that there could be such a risk.

14.11.2 All communications or observations which relate to possible violence should be documented and reported to the patient's responsible medical officer before the patient is discharged from hospital.

14.11.3 A patient's named nurse should ensure that all nursing notes are discussed with the multi-disciplinary team.

14.12 Further, we are aware that William Scott's nursing notes from Pilgrim Ward did not accompany him to Keats Ward on his second admission. Such records may be relevant to the ongoing assessment of a patient.

14.13 **Recommendation:-**

Where a patient is transferred between wards, all records relating to his or her care on the first ward should be sent to the second ward. If there is a transfer between wards in different Trusts, then the records should be photocopied for onward transmission.

14.14 **Clinical supervision**

Clinical supervision is intended to encourage critical debate about practice activity so that professional development can be enhanced, to redefine and to improve

skills used throughout professional life and to offer protection to independent and accountable practice. It should be an integral part of professional development and should be adequately resourced, both in terms of time and finances. We formed the view that the clinical supervision in operation in Weller Wing in June/July 1996 may have been inadequate although we understand that there are currently models of clinical supervision being piloted.

14.15 **Recommendations:-**

14.15.1 The Trust must ensure that an efficient system of clinical supervision for all levels of staff is in operation as a matter of urgency. The resource implications for this will have to be discussed with the Health Authority.

14.15.2 Consultants themselves should ensure that junior doctors are supervised in the performance of their jobs, especially in aspects of their work which could conceivably mislead others about the risks that may be inherent in the management of a case.

14.15.3 The Trust should ensure that there is an efficient system of clinical audit in place at all times.

14.16 **The presentation of unusual conditions**

During the treatment of psychiatric patients, there may well be occasions when a patient presents with a condition of which the multi-disciplinary team has little, if any, experience such as occurred in William Scott's case with his seemingly chronic and longstanding misuse of anabolic steroids and the possible effect of that on his mental state and behaviour. Where that happens, it is essential that the team takes steps to ensure that its treatment of the patient is based upon its being well-informed as to the nature and possible impact of the unusual presenting condition.

14.17 **Recommendations:-**

14.17.1 Where an unusual condition presents, a full and detailed history of that condition should be taken.

14.17.2 Once that history is known, clinicians and the Trust should ensure that there is easy and rapid access to specialist information and opinion about the unusual condition.

14.17.3 If the presenting condition involves drug misuse, the history taken should record the type of drug or drugs taken, the dosage and length of time over which each drug has been taken and the route of administration of the drug.

14.17.4 Since drug or alcohol misuse can have a significant impact on other conditions and behaviour, links should be made with a substance misuse service to facilitate drug assessments on the ward in appropriate cases. Where there is a dual diagnosis of drug or alcohol misuse and mental illness, treatment may be required from two sets of specialist services and such care must be well monitored and properly co-ordinated.

14.18 **The abuse of anabolic steroids**

Turning to the specific issue of the misuse of anabolic steroids, **we recommend that:-**

14.18.1 The multi-disciplinary team within Weller Wing (in which we include Social Services) should ensure that they are aware of current issues in anabolic steroid misuse and that they know where to obtain such information.

14.18.2 A protocol should be drawn up for the assessment, care and treatment of anabolic steroid misusers where the side effects of such drugs could complicate the diagnosis and treatment of other conditions.

14.18.3 The Royal College of Psychiatrists should be invited to consider drawing up a Guidance of Good Practice on the assessment of, care and treatment of anabolic steroid misusers including the psychological and physical side effects and the effects on other clinical conditions.

14.19 **Diagnostic discipline**

It is essential that the communication between professionals of the diagnosis for a patient is unambiguous in order that all those involved in the care of a patient (and particularly the medical staff) know what conclusions have been reached about that patient. Different diagnoses obviously have different and specific meanings and there must be no room for confusion as to the diagnosis reached in a particular case.

14.20 **Recommendations:-**

14.20.1 There should be a clear record in a patient's medical notes of the reasons why a particular diagnosis has been reached for that patient.

14.20.2 The responsible medical officer should always make an entry in the patient's notes, for example in the form of a formulation of the diagnosis and treatment plan, for which he or she is responsible.

14.20.3 All medical staff making entries in a patient's medical records should be encouraged to give a diagnosis (or diagnoses) which conforms to the international classification system of diagnosis, either ICD 10 or DSM-IV and to use the code numbers contained within those classification systems.

14.21 **Care plans and community support**

We have already set out our conclusions as to the aftercare for which provision was made in this case in chapters 6 and 9. We think it is important to emphasise that aftercare planning must not only begin during a patient's admission to hospital but that all steps which have been identified as necessary to implement the plan should have been taken prior to discharge. There must be clear communication between the multi-disciplinary team as to what has been done and what needs to be done. We are confident that the appointment of the Care Programme Approach co-ordinator will be of benefit to the mental health services provided and that, where improvements may be needed, these will be considered. We therefore make three wide-ranging recommendations in relation to the Trust's operation of the Care Programme Approach.

14.22 **Recommendations:-**

14.22.1 The Health Authority, the Trust and the mental health services should take a close look at the quality of their implementation of the Care Programme Approach, including, in particular, the role and responsibilities of the key worker.

14.22.2 There should be a concerted effort to ensure that the Care Programme Approach policy as formulated is translated into practice in every case.

14.22.3 Each agency's role within the multi-disciplinary team should be clearly defined and understood in relation to the care and treatment of each patient so as to avoid the potential for any misunderstanding.

14.23 **Counselling**

Where counselling is to be provided as part of the aftercare given to a patient, we consider that the multi-disciplinary team, the patient and relatives and carers

should have a clear picture throughout all of the patient's care of the nature and aims of that counselling.

14.24 **Recommendation:-**

If counselling is to be prescribed as a treatment for a specific problem, that problem should be defined at the time of prescription and should include the commitment of the therapist who will provide the counselling. There will inevitably be resource implications which will have to be discussed with the Health Authority.

14.25 **Serious incidents - recommendations:-**

14.25.1 Whenever a serious incident occurs, the Trust should ensure that the "Serious Incident Policy" formulated by the Directorate of Mental Health and Learning Disability is followed and that there is a thorough investigation of the incident, including a clinical audit of it.

14.25.2 Where relevant to the facts of a particular case, early consideration should be given as to when there may need to be contact with a bereaved family and the form which such contact should take.

List of Witnesses

Ms G Tommy	Registered Nurse Weller Wing
Ms L Michel	Senior Nurse Weller Wing
Mr R Bowers	Deputy Ward Manager Weller Wing
Ms V Harrow	Registered Nurse Weller Wing
Mr P Toyloco	Charge Nurse Night Duty Weller Wing
Ms W Miller	Nursing Assistant Weller Wing
Mt C Torn	Adult Services Manager Weller Wing
Ms S Mitchell	Directorate Business Manager Mental Health and Learning Disability Services
Ms L Day	Social Worker Weller Wing
Dr S Basra	General Practitioner
Dr J Pendergast	Senior House Officer Weller Wing
Dr Wagle	Senior House Officer Weller Wing
Dr K Balasubraniam	Consultant Psychiatrist Weller Wing
Dr R Pinto	Consultant Psychiatrist Faringdon Wing South Bedfordshire Community Health Care Trust
Dr G Kanakaratnam	Consultant Psychiatrist Fairmile Hospital
Mr D Frampton	Mental Health Manager Bedfordshire Social Services
Ms S Robson	Head of Occupational Therapy Services Weller Wing
Mrs D Hurrell	mother of Denise Palmacci
Mr D Palmacci	son of Denise Palmacci
Mr S Mackie	Director of Mental Health and Learning Disability Services Bedford and Shires NHS Trust
Mr I Hammond	Chief Executive Bedford and Shires NHS Trust
Mr D Eaton	Chief Executive Bedfordshire Health Authority
Mr R Nessling	Assistant Director Primary Care Bedfordshire Health