Report of the Independent Inquiry into the care and treatment of S

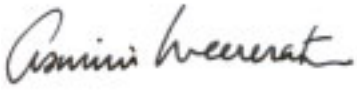
A report commissioned by South West Peninsula Health Authority

Published September 2003

PREFACE

We were commissioned in May 2002 by the South West Peninsula Health Authority to undertake this inquiry into the circumstances surrounding the treatment and care of S

We have now completed our report.



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CONTENTS

ABBREVIATIONS

CHT	-	Cornwall Healthcare Trust (now Cornwall Partnership Trust)
CMHT	-	Community Mental Health Team
CPA	-	Care Programme Approach
CPN	-	Community Psychiatric Nurse
CPT	-	Cornwall Partnership Trust
ECHR	-	European Convention on Human Rights
F grade	-	Grading within A – I grading structure for clinical nurses
GP	-	General Practitioner
HSG	-	Health Service Guidance
HRA	-	Human Rights Act
NMC	-	Nursing and Midwifery Council
NVQ	-	National Vocational Qualification
PREP	-	Post Registration, Education and Practice
RMN	-	Registered Mental Nurse
RMO	-	Responsible Medical Officer
S	-	Subject of the Inquiry
Mrs S	-	Homicide victim
SHO	-	Senior House Officer (doctor)
SWPHA	-	South West Peninsula Health Authority
UKCC	-	United Kingdom Central Council (for nursing)

PREFACE

THE INQUIRY PROCESS

INTRODUCTION

1. This report sets out the findings and recommendations of an Inquiry into the care and treatment of S. The Inquiry was commissioned by the South West Peninsula Health Authority (formerly the Cornwall and Isles of Scilly Health Authority) and established under NHS Executive Guidance (HSG (94)27) following the homicide of his wife Mrs S by S on 28 April 2000. The terms of reference are at Appendix A.

2. At the time of the homicide S was subject to monitoring in the community by a community psychiatric nurse (CPN) from the Restormel community mental health team (CMHT) part of the Cornwall Healthcare Trust (CHT) (Cornwall Partnership Trust since April 2002) and had been referred by his general practitioner to a consultant psychiatrist based at St Lawrence's Hospital, Bodmin.

3. Membership of the Inquiry Panel comprised Ms Aswini Weereratne, barrister in independent practice, Mr Charles Flynn, Director of Secure Services and Deputy Chief Executive of Mersey Care NHS Trust (formerly Nurse Executive, acting Chief Executive and Director of Clinical Services of the Guild Community Healthcare NHS Trust), and Dr Tim Exworthy, consultant forensic psychiatrist, Redford Lodge Hospital, London.

4. In order to promote the treatment and rehabilitation of S, insofar as possible, without the glare of publicity surrounding the publication of this Inquiry report, it was agreed that all references to him would be anonymised. We have adopted the expedient of a single capital letter "S". To make this as effective as possible the deceased is simply referred to as "Mrs S". However, the need for the accountability of the services involved in providing care to S prior to the homicide requires that references to the services and professionals involved in his care be open and full. This approach was discussed with and approved by the families of S and Mrs S.

5. There have now been close to one hundred inquiries after a homicide by a person under the care of mental health services and, as here, the majority

have been commissioned in compliance with HSG (94)27. Even so, there are no prescribed procedures to be followed by such inquiries which have no statutory powers or status[1]. Until recently the sole guiding principle has been the concept of "fairness", recognised by the common law of England and Wales.

6. Since October 2000 it has also been necessary to consider the requirements of the European Convention on Human Rights (ECHR) as applied in the UK courts pursuant to the Human Rights Act 1998 (HRA). Of particular relevance to homicide inquiries is article 2, the right to life, and the associated investigative process that is required when a death has occurred to protect and promote the right to life in the future.

7. This is the second Panel appointed to investigate the death of Mrs S and the care and treatment received by S from the mental health services. The first was appointed in early 2001, regrettably the Chair was taken ill early in 2002 and a new chair was appointed in April 2002. Thereafter, it also became necessary to replace the medical member as the first had taken up a post in the USA.

8. S had not consented to the first Inquiry Panel having access to his records. He understood the purpose of the Inquiry but did not want to put his family through any more grief and also felt that the health service had not let him down. As a result it was proposed to conduct a limited inquiry into some of the issues highlighted by the CHT's own internal review and compliance with policy and national standards.

9. When the second panel was appointed, Mrs Rae Wallin, Inquiry manager, liaised with S's probation officer to see whether he would reconsider his decision not to give the Panel permission to access his records. This led to a meeting with the Inquiry Chair, in the presence of his probation officer. It was explained to S that the Inquiry would not open up issues before the court when he was sentenced, but would focus on the services available to him prior to the homicide and the assessments carried out by those services.

[1] In the future the process is to be streamlined by the National Patient Safety Agency.

10. On the basis of this and after considerable thought and advice from, amongst others, his clinical team, S consented to the Inquiry obtaining relevant records. Consent was provided in mid-October 2002 at which time, the process of accessing records was initiated.

11. The Inquiry Panel has endeavoured to deal with matters as expeditiously as possible, but inevitably delays have been incurred, most of which have been completely outside the Panel's control.

12. The Panel is mindful of criticisms of the process often adopted by inquiries into homicides and the inherent difficulties in the methodology adopted [2]. We have striven to overcome these where possible and to adopt procedures which are in accordance with the law as it stands today. The written procedure is at Appendix B.

13. This chapter deals with the procedures followed by the Inquiry and the terms of reference within which it operated. It hopes to explain the aims of the Inquiry and the way in which it discharged its obligations to investigate the death of Mrs S and the care and treatment received by S.

Inquiry procedure

14. The panel was guided by the principle of fairness and the objectives underlying an article 2 ECHR investigation in setting its procedures. The Court of Appeal[3] has held that the procedural requirements of an investigation under article 2 are flexible and dependent on the type of case.

15. In May 2001 the European Court enunciated principles for an article 2 investigation. These were:

    a. Independence

    b. Effectiveness

    c. Reasonable promptness

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[2] See *Reforming inquiries following homicide* by Anselm Eldergill (1999) Journal of Mental Health Law.

[3] *R(Amin)*; *R (Middleton) v Secretary of State for the Home Department*. [2002] EWCA Civ 390 para 31; Also *McCain v UK* 21 EHRR 97 at 161.

d. A sufficient element of public scrutiny

e. Involvement by the deceased's next of kin to a necessary extent[4]

16. The Court of Appeal has stated that the elements of public scrutiny and family involvement are not necessarily compulsory. However, we do consider these to be important features of a homicide inquiry which we have sought to incorporate in the procedures adopted. The families of S and Mrs S met and discussed their concerns with Ms Weereratne, Chair and Rae Wallin, Inquiry manager. Rae Wallin remained in regular contact with them. We also considered it important to see S and discuss with him his experience of the services offered to him. He consented to a meeting with panel medical member, Dr Tim Exworthy, which took place in February 2003.

17. As with the majority of homicide inquiries, this Inquiry heard evidence in private. The procedures were designed to mitigate any unfairness this may result in where, for example, witnesses could not hear the evidence of others which was relevant to them. All witnesses had the opportunity to be accompanied by a legal representative or other person and to comment on conflicts in evidence which emerged through the course of the hearings that were relevant to findings of fact and comments likely to be made by the Inquiry in the final report. The element of public scrutiny has also been preserved by the publication of the final report in its entirety.

18. In our view, our procedures ensured that the Inquiry was undertaken with expedition and allowed for candour in evidence which a public hearing is likely to have inhibited.

19. The independence of the process has firstly been guaranteed by the Panel membership. Secondly, the Inquiry had separate office and postal facilities and thirdly, we were able to rely on the extreme professionalism of our inquiry manager Rae Wallin, whose experience and seniority were such that she was able to maintain the independence of the Inquiry process.

[4] *Jordan v UK*

Approach of the Inquiry

20. The Inquiry has been guided by its obligations under HSG (94)27 and article 2 ECHR. A thorough examination of the events leading up to and surrounding a serious incident such as a homicide is essential in promoting the accountability of public services and professionals to those in their care and the public at large. This is in the public interest.

21. The aim of an Inquiry as set out in the guidance in HSG (94)27 is to minimise the risk to the public or to patients themselves in the future by investigating the care received by the patient and his assessed social care needs and the exercise of professional judgment. These are reinforced and extended by the requirements of an article 2 investigation to include assuaging the anxieties of the public and systemic failures.

22. At the request of the Inquiry Panel an additional term was added to the Terms of Reference that allowed the Inquiry to fulfil its obligations fully. This stated "To consider such other matters relating to the issues arising in the course of the inquiry as the public interest may require".

23. We also requested that a term be included to allow the Inquiry to look into the adequacy of the internal reviews undertaken.

24. The Inquiry Panel's opinion was that these additional terms were necessary to ensure its ability to fulfil the aims of an investigation as described under paragraph 20 (above) which expressly articulates the public interest.

25. When evaluating the evidence of witnesses the Inquiry had to take cognisance of the lapse of time of over two and a half years between the events being inquired into and the hearings. It was clear in some cases that knowledge gained after the homicide from the press and reflection on events, had confused recollections of the real facts.

26. The Inquiry Panel was acutely aware of the stress that is experienced by individuals and agencies while an Inquiry is under way and the perception of a "climate of blame" that an Inquiry creates. It is clear from the tension in the relationship between an Inquiry and those being inquired into which is

apparent in the course of hearings and the correspondence generated by the process, that feelings of fear and mistrust are aroused.

27. The Inquiry is firm in its view that attaching "blame" or finding "scapegoats" is not a positive way forward. We have found, however, that it is difficult to adopt an approach or procedure that removes stress altogether. In an attempt to address this problem, a readily accessible point of contact with the Inquiry for all witnesses was available in the form of the Inquiry manager, Rae Wallin. Written procedures and terms of reference were provided to every witness written to and witnesses and agencies were kept informed of changes in the Inquiry's timetable.

28. In finalising our report we have tried to be constructive in our criticisms and offer praise where in our opinion it is due. It has not been our mission to find individuals to blame. The involvement of the CMHT with S was limited to one month prior to the homicide and as such the Inquiry has focused particularly on the weeks prior to the death of Mrs S and on drawing on any matters seen to be relevant from his previous history. The limited nature of S's involvement with mental health services has not necessitated an in depth investigation into the systems and managerial framework within which they functioned.

29. We are also only too aware that some tragic incidents are unavoidable and we do not wish to perpetuate a culture which believes otherwise. As a society we must learn to understand that serious adverse incidents will sometimes happen and it is not always necessary or productive to find someone to blame as long as lessons are learnt along the way.

30. Although mental health professionals must be accountable for good practice, they cannot ultimately be expected to carry complete responsibility for the actions of their patients. There is a limit to the control and influence which it is possible for them to achieve over any individual. It would also be wrong to overlook the right of a patient to refuse interventions by the services.

31. The Inquiry has considered the care and treatment received by S throughout his time in contact with the mental health services. We have endeavoured during our deliberations to come to conclusions without the benefit of hindsight and to consider the standards of practice that would have prevailed

at the relevant time. However, some degree of hindsight is both an acceptable and unavoidable aspect of any inquiry.

32. The practice of individual practitioners has been judged by reference to that of a reasonable and responsible body of practitioners in the relevant field. To assist in that process, additional expert evidence was sought, where it was considered necessary. We have throughout applied the standard of proof used in civil law, namely, a balance of probabilities.

33. The Inquiry is not and cannot operate as a court of law. We believe that it has fulfilled its aims and obligations as fully and properly as possible, taking account of the flexibility allowed by the courts in terms of procedures and the need to act fairly and expeditiously.

34. It is crucial that employees are fully supported by those employing them at the time of the relevant incident through to the conclusion of legal proceedings and any Inquiry. Legal services are only one form of support. A full debriefing, counselling and a timely internal review are also relevant.

35. The Inquiry has treated all evidence, written and oral, including S's records, as being received in confidence. We have considered its relevance to the terms of reference and in using and disclosing information within the report the Inquiry has weighed the public interest and whether disclosing confidential information is proportionate to the legitimate aims of the Inquiry. The evidence provided to the Inquiry will remain confidential save to the extent that it is set out or referred to in the text of the report. We consider that the agreement to anonymise references to S and Mrs S is consistent with this approach. This report contains the unanimous findings and conclusions of the Inquiry Panel.

Documentation

36. We received the written consent of S for disclosure of his medical and other relevant records to the Inquiry. He was advised by his solicitors on this issue. The Inquiry required information relating to his past history relevant to his mental illness, conduct and behaviour. The chronology at chapter 2 shows which agencies S was in contact with and had records relevant to the Inquiry.

37. The Inquiry, with S's consent, also had access to the statements and material gathered by the police during their investigation into the homicide. This was of particular importance in identifying friends and the names of family who could enlarge on S's activities and behaviour in the community and offered the Inquiry a point of balance to evidence otherwise solely provided by practitioners and agencies.

38. Documents which we sought but did not receive were S's prison records following the homicide and prior to his being sentenced. We were told by the Prison Service that these are missing. The CHT medical records we received were not kept in good order making it difficult to locate relevant documents.

Hearings

39. Save where indicated (see witnesses marked * in Appendix C), meetings with witnesses were held at the Crossroads Hotel in Redruth in Cornwall in February 2003. The evidence was recorded by Harry Counsell Limited, who managed the transcription service for the hearings, and transcripts were provided to the Inquiry and the witnesses who were asked to check them for accuracy.

40. A list of all witnesses is at Appendix C.

Administration

41. The Inquiry was skilfully and cheerfully managed by Rae Wallin, a former health service manager, but who was never employed by any healthcare organisations in Cornwall. This was an onerous task not least because the Inquiry Panel was investigating two homicides simultaneously. Managing an inquiry requires high level skills of organisation, investigation, sensitivity and diplomacy all of which Rae Wallin has in abundance. The work is intensive and ideally benefits from a dedicated and independent manager such as her. This also assists in complying with timetables and minimising cost.

42. Rae Wallin was the main point of contact between witnesses, agencies, families and the Inquiry Panel. She tirelessly pursued lines of investigation and ensured that everyone was kept informed of any changes to the timetable.

Acknowledgements

43. We would like to offer our sympathies to the family and friends of Mrs S.

44. We would like to thank the following individuals and agencies for their co-operation and patience: S, the families of Mrs S and S, all witnesses, the Cornwall Partnership Trust and the Cornwall Probation Service.

45. We must also thank and praise staff at Harry Counsell Limited for their excellent service. The Panel were comfortably accommodated at the Crossroads Hotel, Redruth for the duration of the hearings in Cornwall. We thank them for their flexibility in catering to the needs of the Inquiry. Of course enormous thanks and gratitude to Rae Wallin.

CHAPTER 1

INTRODUCTION

FACTUAL SUMMARY AND OVERVIEW

INTRODUCTION

1. On 28 April 2000 S killed his wife in the kitchen of their home at about 8 a.m. He stabbed her sixteen times with a kitchen knife and then called the police. S had suffered from episodes of depression, diagnosed as unipolar (agitated) depression since 1986. During 2000 he and his wife had been experiencing difficulties in their marriage and were preparing to divorce.

2. On 11 December 2000, at Exeter Crown Court, S was sentenced to three years probation by Mr Justice Potts. He was ordered by the court to submit to treatment as determined by Dr Angela Rouncefield, consultant psychiatrist. S's plea of guilty to manslaughter on the grounds of diminished responsibility was accepted by the prosecuting authorities and the judge due to his history of depression.

3. In sentencing him to probation the judge accepted that S had made no prior plan to kill his wife but had acted while suffering from an increasingly severe major depressive disorder. He was persuaded to take a lenient course by the exceptional level of support S received from his own and his wife's family. The judge accepted that S did not represent a risk to the public.

4. Subsequently, and in about December 2000, S's diagnosis was revised to one of bipolar manic depressive disorder and he is being treated accordingly.

5. In this chapter we provide a brief biography of S in an attempt to present what the Inquiry considers to be relevant and useful in understanding the personal context within which the events investigated took place. We also summarise the events leading to the homicide and the issues arising for the consideration of the Inquiry Panel, including those raised by the families of S and Mrs S.

S: quiet family man

6. S was born on 21 May 1949 in Cornwall. A host of witness statements from neighbours and friends after the homicide, as well as evidence the Inquiry received from the families of S and Mrs S, testify to the fact that S was a quiet and unassuming man who did not want to cause difficulty to anybody. We were told that by his nature S tries to give everyone the impression that he is fine and so, during the time leading up to the killing of his wife, it was easy for those around him to assume that he was all right.

7. His family believe that due to S's reserved nature, the Community Psychiatric Nurse (CPN) involved in his care in April 2000 is highly unlikely to have obtained full details of exactly what was happening to him at that time. S is a private person who dealt with family problems as intensely personal and private matters. The family firmly believe that there are things that S would never have told the CPN.

8. S's wife also believed in keeping their difficulties to themselves. Neither of them wanted to let others see their problems or to cause upset to their children.

9. S and his wife were married in 1971 after knowing each other for one year. When he was seen by Dr Tim Exworthy, Panel member, he recalled the early years of his marriage as being "brilliant". They knew and were well thought of by many, but had few really close friends. S acknowledged being "more private than most" people. He said he was not an extrovert. His interests ranged from his motorcycle to fishing and carpentry. They had two children, now adults.

10. Mrs S was described as being strong and always looked after S. She had said that on separation she would sort out their finances, find S a new home and continue to cook his evening meal for him. She wanted them to remain friends after the divorce.

11. S had never been violent or threatening to Mrs S or anyone else. It was not in his nature to be so. It is clear that families, friends and professionals have been completely taken by surprise by S's actions which they consider to be totally out of character for him. It can be said with considerable confidence that the killing of Mrs S by S was one of those unpredictable events that sometimes happen.

Concerns of families of S and Mrs S

12. Both sides of this family have been united in their support of S. They are eager for lessons to be learnt in order that other families should not experience anything similar in the future.

13. The families blame S's medication for his illness and the death of Mrs S. S had been on Prozac (fluoxetine) for short periods of time since 1992. In their view the only times that he had seemed irrational was when he was on Prozac. They told us that he was "totally different" and would run around the house, happy but erratic and also verbally aggressive.

Summary of contact with mental health services and issues

14. Prior to the killing of Mrs S, S had six episodes of depression for which he was seen either by his GP alone or was referred for consultant psychiatric assessment. The longest of these as shown by his records was about six months:

Period 1

12 September 1986 to 18 February 1987. S was seen by Dr Rouncefield, consultant psychiatrist, at St Lawrence's Hospital, Bodmin.

Period 2

14 January 1992 to 8 July 1992. S was off work for three months. He was referred to Dr Rouncefield and seen by her senior house officer. He was prescribed Prozac for a period of nine months.

Period 3

24 June 1996 to 22 November 1996. S was seen by his GP, Dr David Mackrell only.

Period 4

24 November 1997 to 23 January 1998. S was seen by his GP.

Period 5

29 September 1998 to 31 March 1999. S was seen by his GP.

Period 6

6 March 2000 to 28 April 2000. S was seen by his GP and CPN, Mike Kellow, attached to the Restormel Community Mental Health Team (CMHT). He was referred to Dr Rouncefield but not seen before homicide. S's prescription was changed from Prozac to Seroxat (paroxetine) on 7 April 2000.

15. S was not seen by social services, or any other agency during this time.

16. There are no real factual disputes arising during this Inquiry and so we have set out the factual background in the form of a Chronology in chapter 2. We consider the events of the final period in March and April 2000 separately and the issues arising in chapter 3.

17. We considered many issues in detail with witnesses either in writing or orally. The following three main issues have emerged for discussion in this report:

- Diagnosis: unipolar vs bipolar depression
- Treatment: the role and effect of Prozac and Seroxat. The Inquiry obtained expert evidence from Professor Robert Kerwin of University of London.
- Contact and communication between GP, CPN, consultant and CMHT, including the process of urgent referrals to secondary services and the application of the care programme approach (CPA).

18. We also discuss the process of internal review.

CHAPTER 2

CHRONOLOGY

1. We have reconstructed S's relevant history from contemporaneous health records, statements taken by the police following the homicide and from the evidence received directly by the Inquiry. We have been careful to exclude confusions caused by knowledge gained after the homicide. This is particularly pertinent to the evidence of Dr Angela Rouncefield and Mr Mike Kellow, CPN, who were involved in the care of S following disposal by the court.

DATE	EVENT
Period 1	
12/9/86	S was referred to Dr Rouncefield as a matter of urgency by Dr R. Adkins his general practitioner. He had been seen on 6 September complaining of insomnia, anxiety and forgetfulness. He had been unable to go to work and reported "getting paranoid". His wife, Mrs S, reported that she thought he was "going mad". Dr Adkins requested that S be seen in the home setting.
15/9/86	S was seen by Dr Rouncefield. She summarised her findings in a letter to Dr Adkins on 18 September. S had recounted that he had not been feeling well for about nine months. He was concerned that he may be developing senile dementia as his mother had done. S and Mrs S told Dr Rouncefield that they were happily married. Mrs S had been increasingly worried about S over a period of eighteen months. Dr Rouncefield noted the following symptoms: • complete loss of interest • no energy • inability to concentrate • difficulty doing anything • low self esteem • often sits staring into space

	• decreased libido She felt certain that he was suffering from a unipolar affective disorder (agitated). She changed the GP's prescription of anti-depressants from Anafranil to Prothiaden for its tranquillising effects because S appeared agitated. He was to be reviewed as an out patient three weeks later.
9/10/86	Dr Rouncefield noted an initial improvement and then a deterioration after one week. She found him far brighter and more cheerful and less anxious. Mrs S confirmed that there had been an improvement.
10/11/86	A fluctuation in S's condition was noted the previous week when he was quite ill again, followed by an improvement. His medication was increased. It was noted that he may try and return to work.
8/12/86	S was seen by Dr Rouncefield's senior house officer (SHO). He had improved. Some slight side effects to Prothiaden were noted.
8/1/87	S said he was "feeling wonderful".
12/2/87	S continued to improve and was offered no further out patient appointments. He was advised to continue his medication for one month and then tail it off. S was back at work and the side effects had disappeared.
Period 2	
14/1/92	S was seen by Dr D Mackrell, his general practitioner, who noted that he was "depressed again" and • Agitated at work • Not sleeping • Appetite down • Passed out x 3 He prescribed fluoxetine (Prozac) 20 mg daily and certified S off work for one week. He did not find S to be withdrawn.
27/1/92	Dr Mackrell saw S again twice. He noted palpitations. S remained unwell and he was referred back to Dr Rouncefield.

31/1/92	In his referral letter Dr Mackrell mentioned "agitated depression" and that while S had initially done well on Prozac, he had a recurrence of fainting attacks, shaking and palpitations. Dr Mackrell told us that "agitated depression" referred to the level of anxiety being expressed by S. He made the referral because S had not progressed on Prozac as well as he would have hoped. He thought that Dr Rouncefield would decide if a different form of treatment or a referral to any other service was necessary. His view of the fainting was that it was temporary and caused by the anxiety in that S was getting 'worked up".
24/2/92	S was seen as an out patient by Dr Rouncefield's SHO. At this time a three month history of increasing anxiety on social contact and declining mood was noted. S recognised these as the start of a depression. In relation to the fainting episodes S said that he bottled things up and then it "all had to come out". At that time he felt he was in a deep depression and was considering hanging himself. S described a number of problems over the last year: change of house, death of his mother, wife's illness and difficulty with his son. On this day he was much improved and had no further suicidal ideas. He made good progress on Prozac for three weeks until an episode of 'flu set him back. S was advised to continue with his medication.
6/3/92	S was back at work and more cheerful.
25/3/92	S was seen by the SHO to Dr Rouncefield. He was much better and "now feels really good". It was noted that "He now seems almost high but I note from his previous depressive illness that that was the course of his last recovery and did not cause any problems". S was to be seen in two months.
15/6/92	S was doing well. He had been on Prozac for four months and was advised that he continue for a further two months and then stop. He was discharged from the out patient clinic unless he experienced a recurrence of symptoms. Dr Mackrell told us with

	confidence that the last prescription of Prozac on this occasion was in July and for one month. S would have ceased his medication in August. This is supported by the records.
Period 3	
24/6/96	S presented at his GP's complaining of problems at home and feeling stressed. Dr Mackrell explained to us that after 1992 S presented earlier in the course of his illness and was recognising the symptoms from before. He was not as severely ill on these subsequent occasions as he had been in 1986 and 1992. S was prescribed Prozac 20 mgs daily again.
24/7/96	Dr Mackrell noted that S was "v much better. (?slightly high)" The treatment with Prozac was continued. Dr Mackrell told us S was assessed by him to be presenting with similar problems to the past. The query in his note he felt reflected S's mood on that day.
22/11/96	S was advised to reduce his Prozac to alternate days for a month and then every third day until stopped.
Period 4	
24/11/97	S was seen by Dr Mackrell. This was very brief episode of depression lasting no more that two or three months which responded relatively fast to Prozac. S complained of 3-4 weeks of depression. His sleep and work were all right but his appetite was variable. There were no problems at home. The possibility of seasonal affective disorder (SAD) was noted.
23/1/98	S was very well. It was suggested that he continue Prozac for two months and stop. S would have ceased Prozac in March.
Period 5	
29/9/98	S presented to Dr Mackrell as depressed again having recognised his symptoms. He was re-prescribed Prozac 20 mgs daily.
27/10/98	The Prozac was helping and S was more positive.

31/3/99	S started to wean off Prozac on the basis of one every other day.
Period 6	
6/3/00	In the very early stages of this presentation S responded well to Prozac.
22/3/00	There was a sudden change and deterioration and Dr Mackrell referred him back to Dr Rouncefield and also to the practice counsellors. In Dr Mackrell's assessment this presentation was not the same as before and he was not responding to Prozac. He noted marital problems
30/3/00	Mrs S called to see Dr Mackrell regarding an incident at home with S which had frightened her. Dr Mackrell visited S that evening and the next day referred him to the practice CPN, Mr Kellow.
	After this S was seen by Mr Kellow and at the GP practice. See the next section for the detail.
3/4/00	S was seen by Mr Kellow at home. He advised a referral to Dr Rouncefield.
7/4/00	Dr Mackrell saw S who was not much better. He changed S's medication to paroxetine (Seroxat) 30 mg for a greater positive effect on the anxiety symptoms.
10/4/00	S was seen by Mr Kellow and was again quite low. He felt he could not cope without his wife.
17/4/00	S was seen by Mr Kellow and was slightly better. A colleague from work visited with whom he had worked closely for 7-8 years. This man had never met Mrs S. He found S to be quiet, shaking and withdrawn.
18/4/00	Mrs S telephoned Mr Kellow to inform him of an incident when S drove her to work and would not let her out of the car and

	confronted her with whether she was having an affair. She denied that she was seeing anyone else. S denied thoughts of self harm or harm to anyone else. He saw the GP on this day who noted that S was feeling better.
20/4/00	S seen by Mr Kellow and said he would never harm Mrs S or himself.
25/4/00	S was visited by his colleague again who thought that he had gone down hill since 17/4. It is not clear what he meant by this.
26/4/00	Mrs S was last seen at GP surgery. She commented that the divorce was going through and was given a new prescription for Prothiaden, an anti-depressant. Mr Kellow saw S at home when his wife and daughter were initially present. S appeared to be managing his situation but continued to express anxiety about the future. He denied any thoughts of harm to himself or to his wife.
28/4/00	S stabbed his wife to death with a kitchen knife at about 8 a.m.
11/12/00	S pleaded guilty to manslaughter on the grounds of diminished responsibility at Exeter Crown Court and was sentenced to three years probation and ordered to submit to treatment as determined by Dr Rouncefield, consultant psychiatrist.

CHAPTER 3

MARCH AND APRIL 2000

- **Referral to consultant psychiatrist**
- **Referral to CPN**
- **Diagnosis**
- **Treatment (medication)**
- **Internal review**
- **Conclusion.**

A list of recommendations appearing in this chapter is at page 54 (hard copy 47).

INTRODUCTION

1. Approximately one year after S saw his general practitioner on 31 March 1999 he was seen again by Dr Jonathan Leigh on 6 March 2000. It was noted that S was depressed again, but not suicidal, and that Prozac had helped in the past. He was prescribed Prozac 20 mgs as before. At about this time, his wife Mrs S had expressed her unhappiness within the relationship and that she wanted a divorce.

2. It may also be that around this time S's father told S that Mrs S had had a sexual relationship with another man in the past. There was also an incident at work when someone showed S a pornographic photograph, including a naked woman, and had jokingly suggested that it may be Mrs S. It was not, but this played on S's mind also. These two events were not known to those monitoring S until after the death of Mrs S. The precise timing of them has not been possible.

3. He was seen twice more by Dr Leigh (13 and 20 March) when an improvement was noted and S was planning to return to work. The prescription of Prozac was continued. Thereafter, there was quite a sudden deterioration in his mental state.

4. S saw Dr David Mackrell on 22 March. He complained of marital problems that he could not handle. The Prozac was not "kicking in as usual". He was not eating or sleeping well and felt worse in the mornings. He was given an anti-depressant, Molipaxin (trazodone), in addition for its sedative effects to help him sleep. S was referred to Dr Rouncefield and the practice counselling service.

5. By 30 March there appeared to have been a further deterioration. Mrs S attended the GP surgery in distress and told Dr Mackrell that S had "lost it". He had rolled on the floor and said he could not stand the thought of losing her. He had wandered into the garage and Mrs S had been concerned that he might use a knife which was in the garage. She was frightened, but he did not attack her, nor did he touch the knife.

6. This caused Dr Mackrell to visit S at home that evening. He noted that S had calmed down and told us that he seemed much his usual self. He was able to discuss how he felt and understood his problem to be his inability to adjust to the split with his wife. He said he had no thoughts of harming himself or his wife. Dr Mackrell prescribed diazepam to be taken as required and referred S to be seen by a CPN.

7. S was seen by CPN, Mike Kellow on 3 April. He advised a referral to Dr Rouncefield. On 7 April Dr Mackrell changed S's medication from Prozac to Seroxat (paroxetine). He had been shaky and anxious and not much better. Dr Mackrell hoped that the change in medication would benefit S's anxiety symptoms.

8. There is evidence that by about this time S was preoccupied with what he believed to be his wife's promiscuous activities and infidelity but the extent of his preoccupation was not known to those monitoring him.

9. By 17 April Mr Kellow noted that S seemed a little brighter and able to discuss the positive aspects of his life, but on 18 April he received a telephone call from Mrs S describing an incident when S had driven her to work but drove past her workplace and confronted her about an affair he thought she was having which she denied. S had apologised for his behaviour. On seeing him on 20 April S told Mr Kellow that he regretted his behaviour and would never hurt Mrs S.

10. Mr Kellow saw S again on 26 April. Mrs S and their daughter were present initially. S appeared to be coping though still anxious about the future. He denied thoughts of self harm or harm to his wife.

11. S never saw Dr Rouncefield or her staff grade doctor on this occasion. Delays in receiving appointments were known to be up to four weeks, but on this occasion, Dr Rouncefield was on sick leave between 25 April and 7 May, with locum cover until 14 May. This was most unusual for her. She had assigned S to her staff grade doctor on the basis that he was a known patient and would be suitable for treatment by a more junior, though experienced, doctor.

12. On the morning of 28 April 2000 S stabbed Mrs S to death. The police were summoned by S at 8.21 a.m. Mrs S showed no signs of life when they arrived. The killing of Mrs S came as total surprise to all those people, family, friends and professionals who knew S. This was an unpredictable event because there were no specific factors, above and beyond the fact of a mental illness, which could properly have alerted those monitoring S to the possibility of a risk of harm to Mrs S or to anyone else. The most identifiable risk posed by S was to himself.

Dr David Mackrell: referral to Dr Rouncefield on 24 March 2000

> "I would be grateful if you could see this man again.
> He was last seen in your Clinic in the mid-1980s with a diagnosis of depression, which responded well to treatment with Prothiaden and Pacitron.
> Since then he has had a number of relapses, which have always responded fairly quickly to treatment with Fluoxetine. He would take this for four to six months and then stop it for quite a number of months.
> [S] and [Mrs S] have had problems with their marriage for some time. He has always coped with this in the past, although, I think it has been a factor in his frequent relapses of his depression. However, it would appear that the final split is now approaching and he finds this much more difficult to cope with. He has taken Fluoxetine for two and a half weeks now, without any benefit. I have added Trazodone [molipaxin] 50 mg nocte to try and help him sleep but in view of the failure of his current treatment however, I would be grateful if you could see him in your clinic to advise on further management."

13. Dr Mackrell is a GP in practice at the Woodland Road Surgery, St Austell since1985. S had been his patient since 1991. Mrs S was also his patient. They had both been at the same surgery and patients of Dr R Adkins until 1987 when he retired.

14. Unusually Dr Mackrell had been a surgical registrar in Cornwall prior to changing to become a general practitioner and this required an extra twelve months of GP training plus six or seven months training from a prescribed list. He completed this latter training in psychiatry at St Lawrence's Hospital, Bodmin.

15. His face to face contact with the secondary psychiatric services was primarily through CPNs. Contact with consultant grade staff was largely through written referrals. Dr Mackrell was involved in few Mental Health Act assessments and possibly less that one every two years. While many of his patients may have diagnosed mental illness, they were not usually severely mentally ill enough to fulfil the criteria to be seen by a CMHT. We were left with the impression that his contact with the CMHT was infrequent.

16. Dr Mackrell told us that over the previous three episodes (1996-1999) when he had seen S for depression he had presented himself at the surgery early on in his illness and responded quickly to medication. He did not, therefore, consider there to be a need to refer to secondary services and Dr Rouncefield.

17. The criteria he applied for referral to the secondary services included the severity of an initial presentation and if it was more serious than could be dealt with in general practice, or if treatment had been tried but was unsatisfactory.

18. Dr Mackrell agreed that S had deteriorated in the period between 20 and 22 March which triggered the referral to Dr Rouncefield. In his opinion, this episode of illness did not seem to be the same as the previous ones. S had failed to respond to treatment and was simply worse this time. He felt that they had gone as far as they could with S in general practice.

19. Dr Mackrell told us that although he had recently changed S's medication, he did not like the idea of continually trying different treatments, finding that they

fail and then trying something else. Instead of waiting to see what response S made to the change, he said he felt that it was "important to get the referral underway at that stage". He accepted that there may have been an element in his thinking of referring early to compensate for the delays in the system.

20. In making that referral he anticipated a delay of up to four weeks but he had thought that S may be seen sooner by the counselling service associated with the surgery. There had been a persistently high demand for psychiatric outpatient appointments. However, at this stage he did not consider this to be more than an ordinary referral. It was not an urgent referral in his view. If he had wanted to make such an urgent referral he could have picked up the telephone to the consultant.

21. Dr Mackrell said this referral was not urgent because S was not suicidal, "he was bad enough to be referred but not so bad as to require great urgency". Dr Mackrell did not know why S had not been seen by the counselling service.

22. In his referral letter to Dr Rouncefield, Dr Mackrell focused on the marital problems as the key factor in S's presentation and that the final separation was approaching. He requested advice on further management. He told the Inquiry that this might have been drug treatment or input from psychologists if necessary. There are clinical psychologists attached to the CMHT and working within the hospital (St Lawrence's) as well. His experience was that waiting lists for such appointments were "extremely long", longer than that for the consultant.

23. Dr Rouncefield acknowledged the delay of up to four weeks for an outpatient psychiatric appointment. This particular referral was received on 28 March. The document shows when it was received and that it was given a reference number. Dr Rouncefield looked at the new referrals on the next day (Wednesday) in accordance with her usual practice and allocated patients to clinics according to their urgency.

24. An urgent referral is likely to have been given an appointment within two weeks. From the fact that she had allocated S's referral to her staff grade doctor, to be seen under Dr Rouncefield's supervision, she was able to say that she did not judge this to be an urgent referral. Her experience of S told

her that this was likely to be a straightforward case. Additionally she told us that she would have taken into account the fact that the GP had just added another anti-depressant (Trazodone). She would probably have thought that may help and so to "wait and see" was likely to have been part of her thinking on that day. Equally, S had been back on Prozac for only a few weeks and her clinical experience was that it may take longer to take effect. She was not informed of the dose of Prozac being prescribed.

25. If on reading the referral Dr Rouncefield's own assessment was that it was urgent, she may have referred it on for the attention of a CPN. At that time, however, CPN's were more GP practice based and their main source of referral was from GPs, although this has now changed. In any event she would have expected that S would receive an outpatient appointment within three to four weeks and there would have been no need to refer additionally to a CPN at this stage.

Comment

26. Delays in any system of referral to medical services are always regrettable and to be avoided if possible. A referral system must be sensitive to and capable of responding to urgent cases. In this instance we accept the referral to Dr Rouncefield was not urgent and that had it been so S is likely to have been seen sooner and probably within two weeks.

27. In spite of the fact that S was not seen by Dr Rouncefield, he was seen by Mr Kellow, CPN, a week later (see below). CPN contact is likely to have been the response of Dr Rouncefield had she considered the referral to be more urgent. The delay in being seen by Dr Rouncefield or her staff grade doctor, therefore, did not materially affect the outcome in this case.

28. The CMHT referral system has changed now so that all referrals are allocated at a specific CMHT meeting and may be allocated to a CPN in the first instance. This should mean that delays for non-urgent cases are reduced.

Dr Mackrell: referral to Mr Kellow, CPN

> "Dr Mackrell (Woodland Road) has asked if contact can be made asap with : [S] [Date of birth, address and telephone number].
> History of depression on and off over many years (both him and wife). Present marital problems wife is now leaving. Takes prozac.
> His wife found him rolling on the floor in a very distressed state.
> She went to GP and feels [S] could harm her or himself although he denies having any thoughts of harming her or himself.
> [Name] at KA will pass details on to on-call CPN as well."

29. This was precipitated by the events of 30 March when S's wife took the step of coming to see Dr Mackrell about S's behaviour. Dr Mackrell followed this up with a home visit once his day's list had ended. He agreed that there had been a deterioration in S since his referral to Dr Rouncefield on 24 March.

30. He chose to refer to the CPN rather than to make an urgent referral to Dr Rouncefield because it was his belief that the CPN would "get there quicker and, effectively, the CPN is one arm of the secondary care service and that would be the first stage of urgent intervention". He thought S needed "fairly urgent intervention" because Mrs S had expressed feelings of fear over her safety and S seemed to be getting worse.

31. When asked if he saw this as a route to the consultant if that was necessary, he said "definitely, yes". It was Dr Mackrell's understanding the contact between the CPN and consultant would be automatic and although the referral to the CPN made no mention of the earlier referral to Dr Rouncefield, this would have become known to him.

32. Dr Mackrell impressed upon the Inquiry that when he saw S he was in full control of himself and that it was the history provided by Mrs S that caused him to make the second referral. S had explained that he had become distressed about their marital problems.

33. The referral itself was not formally recorded by the person who took it at Hillyar House where Mr Kellow worked, but noted on a spare piece of paper. However, Dr Mackrell accepted that the information received by Mr Kellow was as he had imparted it.

34. In relaying the information that Mrs S was frightened Dr Mackrell was conveying Mrs S's own concerns. Dr Mackrell said he tried to establish exactly what happened regarding the knife. It was clear from what Mrs S said that S had never touched it and her fears arose out of the fact that there was a knife in the garage. His impression was that S was distressed and wandering around without any purpose. He could not establish that there was in fact a great threat; however, Mrs S was frightened and that was what Dr Mackrell responded to.

35. S has said that he had no intention of using any knife which was one of many tools he kept in the garage.

36. Dr Mackrell told the Inquiry that he saw the GP's role as one of facilitator, directing a patient to secondary services where appropriate. In his view referring to the CPN engaged the whole community team. He was less clear on the application of the care programme approach (CPA) in these circumstances.

37. Dr Mackrell had no direct discussions with Mr Kellow after this referral. He said that it would be usual either to get written feed back or some form of discussion. He was aware, however, that Mr Kellow had advised a referral to the consultant, Dr Rouncefield.

38. Dr Mackrell was asked about admitting S to hospital either voluntarily or compulsorily. He did not witness S's rolling on the floor and had assessed that as being the way he expressed his distress at his situation, some "acting out" behaviour. He did not feel that S required hospitalisation at that stage. He said that S was aware that admission was available but is unsure whether he expressly offered him admission. He related S's difficulties to marital problems which were coming to a head and obviously going to be distressing in any event.

39. As Dr Mackrell was Mrs S's GP also he knew through his consultations with her that she had had an extra-marital liaison at least four months previously. As far as he knew, S did not know about this and he said that that knowledge did not add to his concerns about S's response should he become aware of it. He thought it may have made the depression worse, but he never considered

the possibility of violence as realistic. He did not think this indicated any greater level of risk.

Comment

40. We do not criticise Dr Mackrell's decision to refer S to Mr Kellow at this point rather than to make a second and more urgent referral to Dr Rouncefield. In taking this course he achieved a further and rapid assessment of S by Mr Kellow, who continued to monitor S thereafter.

41. We also do not consider that an admission to hospital was indicated at this or any other stage.

42. The referral to Mr Kellow should have been in clearer terms. In particular, it should have noted the type and dosage of medication and that a referral to Dr Rouncefield had already taken place. It was an important piece of information conveying a heightened level of concern about S even if Dr Mackrell did not consider there to be any urgency about it.

43. Although at this time the CPNs were primarily attached to GP surgeries and known as "link CPNs", denoting a link between the surgery and CMHT, there was no contact between Dr Mackrell and Mr Kellow after this referral and we find this surprising. Dr Mackrell did say that it would be usual to get either written or oral feedback and we see this as essential.

44. The lack of communication between Dr Mackrell and Mr Kellow following this referral may, however, reflect the former's view of his role as that of facilitator. He had passed S on to the secondary services and as he saw it engaged the resources of the whole CMHT.

45. We would like to see the integration of services extend to general practices such that even once a case has been referred to secondary services, there remains a channel of communication between a GP, especially one who is still seeing the patient in the community, and the CMHT. We endorse the contents of the Cornwall Mental Health Services Care Co-ordination Handbook (April 2001) in this regard.

46. The Restormel CMHT operational policy (November 1999) sets out the role of the link CPN to GP surgeries and the need for effective communication (section 18). The implementation of this must be reviewed.

RECOMMENDATION 1

The CPT and general practices in Cornwall should review the effectiveness of communication between GPs and CMHTs.

Mike Kellow, CPN. Restormel CMHT.

47. Mr Kellow qualified as a registered mental nurse in 1988 in Norfolk. He came to work for the Cornwall Healthcare NHS Trust in 1992 when he was based at Hillyar House, a supported domestic house in Lostwithiel. His role was to support, as deputy home leader, the five patients who resided in the home. He later went on to manage the home. In about 1998/99 there was a change in his job which he said coincided with the county Mental Health Strategy and he took on a role in the community in addition and was based within the Restormel Community Mental Health Team (CMHT).

48. He said he gained experience in dealing with community-based patients through working at Hillyar House, but did not have any specific training to be a CPN. His role at Hillyar House involved working with Dr Rouncefield and they had links into the local forensic team because of Home Office involvement with some of the residents. He told us that this heightened his awareness of issues concerning risk.

49. He was an F grade nurse working largely with long term patients rather than those presenting with acute problems. He would see new referrals made by various GP surgeries, or referred to him via the CMHT. At the time in question he estimated that his work was evenly split between Hillyar House and the community patients. He carried a case load of roughly 20 - 40 patients in the community and gave the impression of having quite a heavy community commitment. He said that he was able to meet the demands of the job and took it as read that this was what he had to do.

50. In terms of training he attended various in-house training sessions provided by the CMHT although he could not recall the detail of these. He has an additional qualification in training unqualified staff in community mental health practice (NVQ D32/33). This training need was identified through supervision.

51. He described his supervision arrangements as being satisfactory. He would be seen formally by his supervisor at Hillyar House and they would go through the management of the house and discuss community patients. His supervisor would look at any mandatory training which he needed to do. This took place on a regular basis.

52. He told us that he had ready access to Dr Rouncefield to discuss cases. There was a more formal venue for this at a multi-disciplinary team meeting held on Monday mornings. There was no formal system of reviewing all patients. It was for Mr Kellow to instigate reviews of particular patients either with Dr Rouncefield or the GP.

53. When referred a patient by a GP, he said that he might discuss the patient with the GP and suggest alternative appropriate avenues of dealing with them, or he might have advised a referral to Dr Rouncefield. He said that his practice to ask the GP to refer to Dr Rouncefield was based on his view that the GP had " lot more clout than an RMN [Registered Mental Nurse] and maybe somebody could be seen quicker...". Contrast Dr Mackrell's view in paragraph 30 above.

54. He told us that if he felt there was any particular risk with a patient or that s/he needed hospital admission then again he would speak to Dr Rouncefield. At that time most of the patients he saw would have been seen by Dr Rouncefield.

55. The referral system has changed now so that all referrals are allocated at a specific CMHT meeting and may be allocated to a CPN in the first instance. We were told that CPNs may now also see a patient without input from Dr Rouncefield, a situation which in practice does not differ greatly from before. Unified records which were in place in the West of Cornwall CMHT in 2000, have also been introduced more recently to Restormel.

Comment

56. **The system of referral to the CMHT needs to be clear so that all those using it know precisely how to obtain an appointment, whether for an urgent or non-urgent case or with a doctor or CPN or other practitioner.**

57. **The new system of allocation at a CMHT meeting has simplified referral so that the confusion described by Dr Mackrell and Mr Kellow over access to an outpatient appointment with Dr Rouncefield, for example, should not now occur. There is still a need for a clear and full written referral including all relevant information and a system of feedback to the referrer. See Recommendation 1 above.**

58. **Mr Kellow was working largely autonomously at the time of the homicide, a situation which does not seem to have changed subsequently, but rather formalised together with the changes in the referral system. He said that he was not completely alone because at that time he would always discuss the discharge of a patient at least with his supervisor and the other CPN at the CMHT. He said there was regular discussion with Dr Rouncefield. These were steps that at times he took on his own initiative.**

59. **We think this is evidence of limited team working within the Restormel CMHT. It is our view that a basic requirement of team working is a system of formal review for all cases in a multi-disciplinary setting. It offers, at the least, back up to individual practitioners. The use of the CPA for all patients accepted by the specialist mental health services i.e. the CMHT, should ensure such a review takes place. We found no evidence that the requirements of CPA were actively considered for S. CPA has been a requirement since 1991 (Health Circular (90)23/LASSL (90)11 requirement). We do accept that the brief time frame within which contact with S took place would have provided little opportunity for a multi-disciplinary meeting to take place in this case.**

60. **The Restormel CMHT operational policy (10 November 1999) refers to the CPA and care packages based on complex or simple CPA. Simple CPA applies by default to those not classified as in need of complex**

CPA. Complex is defined by reference to the severity of illness, and the involvement of more than one therapist or agency i.e is provision led. The responsibilities of a key worker (care co-ordinator) under complex CPA are described (section 12), but not those working with simple CPA. Most importantly, there is no requirement for a formal, periodic multi-disciplinary review carried out systematically for all patients.

61. Mr Kellow had no specific training for working with patients in the community. He impressed the Panel as a conscientious practitioner. Nevertheless, we consider it vital that practitioners are equipped with the skills and training relevant to their caseload, in this instance patients in the community.

62. We were told by Michael Donnelly, general manager of mental health services from November 2000, that at the time he took up his post, the Trust (CHT) wide arrangements for access to training both clinical and managerial were imprecise and seemed also to act as a disincentive to accessing training.

63. The CHT produced a strategy for education, training and development dated January, 1996. In this document post registration, education and practice (PREP) requirements as defined by the United Kingdom Central Council (UKCC) for Nursing and Midwifery (later replaced by the Nursing and Midwifery Council – NMC) are described:

> "The UKCC requires all nurses to demonstrate their attendance at the equivalent of five study days in 3 years in order to maintain registration. Each registered nurse is accountable and responsible for maintaining an evidence based professional portfolio of learning outcomes gained through work experience and professional development equating to attendance at five study days in three years. It is clear that the Trust must take responsibility for ensuring that a range of in-house study days and/or secondment experiences are available for nurses to select from, that are of relevance to their current practice. Subsequent negotiation of attendance at courses and portfolio maintenance is the responsibility of the individual and will not be a function of the Training Department nor should it be the role of managers to police the fulfilment of the PREP requirement. It is anticipated that nurses will voice, negotiate and agree their development needs at IPR/Appraisal with subsequent liaison with the Training Department".

64. We have not identified any deficiencies in Mr Kellow's practice and it may be that his NVQ qualification is sufficient for the purposes of fulfilling his professional training obligations. We are not in a position to form a conclusion on this issue.

Key Points

1. **All nurses have a statutory requirement to attend the equivalent of 5 study days in 3 years and maintain a professional portfolio of learning outcomes.**
2. **The Trust has a responsibility to ensure all nurses have access to study days of relevance to their specialist area of practice.**
3. **It is the responsibility of the individual to access study days/courses in negotiation with line managers.**

RECOMMENDATION 2

The CPT should within six months:

a. review the drafting and implementation of its CPA policy and

b. ensure regular and effective audit of its use to reinforce the need for comprehensive and systematic review of <u>all</u> patients under the care of the CMHT.

RECOMMENDATION 3

The CPT's clinical supervision arrangements must include checks on the degree of autonomy being exercised by individual practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

RECOMMENDATION 4

The CPT should put in place new arrangements, within six months, to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that a practitioner's skill levels are appropriate to their caseload.

Interaction between Mr Kellow and S

65. Mr Kellow first saw S on 3 April (Monday) the referral having been received on 31 March (Friday). He had not had any contact with him previously. Mr Kellow was the lead CPN for the Woodland Road GP surgery. When seeing S he relied on the referral and his own assessment on the day.

66. The note of 3 April demonstrates a full and detailed assessment. He summarised S's problems as being a recurrence of depressive illness "due to current life situation ie marriage coming to an end after 30 years. Anxious and worried about the future. Withdrawn and de-motivated. Poor appetite. Not going out. No thoughts of suicide, self harm or harm to others expressed. No use of illicit drugs or alcohol". The plan was to contact the surgery regarding medication, a referral to Dr Rouncefield and to visit at home to monitor S's mood and medication.

67. Mr Kellow told the Inquiry that he found S to be quietly spoken, finding it difficult to express himself. He was slow in his speech. He presented in this way even after his wife left the room. Mr Kellow did not know about the referral to Dr Rouncefield that had already been made but did not think that it would have affected the level of urgency with which he considered S needed to be seen by a doctor. This was because he said he did not feel there were significant risks.

68. He had discussed risks including self harm and harm to others with S. Further S had no history of violence and no in-patient history. He had been treated for depression before and had responded to the treatment. Mr Kellow did not feel there was any indication for a Mental Health Act assessment.

69. The referral letter referred to Mrs S's fears that S could harm her or himself. Mr Kellow said that he assessed those risks directly and was confident that S's history did not indicate that he might be violent.

70. As a result of his assessment of S Mr Kellow filled out a risk assessment form. Risks to self and others were assessed as "medium". Mr Kellow said that at that time he had received no training on risk assessment although this form did come with guidance on its use.

71. Mr Kellow said his assessment was based on S's life and emotional situation. In his experience people can be volatile if they feel hurt. S's marriage was coming to an end and Mrs S assured Mr Kellow that she was not involved with anyone else. If she had said otherwise he said he would have assessed the risk as "high". She had stressed that she wanted to stay and support S and she still cared for him, but he would have assessed a higher risk of "something happening" if she had said she was seeing somebody else. He saw this as a social and domestic situation to which S was reacting in terms of his depression. If Mrs S had said she was seeing somebody else he would have advised her to leave the marital home sooner than later because living a lie, in his view, increases the risk of violence.

72. The Inquiry has no evidence that Mrs S was in fact having a relationship with anyone else at that particular time.

73. Mr Kellow was asked to reconcile his assessment of risk with the concerns expressed in the GP's referral letter. Mr Kellow emphasised that with the information he had and S's presentation he had no concerns that S was going to harm himself or others. He felt he had no reason to question S's responses to the questions he was asked around risk to himself or others. He assessed a medium risk because "when a marriage comes to an end it can possibly be an irrational, volatile time....That is not the information he was giving me, but I was still aware of that situation". His risk assessment was based on his experience and instinct and we do not criticise it.

74. He expected Dr Rouncefield to review S's mental health and the necessary treatment. The situational difficulty was to be addressed by S and Mrs S with the support of Mr Kellow. Mrs S had indicated that she was having counselling privately.

75. After 3 April Mr Kellow's impression and notes reflect his view that S had improved in his mental state somewhat. By 17 April he seemed brighter and more able to talk about living on his own and a new beginning. He considered that S was responding to the medication.

76. On 7 April S had been seen by Dr Mackrell when he was not much better and was shaking and anxious. Dr Mackrell introduced paroxetine (Seroxat) to

deal with the symptoms of anxiety and a low dose of diazepam. Mr Kellow was not aware of this change in medication.

77. Then on 18 April the incident when S drove Mrs S to work and refused to let her out of the car while he confronted her about any affair she might be having took place. Mrs S telephoned Mr Kellow to tell him about it. He said she was quite anxious and concerned. S had frightened her but later apologised for his behaviour. This did not change Mr Kellow's assessment of the situation. He still felt that S was improving and that there was nothing to indicate that violence would happen. These are things that happen when marriages end and there is friction between the partners.

78. 18 April is the last recorded attendance of S at the GP surgery prior to the death of Mrs S. He was not seen by Dr Mackrell, but it is recorded that he was feeling better.

79. When he saw S on 20 April Mr Kellow explained to S that he had frightened Mrs S. Taking into account that S was now going out of the house, arranging an MOT for his car and shopping, overall, Mr Kellow assessed S as improving. His note indicates that he discussed risk to others and S again.

80. Mr Kellow felt that he had developed a good rapport with S. He spent around one hour with him on his visits. He said the S talked freely in response to specific questions posed by Mr Kellow and for that reason he felt that he did not encounter the reserve that his family and others have subsequently referred to.

81. Further over the weeks that Mr Kellow saw S he did not notice any significant change in his physical appearance as noted by the family. He did not recall S looking grey and pale on the last occasion he saw him on 26 April before Mrs S's death. He told us that when he first saw S he was depressed and withdrawn, but that there was a change and he started engaging more, he was doing things as noted above. His speech, eye contact and social skills improved in Mr Kellow's assessment.

82. He accepted that it was unlikely that the medication would have been effective that quickly and speculated that any improvement may have been due to the natural course of the illness or his own intervention.

Comment

83. Mr Kellow's assessment of the risk S posed to himself or to Mrs S was acceptable. There is evidence that he considered the risk on each occasion that he saw S. We do consider formal risk assessment training to be vital for every member of a CMHT. In this case, even the application of a more sophisticated risk assessment tool is unlikely to have detected a measure of risk posed by S towards others, or Mrs S, sufficient to warrant more intervention.

84. Overall we consider that Mr Kellow demonstrated a good standard of practice which could be enhanced by a tightening of multi-disciplinary work and the system of formal reviews, so that he is more supported in carrying out his role.

See Recommendation 3 above.

Dr Rouncefield

85. Dr Rouncefield qualified in 1962 and was elected a fellow of the Royal College of Psychiatrists in 1984. She took up her post of consultant in adult psychiatry at St Lawrence's Hospital, Bodmin in September 1974 and retired on 31 October 2001. She is currently a locum consultant in north Cornwall and still responsible for the care of S. In 2000 she held outpatient clinics at St Austell, fourteen miles from Bodmin and was responsible, from memory, for eight to ten inpatients. She did not work on Fridays.

86. She held the equivalent of three outpatient clinics in two sessions and regularly held clinics into the evening for the convenience of her patients. At the relevant time in 2000, Dr Rouncefield did not have a senior house officer working with her but did have a staff grade doctor working six sessions who had recently returned to work after a period of absence due to illness. Often this ended up being four sessions because the staff grade doctor was involved in the teaching programme run for trainees. She was unable to say how many patients or new referrals she was dealing with at that time. She had additionally two inpatient sessions a week. She felt she was trying to "put a quart into a pint pot" in fulfilling her role.

87. The Inquiry discussed Dr Rouncefield's earlier contact with S in 1986 and the referral in 1992. We were particularly concerned to ascertain the confidence with which she diagnosed S as suffering from a unipolar depressive disorder and whether, in the context of her later change of diagnosis to bipolar disorder in December 2000, she felt that there were signs of bipolar disorder at these earlier times. She was confident that there were no such signs.

88. In relation to the change of diagnosis she told us that the level of elation she noted would not have drawn attention in the community and was clear to her at that time due to her knowledge of S. She described how S went from being quite tense and anxious to becoming bright and cheerful and confident and that it was an abrupt change. She changed his medication to introduce a mood stabiliser.

89. She agreed that it was likely that S always suffered from bipolar disorder but that he was only ever seen at times when he was depressed. She said "his mood elevation was not of a nature or degree to draw attention to it. I am sure his family must have noticed that he did have these periods….".

90. Dr Rouncefield's attention was drawn to notes in 1987 and 1992 when it was stated that S said he was feeling "wonderful" or that "he seems almost high". She maintained her view that this was not indicative of a bipolar disorder. She said that sometimes people are relieved when they emerge from depressive illness and she would not necessarily think that S was "going high". With hindsight it may be indicative of a bipolar disorder but at the time she was not alerted to this possibility.

91. After seeing S in 1986 Dr Rouncefield did not see him again. He was seen in the outpatient clinic in late 1986, early 1987 and 1992 by her senior house officer (SHO). Dr Rouncefield told us that because S had a history of major depression responding to medication he was suitable to be seen by the SHO in 1992. SHOs see patients all the time she told us, depending on the stage of their training. She would choose cases for her SHOs based on their level of expertise. There was nothing improper in her view doing so with S even after a six year gap because illnesses do recur. She said she always checked the SHO's notes and would see him or her the following day to talk about the cases if she had not seen the patients herself.

92. Dr Rouncefield emphasised that staff grade doctors, on the other hand, have usually undergone full training in psychiatry and are knowledgeable and experienced. On receiving the referral of 24 March 2000 Dr Rouncefield assessed S to be a suitable case for the staff grade doctor under her supervision.

93. The Inquiry sought the response of Dr Rouncefield to the GP entries on 30 March and the subsequent entries by Mr Kellow on 18 and 20 April (see Chronology, chapter 2) with a view to ascertaining what she is likely to have done had she seen S.

94. She agreed with Dr Mackrell's view that rolling on the floor may have been S's way of demonstrating his distress to his wife. If he was just depressed and not experiencing marital problems he may not have felt the need to behave like that. She also agreed that the fact that Mrs S was frightened by S's behaviour on 30 March, sufficient to actually go to the surgery and report her concerns rather than make a telephone call, was important and had to be taken note of. She said that this could have increased the urgency with which the referral to her needed to be treated, but noted that the CPN had been contacted.

95. Dr Rouncefield did not agree that the CPN is likely to have had a quicker route to her. She said the GP would have had as much access to her. The referral by Mr Kellow via the GP did fit the way things were done at that time. A new referral would come via the GP at the instigation of the CPN. She is likely to have treated a re-referral as a matter of priority.

96. There is some evidence from Dr Rouncefield's secretary that Mr Kellow liaised with Dr Rouncefield's office about S. Mr Kellow does not recall making any telephone call to Dr Rouncefield, although we have been told that "liaise" may refer to him coming to the office. On balance, we feel it is unlikely that Dr Rouncefield was aware that S was to be re-referred to her.

97. Dr Rouncefield's evidence regarding the incident on 18 April was somewhat clouded by knowledge she has gained subsequently through her ongoing contact with S. Her response was clearly influenced by information given to her by S after the homicide, that Mrs S had male callers at her work place, thus providing, in her view, a possible factual basis for S's behaviour when he

took Mrs S to work and questioned her about whether she was having an affair, refusing to let her out of the car. As a result initially in evidence she did not see that this is likely to have been a frightening event for Mrs S and interpreted it from S's perspective, but later accepted it must have been frightening.

98. Dr Rouncefield said that, at the time in question, she would have sought to speak to Mrs S about this incident to find out why she was frightened. She assumed that S would have told her that he thought Mrs S was having an affair and meeting a man at her work place. This may again be a reflection of her subsequent relationship with S, rather than of her relationship with him at the time. She would have last seen him in 1986. She said she would have assessed the risk S posed to Mrs S.

99. The Inquiry wanted to determine whether there was any basis in fact to S's fears about Mrs S having an affair at this time or whether they might have been delusional. From Dr Rouncefield's evidence it would appear that S had been told by his father prior to the homicide that Mrs S had had an affair and that the man called to see her at her work place. We have been unable to date when he might have been told this information with any accuracy. We conclude, as Dr Rouncefield did, that given what S is likely to have been told about Mrs S conducting an affair at her work place, S was not acting under any delusions at this time.

100. Another event which had occurred prior to the homicide, but was not known about until after and cannot be dated precisely, is that S had been shown a pornographic photograph at work by a colleague who had suggested that it looked like his wife. It was not Mrs S and was intended as a joke. Dr Rouncefield has discussed this with S after the homicide. He said that once he knew that Mrs S was capable of having an affair he could not rule out that it was her in the picture. S confirmed this to the Inquiry also. Prior to the killing, however, it seems that S did hold a belief of Mrs S's participation in pornographic activities the intensity of which may have been delusional.

101. Had Dr Rouncefield been aware of the incidents of 30 March and 18 April she told us it is likely that he would have been seen sooner in outpatients by a doctor. She considers that this was evidence of an escalation in the situation

between S and his wife that was related to his depressive illness and was also a reaction to the fact his marriage was breaking up. Dr Rouncefield would have sought to ascertain more of the facts such as why Mrs S was frightened and would have talked to both S and his wife about the relevant events. She is unlikely to have offered a change in medication because Dr Mackrell had recently (7 April) changed S's medication to paroxetine and it would have been too early to determine its effects or to change it. Again it is unlikely that an admission to hospital would have been considered appropriate in the absence of an assessed (or assessable) risk to Mrs S. If on discussion it emerged that Mrs S was really frightened of S, Dr Rouncefield is likely to have advised her to move out of the matrimonial home.

102. Dr Rouncefield was clear that from her reading of the notes shown to her S was not presenting with a severe mental illness and likely to cause harm to himself or someone else. She did not think that the notes indicated grounds for detention in hospital either compulsorily or voluntarily.

Comment

103. <u>Diagnosis</u>. S had been diagnosed as suffering from a major depressive illness in 1986, namely, unipolar (agitated) depression. This diagnosis remained undisturbed until some time after the killing of Mrs S when in December 2000 Dr Rouncefield diagnosed and instituted treatment for bipolar affective disorder.

104. Prior to that the only other diagnosis that had been considered was seasonal affective disorder because four of the first five episodes of depression occurred in the latter half of the year, coinciding with autumn and the onset of winter.

105. It is clear from Dr Rouncefield's evidence that even in December 2000 the evidence of S's mood swing to a "high" did not include the classic symptoms which characterise this illness (bipolar affective disorder). There was a mild elation which she, through her knowledge of him, was able to detect as likely to be a hypomanic phase in his illness.

106. Entries in the notes prior to this were drawn to her attention which in retrospect may indicate the existence of such a mood swing during, or at the end of previous episodes of depression. Her evidence is that at the time, they were insufficient to support a change of diagnosis.

107. S's family recalled him becoming disinhibited and even verbally aggressive when ill. They associated this with his medication, Prozac. Their description of S's behaviour at this time is similar to his behaviour in December 2000 when his diagnosis was changed. This behaviour was not known to S's general practitioner, nor available during S's earlier periods of illness.

108. An earlier diagnosis of bipolar disorder is likely to have led to the introduction of a mood stabiliser, such as lithium, which may have averted the sudden deterioration in his condition in April 2000. However, even without such a diagnosis and treatment there is currently no evidence that untreated bipolar disorder is likely to increase the risk posed to others. Further, S's own personality and history showed him to be a very passive individual and any perceived risk was more realistically that he might have harmed himself rather than anyone else.

109. We accept Dr Rouncefield's evidence that there was insufficient evidence recorded during earlier episodes of depression indicating a diagnosis of bipolar disorder. This conclusion is supported by the expert evidence the Inquiry received.

110. In our view, S was suffering from a major depressive illness, complicated by his marriage breaking down and the existence of some delusional symptoms focused on his beliefs regarding his wife's infidelity, the intensity of which was not known to those caring for him.

111. Treatment. The families of S and Mrs S have raised serious concerns over the possibility of a link between the prescription of Prozac (fluoxetine) and the killing of Mrs S by S. It is their view that Prozac caused or contributed to the actions of S on 28 April 2000. They were unaware that S's medication had been changed to Seroxat on 7 April This is a highly controversial issue and the Inquiry sought expert

guidance on it, including the impact of the change of prescription to Seroxat (paroxetine) on 7 April 2000 which was continued until the change in diagnosis in December 2000. We stress that we cannot come close to providing a comprehensive overview of the available literature surrounding this debate and aim simply to set out some of the features of it.

112. There has been much publicity in the last three years or so surrounding the side effects and the addictive nature of these drugs. The issue of addiction does not arise in the case of S. We have clear evidence of prescription and withdrawal of Prozac following treatment.

113. Prozac is the world's most widely used brand name antidepressant and prescribed to more than 38 million people in 100 countries. It was the first of the new breed of selective serotonin re-uptake inhibitor (SSRI) antidepressants, of which Seroxat is also one, marketed as having fewer side effects than the older antidepressants.

114. Prozac was first marketed in 1988 but since the mid-late 1990's links with suicidal tendencies and more recently (2000) to violent crimes including homicide, have been investigated. There has been substantial publicity of such findings by the national press and media[5].

115. While there is no evidence that Prozac is itself a cause of suicide, there is some evidence that for those prescribed Prozac and other drugs in the same family (SSRI's), the frequency of suicide is higher than for patients on the older tri-cyclic antidepressants[6].

116. Another clinical trial, said to be the first of its kind, found that akathisia (a strange, restless and agitated state of mind) could affect one in ten of adults prescribed Prozac resulting in belligerence and the possibility of a risk to others. This study was publicised in the Observer newspaper[7]. Previously such studies were discredited due to the possibility that

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[5] Most recently *Panorama,* BBC, October 2002 and May 2003.

[6] See for example, Donovan et al (2000), *Deliberate self-harm and antidepressant drugs,* , British Journal of Psychiatry 177, 551-556.

[7] *Spiral of violence blamed on Prozac* by Anthony Browne, Health Editor, The Observer, 12 March 2000.

aggressive behaviour could be caused by a patient's personality. This new study claimed that Prozac could affect even healthy individuals.

117. Paradoxically, and fuelling the controversy, other studies have investigated whether Prozac together with traditional psychotherapy could reduce aggression and are based on studies showing that SSRIs could decrease acts of aggression[8].

118. Our expert, Professor Robert Kerwin, questions the relationship between Prozac and homicide. He cites research[9] which found that while "patients may experience anxiety and restlessness, there is no definitive excess of aggression connected with fluoxetine. In fact much research suggests SSRI's have a net anti-aggressive effect". The conclusion was that "in the absence of convincing evidence to link SSRI's causally to violence and suicide, the recent lay media reports are potentially dangerous, unnecessarily increasing the concerns of depressed patients who are prescribed antidepressants". He acknowledges however, that isolated incidents will occur.

119. The BBC's *Panorama* programme has recently aired a significant amount of anecdotal evidence of a link between Seroxat, deliberate self-harm and serious thoughts of committing violent acts, in some people in the first few weeks after prescription. The programme was careful to state that Seroxat is beneficial for the majority of people who are prescribed it and the programme was aimed at improving data sheets and information to patients.

120. CONCLUSION. This Inquiry is not in a position to come to any conclusion on the likely causal effects of either Prozac or Seroxat in the killing of Mrs S. The possibility cannot be discounted. The family of S recall his being disinhibited and verbally aggressive in the past when they say he was on Prozac. Unfortunately this is not documented. It is impossible now to come to a conclusion as to whether such behaviour prior to 2000 constituted akathisia. The description of S's behaviour

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[8] Trials by the National Institute of Alcohol Abuse and Alcoholism, Maryland, USA are ongoing.

[9] Walsh MT., Dinan TG. (2001) Selective serotonin reuptake inhibitors and violence: a review of the available evidence. Acta Scandinavia.

would suggest that it did not reach the level of severity described in clinical studies.

121. The family do not report such behaviour in the days preceding the death of Mrs S and state instead that he was pale and withdrawn. He had been on Prozac since 6 March and then Seroxat from 7 April, i.e for nearly three weeks before the death of Mrs S. The episode when S rolled on the ground was on 30 March and does indicate a significant level of distress at that time. There are no reports of nightmares or homicidal ideas and the records do show that he was asked about the latter by both Dr Mackrell and Mr Kellow on several occasions. On the other hand, it is tempting to use the possibility of a link with a drug side effect to explain what has been to everyone an inexplicable and totally surprising event; completely out of character for S.

122. The Inquiry's role has been to judge the prescription of Prozac and Seroxat to S against the standards prevailing at the relevant time. Our expert has told us that in 1992 the prescription of Prozac was the "gold standard" for unipolar (agitated) depression. He has also noted that S showed periods of improvement on Prozac.

123. Our expert has also endorsed the change in prescription to Seroxat (paroxetine) on 7 April, stating that it was acceptable practice. Paroxetine has a milder side effect profile and is better for agitated depression as Dr Mackrell stated in evidence.

Internal review

124. The recommendations and action plan of the internal review conducted by Mark Steer, then CHT assistant director of nursing, and Dr Mary Lindsey, medical director, were placed before the CHT board in July 2000. They were:

I) The unification of health records. It was recognised that the lack of unified records did not have any direct impact on the care and treatment of S, but that it was possible to envisage other similar situations in which it may have done so. The Inquiry has been informed that unified records are now used by Restormel CMHT.

II) The location and availability of rooms for outpatient clinics at St Austell. This was to be reviewed with a view to achieving flexibility of the available facilities.

III) The lack of medical time and its contribution to the delay for appointments. This was attributed to the health problems faced by the staff grade doctor assisting Dr Rouncefield and the lack of junior The referral and communication process between primary and secondary care and with the CMHT was to be reviewed.

IV) The unification of local risk assessment tools was proposed.

125. The terms of reference for the internal review were set by the then Chief Executive of the CHT, Frank Harsent on 2 May 2000:

a. "to establish the chronology of interactions between the Trust's staff and [S]
b. to examine the actions taken by the Trust staff and form an opinion on their appropriateness

V) to review the use of risk assessment and the care programme doctor support. An in-depth investigation of workload and availability of consultant time was to be undertaken.

VI) The administrative systems for acknowledging referrals and booking outpatient appointments were to be reviewed throughout the CHT.
a. approach for [S]
b. to recommend changes for the management of similar patients as a result of any lessons learnt".

126. While the report to the Board makes no reference to the actions of individual practitioners and the action plan focuses on procedure and system, the report produced does provide such an evaluation of the decisions by Dr Rouncefield and Mr Kellow. In particular, recommendation at VI above reflects an assessment that there was a "lack of structured communication within the healthcare team [which] suggests that clinicians supporting [S] were working in isolation without the benefit of their colleagues' contribution to the care plan…..".

127. The procedure was commenced on 3 May 2000 and interviews completed by 16 May 2000. All interviews were conducted by Mr Steer and Dr Lindsey.

Comment

128. We are satisfied that the internal review fulfilled its terms of reference and made relevant and useful recommendations for future practice. Its findings mirror those of this Inquiry and our findings and recommendations are intended to reinforce and build on those made by the internal review. The Panel has been advised by CPT that the recommendations from their internal review were implemented in October 2000.

129. The CPT Serious Untoward Incident Policy was not available at this time and was ratified by the Board subsequently on 27 June 2000.

Conclusion

130. S was suffering from a depressive illness in the context of marital difficulties, involving suspicions of his wife's infidelity, at the time of the homicide. He was not coping with these problems.

131. There is no evidence of an increased risk to others caused by depressive illness. S has always been known as a gentle, unassuming man, and the greatest risk he posed at times of illness was to himself.

132. It seems clear that his depressive illness deteriorated at the end of March 2000 and as he became more focused on the possibility of his wife's infidelity. He was seen and monitored by a CPN from 3 April and had he been seen by Dr Rouncefield or her staff grade doctor at this time, it is unlikely that she would have changed his medication because it had recently been altered by his GP. Any identified risk to Mrs S would have resulted in advice to Mrs S to move out of the marital home. There is no evidence that S presented a serious risk of harm to Mrs S at any time.

133. The mode of referral to the CMHT should have been clearer and such as to minimise the risk of delays in patients being seen, but the standard of practice of the individual practitioners involved was reasonable throughout.

134. Sadly, the death of Mrs S was a tragic accident which could not have been predicted. S acted in a way which was totally out of character for him and could not have been assessed as presenting a serious risk of harm to her or anyone else. It is likely that the combination of the very particular features of his life at that moment in time, namely, depression, marital breakdown and his suspicions regarding the infidelity of his wife, contributed to his killing Mrs S.

135. It is understandable that S's family should seek a more concrete answer to why S acted as he did and that they should now focus on his medication as a possible factor, especially given the recent publicity surrounding SSRIs. It is correct to say that there is no evidence supporting a causal link between the prescription of Prozac or Seroxat and homicide. The swell of anecdotal evidence in this regard means that such a link cannot be discounted in the future. Judged by the standards of reasonable practice of the time, the medication prescribed to S cannot be criticised.

LIST OF RECOMMENDATIONS

RECOMMENDATION 1

The CPT and general practices in Cornwall should review the effectiveness of communication between GPs and CMHTs.

RECOMMENDATION 2

The CPT should within six months:

a. **review the drafting and implementation of its CPA policy and**
b. **ensure regular and effective audit of its use to reinforce the need for comprehensive and systematic review of all patients under the care of the CMHT.**

RECOMMENDATION 3

The CPT's clinical supervision arrangements must include checks on the degree of autonomy being exercised by individual practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

RECOMMENDATION 4

The CPT should put in place new arrangements, within six months, to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that a practitioner's skill levels are appropriate to their caseload.

The Panel has been advised by CPT that the recommendations from their internal review were implemented in October 2000.

APPENDIX A

TERMS OF REFERENCE

HOMICIDE INQUIRY: S

The remit of the inquiry is as follows having been discussed and agreed with the Chief Executive of the South West Peninsula Health Authority

1. With reference to the homicide that occurred on 28th April 2000, to examine the circumstances of the treatment and care of S by the mental health services, in particular:

   (i) the quality and scope of his health, social care and risk assessments;

   (ii) the appropriateness of his treatment, care and supervision in respect of any of the following that are relevant:

      a) his assessed health and social care needs;

      b) his assessed risk of potential harm to himself or others;

      c) any previous psychiatric history, including drug and alcohol abuse;

      d) the number and nature of any previous court convictions;

      e) statutory obligations, national guidance (including the Care Programme Approach HC(90)23/LASSL(90)11, Supervision Registers JSG(94)5, and the discharge guidance HSG(94)27) and local operational policies for the provision of Mental Health Services

   (iii) the extent to which S's prescribed treatment and care plans were

      a) documented,
      b) agreed with him,
      c) communicated with and between relevant agencies and his family
      d) carried out,
      e) complied with by S

2. To examine the appropriateness of the training and development of those involved in the care of S

3. To review the structure of the internal inquiries into the care of S

4. To consider such other matters relating to the issues arising in the course of the inquiry as the public interest may require

5. To prepare a report and make recommendations as appropriate to the South West Peninsula Health Authority

The following schedule of documents will be used by the panel in undertaking its inquiry:

1. All medical records relating to S, including all hospital records whether as an inpatient or outpatient, GP records, all records prepared by any other Doctor or Nurse

2. All medical records of S relating to his treatment whilst a patient at Hospital

3. All documents relating to S in the possession of the Social Services Department

4. All documents relating to S in the possession of the Education Departments

5. All records relating to S in the possession of the Probation Service

6. All documents in the possession of the Police relating to the investigation into the death of Mrs S and the subsequent prosecution of S

7. All documents in possession of the Home Office relating to S including the C3 Departmental records

APPENDIX B

Inquiry procedure

Introduction

1. The Inquiry is independent of its sponsors.
2. The Inquiry will be known as "the independent inquiry into the care and treatment of S".
3. All hearings of the Inquiry will be held in private: this means that the press and other media will not be allowed to attend hearings. There will be no cross examination of witnesses except by members of the Inquiry panel and counsel for the Inquiry panel.
4. Witnesses will be given an opportunity to comment on the evidence of others where relevant and necessary and as provided for below by way of written representations (see paragraphs 10, 17 and 18).
5. The Inquiry hearings will be conducted as informally as possible. The role of counsel[10] will be predominantly to lead the evidence and to ensure that the views of all those participating in the Inquiry process, and in particular the victim's family, are properly and fully canvassed in evidence (see paragraph 16 below).
6. Factual evidence will be sought from a) those working for the agencies/services involved with S at the relevant time, b) "lay" witnesses, being family, friends or others with direct knowledge of S and not within the identified agencies/services.
7. Advice may be sought from relevant experts on practice issues.

Written evidence

8. Each factual witness will receive letters informing them:
   a) of the terms of reference and the procedure adopted by the Inquiry
   b) of the proposed timetable for the Inquiry

[10] Note: no junior barrister was appointed in this inquiry

c) of specific areas and matters on which the Inquiry wishes them to provide evidence in addition to anything the witness him or herself wishes to raise

d) of the method of accessing records relevant to their own role in the care of S for the limited purpose of responding to the Inquiry.

9. Witness evidence is to be provided in writing in the first instance: written statements will provide the basis for any oral evidence which the Inquiry may deem necessary.

10. Not every witness written to will automatically be invited to give oral evidence unless this is specifically requested by the witness with reasons.

11. All witnesses asked to provide written evidence will be provided with a list of factual witnesses written to so that they may i) indicate whether in their opinion any material witness has been omitted and ii) suggest areas of inquiry with any of the proposed witnesses.

Hearings and oral evidence

12. Details of venue and recoverable expenses incurred in attending to give oral evidence will be provided at the time a factual witness is notified by the Inquiry panel of the need for such evidence. Witnesses will be offered an opportunity to familiarise themselves with the venue in advance of giving evidence.

13. Witnesses attending in person to provide evidence may raise any matter they feel might be relevant to the Inquiry.

14. Witnesses may bring with them, at their own personal cost, a lawyer or a member of a defence organisation, friend, relative, colleague or member of a trade union, provided that no such person is also a witness to the Inquiry: it is the invited witness who will be expected to answer questions. It is expected that if required agencies/services will provide legal assistance to staff/officers from whom evidence is requested by the Inquiry.

15. Factual witnesses will be asked to affirm that their evidence is true.

16. Questions asked will take into account representations made by the family and other factual witnesses or agencies or professional bodies and any advice received from experts.

17. Oral evidence will be recorded and a transcript sent to the relevant witness to check for accuracy.

18. Any points of potential criticism concerning a witness of fact which may be material to the Inquiry's findings will be raised with that witness either directly at the time they first attend to give evidence to the Inquiry in person or in writing at a later time. They will be given a full opportunity to respond (usually in writing). A summary of any relevant evidence or, if appropriate an extract of the same, will be provided by the Inquiry for that purpose.

19. 18 above will also apply to any matter which falls short of a criticism but where the evidence of one witness may be material to that of another.

Other evidence

20. Representations may be invited from relevant professional bodies, agencies and individuals as to their views and any recommendations on the issues arising, including on the present arrangements for persons in similar circumstances to S

Victim's family

21. The family of Mrs S will be given a full opportunity to contribute to the Inquiry process and to consult with the Inquiry. In particular, family members will:

    a) Be provided with copies of the terms of reference and procedure
    b) Meet informally with the panel members, counsel and/or the Inquiry manager
    c) Be asked to provide a list of potential witnesses together with issues/questions they consider to be relevant
    d) Be provided with a list of proposed witnesses prior to hearings for their comments and questions
    e) Give formal evidence to the Inquiry
    f) Be provided with a copy of the final Inquiry report.

Publication of report

22. Findings of fact will be made on the basis of the evidence received by the Inquiry. Comments that appear within the narrative of the report, and any recommendations, will be based on those findings.

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

24. The findings and any recommendations of the Inquiry will be presented in a report and made public by the Health Authority.

APPENDIX C

List of witnesses

1. Witnesses interviewed by the Panel (* one member of the Panel)

S*	**Subject of Independent Inquiry**
Mr M Kellow	**Community Psychiatric Nurse, Cornwall Healthcare Trust**
Dr D Mackrell	**General Practitioner**
Dr A Rouncefield	**Consultant Psychiatrist, Cornwall Healthcare Trust**

2. Witnesses who provided written and/or informal interview/telephone based evidence to the Panel

Dr R B Adkins	**General Practitioner**
Mrs W Bough	**Medical Secretary**
Mr W Avery	**Friend of S**

3. Expert witness who provided written advice to the Panel

Professor Robert Kerwin	**Professor of Clinical Neuropharmacology, Institute of Psychiatry, University of London**

4. Witnesses who were contacted informally for evidence.

TS*	**S's daughter**
MS*	**S's brother**
AS*	**Mrs S's sister**

APPENDIX D

List of recommendations

RECOMMENDATION 1: Chapter 3, Page 34 (Hard copy Page 27)

The CPT and general practices in Cornwall should review the effectiveness of communication between GPs and CMHTs.

RECOMMENDATION 2: Chapter 3, Page 38 (Hard copy Page 32)

The CPT should within six months:

a. review the drafting and implementation of its CPA policy and

b. ensure regular and effective audit of its use to reinforce the need for comprehensive and systematic review of <u>all</u> patients under the care of the CMHT.

RECOMMENDATION 3: Chapter 3, Page 38 (Hard copy Page 32)

The CPT's clinical supervision arrangements must include checks on the degree of autonomy being exercised by individual practitioners and the balance struck between this autonomy and multi-disciplinary and multi-agency working.

RECOMMENDATION 4: Chapter 3, Page 38 (Hard copy Page 32)

The CPT should put in place new arrangements, as a priority, to ensure staff are able to access relevant and timely in-service training, identified via supervision and appraisal, and that a practitioner's skill levels are appropriate to their caseload.

The Panel has been advised by CPT that the recommendations from their internal review were implemented in October 2000.