County Durham and Tees Valley NHS
Strategic Health Authority

REPORT OF THE
INDEPENDENT INQUIRY
INTO THE CARE AND TREATMENT
OF GEORGE LEIGERS

June 2006

CONTENTS

PREFACE

A panel consisting of the persons listed below was established by County Durham and Tees Valley Strategic Health Authority in October 2005 to undertake an inquiry into the care and treatment of George Leigers.

Mrs Anne Galbraith, OBE, LLB, Chairman	Formerly a senior lecturer in law at University of Northumbria, and a member of the Lord Chancellor's Council on Tribunals. Chairman of the Valuation Tribunal Service, and vice chairman of the council of the University of Durham.
Professor Don Grubin, MD, FRCPsych	Professor of forensic psychiatry, Newcastle University and (hon) consultant forensic psychiatrist, Northumberland, Tyne and Wear NHS Trust.
Ms Rachel Morphew, BA, MSc, C.Psychol, AFBPsS	Chartered forensic psychologist for HM Prison Service, head of psychology at HMP YOI Castington and HMP Acklington. Previously worked as a researcher in the NHS and local government.
Mr William Morgan, BA, DASS	Retired psychiatric social worker and lecturer in social policy, Newcastle University. An associate member of

	the Association of Psychiatric Social Workers and the British Association for Behavioural and Cognitive Psychotherapies. Lay member of the Mental Health Review Tribunal.

A GP adviser and a specialist in root cause analysis were retained to provide expertise and advice to the panel:

Dr David Smart, MB ChB, DRCOG, MRCGP	General practitioner, Dunelm Medical Practice, Durham City and Bearpark, Durham
Dr Keith Farmery, BSc, PhD	Consultant in clinical governance and risk management

We now present our report, having had regard to the terms of reference set down for us by the authority.

Anne Galbraith

Prof D Grubin

Rachel Morphew

Mr W Morgan June 2006

Chapter 1

Background to the inquiry

1.1 This inquiry was established by County Durham and Tees Valley Strategic Health Authority, following on from the guidance contained in the NHS Management Executive document HSG (94) 27, which requires such an inquiry to be held where there has been a homicide committed by a person who has been receiving mental health services. This guidance was amended in 2005 through a Department of Health paper entitled "*Independent Investigation of Adverse Events in Mental Health Services"* and now requires the independent inquiry to employ a process called root cause analysis in order to facilitate openness, learning lessons and creating change. The central issue for the panel concerned what lessons could be learned for the future from the incident, which formed the subject of the inquiry. That is the purpose of this inquiry.

1.2 The incident leading to this inquiry concerned the murder of a young woman on August 6 2003 in Middlesbrough. On August 12 2003, George Leigers flagged down a police car in Inverness and informed officers of his address and that he had committed a murder in his bedroom. Police in Middlesbrough were alerted to this and found the body at 11 Montrose Street, George Leigers' home. George Leigers was returned to Teesside and charged with murder. The trial took place in April 2004 and George Leigers was sentenced to life imprisonment with an order that early release provisions should not apply. Shortly before the trial commenced a Home Office direction was given that George Leigers be transferred and detained in Rampton Hospital under the Mental Health Act 1983. This took effect

after the trial and George Leigers remains in Rampton Hospital, which is a high security hospital for individuals detainable under the Mental Health Act.

1.3 In March 2005, George Leigers appealed against the early release provisions order. The appeal was heard at the Independent Inquiry of Appeal, Criminal Division in London. The appeal was allowed and the minimum period to be served by George Leigers set at 21 years and 193 days before he would become eligible for consideration for early release by the Parole Board.

1.4 Some delay occurred in the setting up of the inquiry whilst advice was sought from the Department of Health on the revised guidance for inquiries, panel members were approached and confirmed, and agencies involved with George Leigers given an opportunity to comment on the draft terms of reference. The panel was able to start preliminary work from July 2005 prior to the announcement of the inquiry at the health authority meeting in October 2005.

1.5 George Leigers received mental health services over a long period starting in the 1980s, from a number of NHS organisations and other agencies. In his more recent history he received care from the Tees and North East Yorkshire NHS Trust, the Avenue Community Nursing Home, his general practice and from social services. George Leigers was also in receipt of services from New Horizons (an organisation whose services include supported living schemes, peer support groups and grants) and was both in contact with, and working in, a voluntary capacity for STAMP, (the South Tees Advocacy in Mental Health Project). All these services were provided in Middlesbrough.

1.6 The inquiry panel met on a number of occasions in the summer of 2005 to determine its method of working, and to decide which records, documents and publications it required. Work was then put in hand to obtain these. It also received a presentation on the technique of root cause analysis. Dates were fixed in advance for panel meetings and the oral hearings to minimise delays.

1.7 The approach to the conduct of the inquiry adopted by the panel was based on the experience of earlier panels, in County Durham, Teesside and elsewhere.

1.8 This report is the result of the combined views and opinions of all the panel members, who have participated fully in its drafting.

Terms of reference for the inquiry

1.9 The terms of reference established for the inquiry panel are set out in *Appendix A.*

Obtaining records and documents

1.10 George Leigers was approached via his solicitor to obtain consent for the release of all the records relating to his care and treatment.

1.11 The panel also identified general practice, NHS Trust, social services policy documents, independent inquiry records and documentation and reports summarising the findings of earlier inquiries, which were regarded as essential preparation for the inquiry. Additional documents were obtained from Rampton Hospital and New Horizons and the panel had access to copies of press cuttings. The documents

the panel had access to are listed in a bibliography in *Appendix B.* The panel is grateful to those who played a part in locating, gathering and compiling the necessary documentation.

Witnesses

1.12 In parallel with the assembly of records, the panel met and decided who they wished to meet in person to discuss further the care and treatment of George Leigers.

Preliminary meetings

1.13 The panel recognised that the inquiry would be stressful for the parents of the victim and decided that it was appropriate for the chairman to offer to meet with them in advance of the oral hearings, to explain the terms of reference and to answer any questions they might have. This offer was accepted and a constructive and useful meeting resulted with the parents who were accompanied by a worker from victim support. They also chose to meet with the panel as a whole during their sittings and were also accompanied for this meeting.

1.14 Contact was established with a relative of George Leigers who had kept in touch with him in recent years, to offer a meeting prior to the hearings, for the same purpose as the meeting with the victim's parents. This was not taken up.

Visit to Rampton Hospital

1.15 The panel visited Rampton Hospital in October 2005. George Leigers had agreed to meet with the panel and he was interviewed by the clinical members of the panel in the presence of his solicitor. This meeting was later joined by other panel members. In addition the panel also met with other members of staff at Rampton currently caring for George Leigers, including his psychiatrist, named nurse and a ward manager where George Leigers was held. During the visit the panel had access to records kept at the hospital. The panel wish to place on record their thanks for the courtesy and assistance they received from Rampton Hospital staff on the day of the visit and beforehand.

Oral hearings

1.16 Decisions were taken about the order in which the panel wished to meet those invited to oral hearings, but this inevitably required some flexibility to accommodate the availability of those concerned. The letter sent to those invited to attend oral hearings is reproduced at *Appendix C.*

1.17 A small number of those attending were accompanied by a professional colleague or supporters from the voluntary sector. Two attendees had moved job within the same organisation they were employed with at the time of caring for George Leigers, one had moved to a similar role with another organisation and one had retired from paid employment. One person declined to meet the panel when invited to do so, but they referred the panel to some case notes they had created at the time of their contact with George Leigers of which

the panel subsequently acquired a copy. An additional witness came to the attention of the panel during the hearings and arrangements were subsequently made for this person to meet with the panel on another occasion.

1.18 All those attending the oral hearings were given an overview by the chairman of the process being adopted, including information about note taking, the order in which the panel would put their questions, how the draft report would be prepared, what the likely timescale would be, and the opportunity which would be afforded for further comment and response at draft stage to anyone who might be the subject of criticism in the draft. Written notes were taken at the hearings and the draft evidence sent to each of the attendees for them to comment on any matters of factual accuracy with a deadline for reply. Comments were received back from six attendees, of whom one confirmed that the record was correct. Four did not respond. Any comments received from the remaining witnesses were passed on to the panel and the record amended.

Expert advice

1.19 The GP adviser attached to the panel made a suggestion for an additional witness which the panel acted on, attended some of the hearings where staff with a particular responsibility for primary and community care were interviewed taking a role in the questioning, made written contributions and took a full part in the drafting of this report.

1.20 The root cause analysis consultant made an initial presentation to the panel about the principles of root cause analysis and was consulted

about the content of the report as it was being drafted. He made a number of constructive suggestions, which assisted, with the compilation of the report.

1.21 Pharmacological advice was sought on the effects of taking lithium in the period immediately before a blood test was required.

The report

1.22 At the close of the oral hearings, the panel members took time to formulate their thinking about the key issues which had emerged during the hearings and from the written material gathered. A working draft of the report was then prepared by the chairman, with appropriate contributions from members of the panel, which was considered in detail at a number of meetings of the full panel. Revisions were made in the light of the drafting meetings.

1.23 The panel also agreed those sections which needed to be circulated in draft form to one of the parties who might be subjected to criticism, to allow the person concerned a full opportunity to comment further. Once their response was received, the panel chairman then gave it consideration, and further re-drafting was undertaken where appropriate.

NHS organisational changes

1.24 During the lifetime of the inquiry a number of NHS organisational changes took place. These did not affect the panel's work but are recorded here for clarity. The Tees and North East Yorkshire NHS Trust merged with the County Durham and Darlington Priority

Services NHS Trust to form the Tees, Esk and Wear Valleys NHS Trust with effect from April 1 2006. County Durham and Tees Valley Strategic Health Authority will merge with Northumberland, Tyne and Wear Strategic Health Authority to form the North East Strategic Health Authority with effect from July 1 2006. Throughout this report the former organisational names are used because the former arrangements applied during the main part of George Leigers' contact with health services covered by the inquiry terms of reference.

1.25 The panel wish to acknowledge the assistance of administrative and facilities staff at Teesdale House (the headquarters of County Durham and Tees Valley Strategic Health Authority) who made an essential contribution to the smooth running of the inquiry.

Chapter 2

A synopsis of the offence

2.1 The event giving rise to this inquiry was a murder committed by George Leigers in August 2003.

2.2 In 1986, George Leigers killed his wife. At the court hearing in connection with that killing, George Leigers was found guilty of manslaughter, the court having accepted that his responsibility for his actions was substantially diminished on the basis that he was suffering from a severe depressive illness at the time of the killing. He received a hospital order under the provisions of S.37 of the Mental Health Act 1983, together with a S.41 restriction order.

2.3 Between 1986 and 1993, George Leigers received inpatient care, mainly at St Luke's Hospital, Middlesbrough. He was conditionally discharged into the community in September 1993, when he took up residence at the Avenue Community Nursing Home. George Leigers subsequently moved to independent accommodation in February 1997.

2.4 In January 1999, the Home Office directed his absolute discharge from the restriction order that required him to comply with psychiatric follow-up and treatment. However, he continued to receive support on a voluntary basis from the multi-disciplinary team, and S.117 aftercare. He also maintained regular contact with workers from New Horizons, and with the advocacy service STAMP.

2.5 Although George Leigers' continued involvement with mental health services was entirely voluntary from January 1999, he nevertheless

continued to be compliant with regular depot injections of the antipsychotic medication depixol. In March 2003, a decision was taken that George Leigers no longer required aftercare under S.117 of the Mental Health Act 1983, and in consequence he was discharged from psychiatric and social work follow up.

2.6 In August 2003, in his home in Middlesbrough, George Leigers murdered a young woman who had been working as a prostitute. While on remand, he was transferred to Rampton Hospital for assessment and treatment, primarily because of concerns regarding his risk of self harm. In April 2004, he was convicted of murder, and sentenced to life imprisonment. He remained in Rampton Hospital as a transferred prisoner under S.47 and S.49 of the Mental Health Act 1983.

2.7 Following the conclusion of all criminal proceedings and a subsequent appeal, this independent inquiry was established.

Chapter 3

Consideration of the terms of reference

Introduction

3.1 At the heart of this inquiry is the question of whether George Leigers had a mental disorder at the time of the offence in August 2003, and if so, the nature of that mental disorder. The terms of reference also require the panel to investigate whether there was any deterioration in George Leigers' mental condition in the period leading up to the offence.

3.2 In order to determine their view on the matters under review across the whole spectrum of the terms of reference, panel members had access to a wide variety of records for the period between 1993 and 2003, the period specified by the terms of reference. However, when appropriate, panel members extended their inquiries with witnesses and from the records to earlier periods in order to have a more complete understanding of George Leigers' mental state, and his progress over the period under review. Reference sources are listed in *Appendix B.*

A brief overview of George Leigers' mental state up to 1993

3.3 The clinical records show that George Leigers had suffered from recurring episodes of a severe depressive illness commencing in about 1982 associated with unresolved grief problems following the death of his baby daughter in 1979, and violence towards his wife. When seen by Dr K in September 1983, he was thought to suffer from a schizo-affective illness, (a condition that presents with symptoms of both depression and schizophrenia), likely to render

him insightless and cause him to behave in an impulsive and unpredictable manner. He was admitted to hospital for two brief periods, and then continued treatment as an outpatient. He was prescribed antipsychotic medication, which was discontinued in May 1985 as his mental state had shown a sustained improvement.

3.4 During this period George Leigers on occasions disappeared from home for days at a time, wandering to different parts of the country. In April 1986, during one of these absences from home, he stole money from a man on a train in London, after threatening him with a pocket knife. In August 1986 he was given a two year probation order with a condition of medical treatment, but before this treatment commenced, he murdered his wife in September 1986 (the first offence). The records available from that time include the report from the consultant psychiatrist, Dr S, who saw George Leigers while he was on remand in Durham prison. Dr S concluded that George Leigers suffered from severe personality limitations and that he had been seriously affected by mental illness, which had only incompletely remitted at times. Dr S believed that due to lack of treatment, George Leigers' psychiatric condition deteriorated to a severe depression of psychotic proportion, with his irritability and agitation causing tension and friction at home. He concluded that George Leigers gave the clinical impression of being a schizoid personality who lacks initiative.

3.5 There was a further report provided at that time by Dr MS, a consultant forensic psychiatrist. Her view was that at the time of the murder of his wife, George Leigers was suffering from a depressive psychosis. She went on to say that although there was no positive evidence to indicate the presence of schizophrenia, there were

features of the case that suggested this diagnosis should be borne in mind. Tests done at that stage showed that George Leigers was of average intelligence.

3.6 Following the murder of his wife, George Leigers was treated in St Luke's Hospital, Middlesbrough from 1986 to 1993, first in a secure unit in the hospital, and latterly on an open ward. At the time when he was being considered for conditional discharge in 1993, records indicate that he showed no overt signs of psychosis or mood disorder. His mental state was noted to be stable and clear of any active mental illness or behavioural disturbance. It was considered that he was not currently suffering from mental illness which was of a nature or degree which required inpatient hospital treatment.

3.7 While an inpatient in 1988, George Leigers was seen by Professor E, the professor of psychiatry at University of Newcastle. His view was that George Leigers suffered from chronic schizophrenia, although this diagnosis does not appear to have been accepted by the clinical team responsible for his treatment.

3.8 In March 1992, following an episode of absconding from hospital, apparently associated with a failed relationship with a woman in hospital, George Leigers appears to have suffered a relapse of his depressive illness, but this responded to an increase in his antidepressant medication, and by August 1992, his mental state had again stabilised. There had also been some reports that George Leigers appeared to have been responding to auditory hallucinations involving the voice of his dead wife, but this was not clear cut. When seen by Dr F following this incident, George Leigers was noted to be very tense and quiet, and he told Dr F that he was scared that what

had happened to his first wife could happen to the woman with whom he was having the relationship in hospital, which is why they had split up. By 1993, in a report for a Mental Health Review Tribunal, Dr B stated that his mental state seemed to be stable and clear of any active mental illness or behavioural disturbance.

3.9 It was at this point (January 1993) that Dr B recommended that George Leigers should be conditionally discharged from hospital once a suitable and adequate placement could be identified. A Mental Health Review Tribunal held in June 1993 deferred a conditional discharge until such arrangements as appeared satisfactory to the tribunal could be made. At this time, visits were already being made by George Leigers to the Avenue nursing home, which was considered to be suitable for his needs. However, there was some confusion about the legal status of the Avenue, as to whether it was a hospital or a nursing home, and discharge was delayed until this could be resolved.

3.10 This matter was subsequently clarified in correspondence with the Department of Health in July 1993, and in consequence, a further Mental Health Review Tribunal was held in September 1993 at which George Leigers was conditionally discharged, subject to him residing at the Avenue Community Nursing Home and remaining under the psychiatric supervision of Dr N and under the social work supervision of TS. He was conditionally discharged on September 24, 1993. At that time he was being prescribed antidepressant medication, lithium (a drug commonly used to prevent or delay relapse in mood disorders), and a two weekly injection of the antipsychotic drug flupentixol. The latter two medications continued to be prescribed up to the time of the killing, although unknown to those responsible for

his treatment, George Leigers appears to have stopped taking the lithium, possibly about two years before the killing.

3.11 **Panel comment.** The panel has sought to clarify the diagnostic understanding of George Leigers' condition at the time of the conditional discharge. Although a number of diagnoses were suggested during his inpatient stay, it appears that those treating George Leigers concluded that he had been suffering from an affective disorder (that is, psychotic depression), which by 1993 was in remission. The panel understood from Dr N that this was the diagnosis he was working to when George Leigers was discharged in 1993, a conclusion with which the panel is in agreement.

3.12 The panel has particularly noted (see paragraph 3.8) entries in the clinical notes dealing with the period immediately after George Leigers absconded from hospital in March 1992, which documented George Leigers' concern that a woman with whom he was in a relationship could be at risk from him. This risk, however, was never set out explicitly in any subsequent documentation.

3.13 **Panel comment**. The panel regards it as a significant omission that the risk inherent in George Leigers forming a new relationship was never explicitly set out in any documentation created after this date. This matter is further developed at a later stage in this report.

Term of reference 1a - George Leigers' mental state post September 1993

3.14 Dr N took over George Leigers' care in June 1993, a few months before his conditional discharge. As indicated above, it was his view

that George Leigers suffered mainly from an affective disorder (that is, a mood disorder). In discussions with the panel, Dr N made clear that over the ten years that he saw George Leigers, his mental state was consistently stable with no signs of acute psychopathology. He was aware that the possibility of schizophrenia had been raised at an earlier stage, but in his view there was no evidence of schizophrenia, either in terms of acute or chronic symptomatology. He also considered there to be no particular evidence of a personality disorder. Dr N was aware that there had been a long term issue about George Leigers hearing voices, but they appeared to be closely associated with anniversaries relating to the death of his wife, and Dr N did not view these to be psychotic in nature.

3.15 In discussion with other witnesses who had contact with George Leigers between 1993 and 2003, the panel sought their observations on George Leigers' mental state. One of the staff of the Avenue (Mrs F) reported that she saw no signs of clinical depression, hallucinations or voices, and although she accepted that the first murder could have been committed during a psychotic episode, she did not think that George Leigers was psychotic later. Another of the qualified staff at the Avenue (Mrs B) believed that George Leigers suffered from a schizo-affective disorder (which is a condition characterised by abnormality in mood together with psychotic symptoms more typically seen in schizophrenia), but she too did not observe any abnormalities in his mental state.

3.16 The community psychiatric nurse (CPN) who took over George Leigers' care between 1996 and 2001 indicated to the panel that over that period, George Leigers was stable. He would get fed up,

reacting to things such as his back pain, but he never showed signs of clinical depression or mania.

3.17 BW, the approved social worker who saw George Leigers on a weekly and latterly monthly basis between 1997 and 2003, indicated that he was George Leigers' social supervisor. He reported that he saw no signs of mental illness, with no manifestations of depression or schizophrenia. In the social supervisor's view, George Leigers' main problem seemed to be a physical one of getting to sleep.

3.18 The GP with whom George Leigers was registered, Dr C, indicated that his working diagnosis for George Leigers was psychotic illness. He was aware that there had been some earlier variation of opinion around depression and schizophrenia. However, during the period George Leigers was registered with him, (1993 – 2003) the GP viewed him as mentally well, although until March 2003, the GP was only responsible for the physical care of George Leigers and for ensuring the prescribing, compliance with, and, in part, the administration of his medication. Monitoring of his mental state was a shared responsibility until March 2003, when his psychiatric care was fully transferred to the GP.

Expert views on George Leigers' mental state at the time of the second trial

3.19 Two major psychiatric reports were prepared on George Leigers for his trial in 2004. They reached very different conclusions about his mental state before and at the time of the second offence.

3.20 The first report was prepared for the Crown by a consultant forensic psychiatrist, Dr SB. After an exhaustive review of documentation and three interviews with George Leigers, he concluded that George Leigers did not suffer from personality disorder or mental illness, and his opinion was that George Leigers did not suffer from any abnormality of mind at the time of the offence that would have diminished his responsibility for the killing.

3.21 The second report was prepared for the defence by an emeritus professor of forensic psychiatry, Professor G. After a similar exhaustive review of documentation and two interviews with George Leigers, Professor G expressed the view that George Leigers “has a pervasive persistent disorder of personality; he has a recurrent depressive disorder; the core features of schizophrenia are absent in this case; but George Leigers does have a non organic psychotic disorder, which includes chronic hallucinatory psychosis”.

3.22 Despite the radically different views expressed in these two reports, both experts found George Leigers fit to stand trial and fit to plead.

Evidence of mental state in the immediate period of the second murder

3.23 The panel has also taken note of all the evidence from witnesses and from police statements taken shortly after the second murder regarding George Leigers' reaction and behaviour in the period around the time of the murder, in order to shed some light on his state of mind at the time leading up to and immediately after the killing.

3.24 On August 5, the day before he committed the offence, George Leigers had called in at the Avenue nursing home to have his hair cut. This was something he was in the regular habit of doing. Mrs F from the Avenue discerned no apparent change in his mood or his behaviour. She commented that she had been qualified as a registered mental nurse for over thirty years, and she believed that she would have picked up anything different about George Leigers' presentation or demeanour.

3.25 A friend of George Leigers' reported that he had seen George Leigers in the Princess Alice pub on the evening before the murder, where George Leigers was involved in a quiz with one or two other regulars in the pub. He reported that on that occasion, George Leigers “was his normal friendly self and nothing appeared out of the usual”. In his statement to the police, the friend noted that George Leigers “seemed fine, he told me he had arranged for his medication to be brought forward from the Friday of that week to the Wednesday as he was going to Scotland that Thursday. George Leigers "was fine the last time I saw him”.

3.26 Although George Leigers himself gave a later account that he had “just snapped, cracked” because he heard “the wife’s voice”, which suggested a frenzied attack upon the victim, it is clear from the documentation that the killing was a sustained and extended attack on her. The trial judge’s account, for example, described it as a dreadful and torturing killing, where the duration of the assault had been some 30 to 45 minutes. Within a very short space of time, George Leigers had cleaned himself up and visited the local shop to buy cigarettes, explaining away his scratches by telling the shopkeeper that he had fallen down the stairs.

3.27 Quite early that same morning, George Leigers telephoned Mrs B at the Avenue, as was his normal habit on days when he went to work at STAMP, the advocacy project. This call would regularly occur at about 8 am, and he made that call as usual on the day of the murder, quite a short time after he committed the offence. He had also called in at the Avenue the day before the offence, just as he usually did, when Mrs B observed nothing amiss.

3.28 Shortly after his call to Mrs B, George Leigers then went to the GP practice for his regular depot injection. These were given at two weekly intervals. As usual, he was the first person there, and on the day of the offence the sister at the practice described him as being "no different, had spoken as usual, showed no evident change in his behaviour and had arrived early". In her statement to the police given shortly after the murder, the sister noted that George Leigers "appeared to be his usual self, calm and polite".

3.29 After leaving the GP practice, George Leigers went to meet a colleague with whom he worked at STAMP. In a statement to the police at the time, the colleague reported that, "specifically, every Wednesday, George Leigers would assist me with a stall located in the Cleveland Health Centre foyer. On Wednesday, August 6, 2003, George Leigers and I met and carried out our regular routine, which is at 9.45 to 10 am, George Leigers met me in the Cleveland Centre car park. On this day, it was just before 9.50 am. As we set out to the stall I noticed George Leigers rubbing his right hand. He told me he had sore knuckles as he had been "jumped by a druggie on the way home from the pub last night and indicated he had beaten up the druggie. We sat and chatted like normal. There was nothing at all different or unusual."

3.30 A friend of George Leigers, in his statement to the police, reported that he spoke to George Leigers on the telephone during the afternoon of the day of the murder, when “he seemed fine and I didn’t detect anything unusual in our telephone conversation”.

3.31 In the evening of the day he committed the offence, George Leigers went out for a drink to the pub, where he met a woman friend. She is the only person who notes in her statement to the police that George Leigers did not seem his normal self. She reports that George Leigers “didn’t greet me in the normal way in that he didn’t give me a cuddle, it was obvious there was something wrong with him”. She did however report that he had showed her the bruising to his hand, saying he had injured it falling down the stairs.

3.32 George Leigers then appears to have stayed in his home that night. He told the psychiatrist who prepared the report for the Crown that he spent the night downstairs. The next day, August 7, he travelled to Penzance, arriving on August 8, where he paid in advance for four nights’ bed and breakfast. However, he left Penzance the next day, August 9, travelling to London and then taking a coach to Inverness. By his account, he denies having returned to Middlesbrough during this period but he did not arrive in Inverness until the morning of Monday August 11.

3.33 There is some uncertainty about events over this time, as Mrs F from the Avenue reported to the police in her statement that she saw him on Friday 8 August, “when he turned up during the day his behaviour was completely normal. I can say this with professional certainty. There was nothing said or done that caused me concern. We again chatted about his trip to Scotland”. The meeting with Mrs F is

included as one of the statement of facts in the case summary on behalf of the Crown at George Leigers' trial, where it was said that George Leigers had brought some walking boots which he offered to her, and although he was there for only a few minutes, his behaviour was perfectly normal and there was nothing causing her concern.

3.34 The case summary also refers to George Leigers having been seen outside his home in Montrose Street at about 6.50 am and 11 am on August 8 by his neighbours. In their report, they state that he seemed to be still at home on August 9.

3.35 What is clear is that by 1.30 am on August 12, George Leigers was in Inverness, when he flagged down a police car and reported the murder. He told the police officers that he had arrived in Inverness at about lunchtime the previous day, August 11. He was seen relatively quickly by a consultant psychiatrist, who did not find any indication of mental illness.

3.36 The panel heard evidence with regard to George Leigers' demeanour during the period of his journey back to Teesside with police officers. They travelled by train, and during the journey George Leigers is reported to have said very little. Once back on Teesside, however, his demeanour and behaviour was noticed to deteriorate, particularly after the commencement of formal interviews with him and his defence solicitor. He required medical assessment on several occasions, and was noted to be visibly shrinking, bowing his head and starting a rocking motion.

3.37 The next report available to the panel was from a consultant forensic psychiatrist with the Tees and North East Yorkshire NHS Trust, who

conducted a regular session at Holme House Prison in Stockton. He saw George Leigers on August 19, 2003, as prison staff were concerned about the risk of George Leigers harming himself. On mental state examination, the consultant found that George Leigers "was clearly low in mood. I found his affect to be blunted" (by which he meant that George Leigers was emotionally unresponsive and his emotional expression was flat). The psychiatrist went on to observe that he did not find any evidence of formal thought disorder, as is found in schizophrenia, although there was considerable depressive content. The psychiatrist concluded that in his current mental state George Leigers was at high risk of deliberate self harm, and he sought his admission to hospital in conditions of maximum security for treatment.

3.38 As a consequence of this referral, George Leigers was assessed by Dr Z, consultant forensic psychiatrist from Rampton Hospital. In his report on his mental state examination, Dr Z indicated that he did not elicit any gross impairment of cognitive functioning, nor did he elicit thought disorder. He did not find George Leigers to be paranoid, nor could he elicit any obvious delusions. George Leigers was not thought to be depressed or elated in his mood. George Leigers reported that he continued to hear the voice of his deceased wife saying "why, why," but he did not elaborate on any other hallucinatory experiences, nor did he report any other psychotic symptoms such as passivity or interference with his thoughts.

3.39 Dr Z went on to conclude that based on the information available, there was reason to at least suspect that George Leigers might be suffering from a mental illness even though it was not possible to elicit any clear symptoms of it during one interview with him. He

recommended that George Leigers should be admitted to Rampton Hospital for a full and comprehensive assessment to fully clarify his diagnosis and also to determine whether a personality disorder had any role in the index offence.

3.40 **Panel comment.** At the time of the first killing, George Leigers was found to be suffering from a depressive psychosis, which had resolved by the time of his conditional discharge in 1993. Based on the witness statements and the oral accounts heard by the panel, there is nothing to suggest that this illness had relapsed at the time of the second killing.

3.41 The panel came to the same view as the Independent inquiry, that is, that mental disorder was not the cause of the second killing. In particular, the panel found no evidence to indicate that George Leigers was suffering from depression at the time of the second murder; there was no depressive content to his talk, no change in his interactions with other people, his functioning remained at a high level, no-one involved in his care reported any deterioration in his mood or presentation, his concentration was good, and his self care remained of a high standard.

3.42 The panel is aware of the report for the defence, where Professor G expressed the view that George Leigers was good at concealing feelings and thoughts. While this may be the case, the panel does not believe that this would have extended to him being able to conceal a severe depressive illness of a nature that would have led to a killing, particularly in the light of evidence that when George Leigers was depressed in the past, his symptoms were obvious. The panel is aware that George Leigers was still taking psychotropic

medication at the time of the second murder, largely unchanged since 1993. The panel notes, however, that this medication was being prescribed as a preventative measure rather than as a treatment for acute symptoms, and there is nothing to suggest that his failure to take lithium as referred to above had any particular effect on his mental state.

3.43 The panel gave consideration to the question of whether George Leigers could have been suffering from schizophrenia at that time of the second murder as this diagnosis had been raised a number of years ago. With the passage of time, however, George Leigers did not demonstrate any symptoms consistent with schizophrenia nor the deterioration in functioning characteristic of this illness. Over the years, George Leigers occasionally reported hearing his wife's voice, or less frequently that of his deceased baby daughter's, but this was related to a bereavement or grief reaction rather than indicative of an underlying mental illness. In the view of the panel, there is no evidence to support a diagnosis of schizophrenia.

3.44 The panel further gave consideration to whether George Leigers may have been suffering from a personality disorder at the relevant time. Personality disorder is distinct from mental illness, and refers to enduring and pervasive abnormalities in the way in which a person thinks, experiences emotion, and behaves. In this respect, the panel has taken particular note of Professor G's suggestion of such a condition. However, the panel considers that in the light of interviews with a wide range of people who had regular social and professional contact with George Leigers over an extended period, there is no evidence of any behaviour or personality characteristics indicative of such a severe abnormality in his personality; he does not meet the

criteria for any of the personality disorders contained in the standard psychiatric classifications used by psychiatrists, the *International Classification of Diseases, 10th Edition, (ICD 10)* and *the Diagnostic and Statistical Manual, 4th Edition (DSM-IV).*

Term of reference 1b – is there evidence that George Leigers' mental state deteriorated in the months preceding the offence?

Introduction

3.45 The panel's finding that George Leigers was not suffering from a mental disorder at the time of the second killing is of relevance when considering evidence regarding whether George Leigers' mental state deteriorated in the months preceding the offence. The panel has considered a number of strands of evidence that could provide an indication of a possible deterioration in George Leigers' mental state. These strands of evidence also influenced the panel's thinking when forming the view expressed above that George Leigers was not suffering from mental disorder at the time of the second killing.

Hearing voices

3.46 Over the long period of George Leigers' care, there are frequent references to "voices" in the notes and records. Many pre-date the period specified in the panel's terms of reference. However, in order to gain some insight into any relevant pattern, and to determine whether this was a problem which was improving or deteriorating, the panel has assessed some of this earlier material.

3.47 The first manifestation of these voices appears to have been in 1986, shortly before he killed his wife. There had been friction between

them regarding his failure to attend psychiatric appointments, and he indicated that in the two weeks before the killing he heard her voice telling him it was his fault that he was not receiving appropriate treatment. Subsequently, in February 1987, some five months after the killing, while a patient at the Hutton Centre and in the context of a moderately severe depressive illness, he reported hearing the voice of his wife calling out his children's names, and asking "Why did you do it?"

3.48 These auditory hallucinations continued over the following months, and it was noted at a case conference in March 1988 that George Leigers was being prescribed the antipsychotic drug stelazine. He was thought to have no insight into these hallucinations, believing them truly to be the voice of his wife.

3.49 By 1990, at which stage George Leigers was in a non secure ward in St Luke's Hospital, it was noted that he continued to have auditory hallucinations, which were present most of the day, but which he could put to the back of his mind much of the time. A report prepared for a Mental Health Review Tribunal in May 1990 indicated that the auditory hallucinations were more intrusive and troublesome when his mood was low.

3.50 In a July 1994 case conference, it was noted that George Leigers still experienced auditory hallucinations, hearing his wife most days saying "Why did you do it?" but it was also noted that he indicated that this did not trouble him unduly. Similar accounts of the voices being less troublesome or disturbing are recorded for May 15, 1995. By April 1996, the record indicates that while the voices were still there, George Leigers ignored them. By January 1998, George

Leigers indicated that there was some background of his wife's voice saying "why" but it had not bothered him for years as he said he was used to it.

3.51 The panel questioned witnesses as to their recall of the extent of the auditory hallucinations, and the effect if any they had on George Leigers. Dr N indicated that George Leigers would sometimes mention his wife's voice, but that had been a long time ago. Mrs F, a registered mental nurse from the Avenue who had been his key worker for a period, indicated that she was never aware of the voices that George Leigers was supposed to have heard. Mr W, his social worker, asked George Leigers about whether he was hearing voices, but told the panel that George Leigers would reply that he was OK and there was not a problem. Mrs B from the Avenue indicated that he claimed to have heard intimidating voices at his wife's death which told him to hit her.

3.52 There is limited comment on this matter in the two reports prepared for George Leigers' trial. In the report prepared for the Crown, the consultant psychiatrist who saw George Leigers on three occasions indicates that George Leigers told him that he had heard the voice of his wife constantly from around the time he killed her repeating the word "why" over and over again, and that this was constant "twenty four hours a day". George Leigers told the psychiatrist that since he stopped taking lithium two years ago, the voice had gradually got louder. Up to the point where he stopped taking the drug, George Leigers indicated that he felt "alright" within himself. The voices were still present, but he was not getting depressed as much.

3.53 In relation to the murder of his victim, when asked by the consultant psychiatrist who prepared the report for the Crown to say what made him “snap” and commit the murder, George Leigers replied, “the wife’s voice”.

3.54 When interviewed by Professor G for the defence, George Leigers told him that after the death of his first baby, a little girl born prematurely, he had taken to spending hours at her grave, having conversations with her. He was insistent that she answered him back and they were able to discuss things. Subsequently, the voice was that of his deceased wife. The professor considered that these hallucinations “might be attributed to either schizophrenia or the recurrent depressive illness, were it not for the fact that the core features of schizophrenia are absent in this case, and the voices themselves do not have a particularly depressive quality”.

3.55 Panel members also had the opportunity to interview George Leigers in October 2005. George Leigers indicated that he perceived himself in the period just before the offence as “bottling things up” and “going downhill”. He stated that he was listening to the voice of Pat, his deceased daughter, more, but he did not refer to the voice of his wife. He said that he did not tell anyone about this, as he did not want to go back to hospital. He indicated to panel members that he was aware of the risks of listening to Pat, and though he did not tell doctors that her voice was bothering him, he would have done so had they asked.

3.56 When giving an account of the index offence to panel members, George Leigers stated that when he and his victim were in the bedroom having sex and he “could not finish it” because he had lost

his erection, he lay there for a while listening to the voice of his daughter Pat saying “kill”. This is in contrast with what he appears to have told the consultant psychiatrist who prepared a report for the Crown where George Leigers is noted to have said it was “the wife’s voice” that made him snap. After the killing, George Leigers told panel members that Pat was quiet for around ten minutes to half an hour.

3.57 **Panel Comment.** The panel accepts that in the past George Leigers probably did hear voices and that these were likely to have been at their most intense at the time of his baby daughter’s death and at the anniversary of his wife’s murder, or other significant anniversaries. It is the view of the panel that these hallucinations took place in the context of a grief reaction rather than a mental illness per se, and agrees with Professor G that the quality and nature of the voices were not consistent with either a schizophrenic or a depressive illness. In any case, the evidence indicates that the voices decreased significantly in importance and intensity in recent years, to the extent that George Leigers himself reported that they were not troubling for him. The panel considers that the reliability of his later self report regarding their pervasiveness is questionable. The panel does not consider that hearing voices was a significant factor leading up to the second murder.

Compliance with medication

3.58 Over the period covered by the terms of reference (1993 – 2003) George Leigers was on a stable regime of medication. Prescribing was undertaken by George Leigers' GP, Dr C under the advice of the consultant forensic psychiatrist, Dr N. It consisted of a regular depot injection of depixol 40 mg, once every two weeks, tablets of the antidepressant dothiepin, which were discontinued at the end of 1998, and lithium 1250 mg a day, which was supplied in quantities of 140 x 250mg tablets each month.

3.59 Depixol is used to prevent a relapse of symptoms in schizophrenia or psychosis more generally, or to prevent relapse in mania. The panel understood that in George Leigers' case, it was given to prevent a relapse of the psychotic symptoms associated with depression. George Leigers did have psychotic symptoms when this medication was first prescribed, when there was also a lack of clarity about his diagnosis. The panel can find no evidence that the dose or indeed the need for depixol was ever reviewed, either while George Leigers was an inpatient, or during his subsequent care as an outpatient.

3.60 George Leigers was usually absolutely regular in his attendance for the depot injection. He originally received it at the Avenue, but this was transferred to the GP surgery in 1994. All the evidence available to the panel points to him being an early attender at the GP surgery on the dates fixed for his appointment, where he seemed to be keen to have the first appointment and then to go about his other activities. There were only two occasions in the ten years covered by the terms of reference when he failed to turn up at the appointed time. One was on July 25, 2002. On this occasion, the GP notes indicate that

he came the next day when the depot was administered, explaining that his failure to attend the previous day was because he got the weeks mixed up. The other occasion was in July 1997, when George Leigers went absent from home for a couple of days. This incident is dealt with in greater detail below.

3.61 This combination of medication was what George Leigers was being prescribed when he was discharged from St Luke's. His GP, Dr C, indicated to the panel that he would not have changed it without seeking advice from the consultant forensic psychiatrist. George Leigers presented to Dr C as being mentally well, and thus Dr C saw no reason to question the medication regime.

3.62 Lithium is used in the acute treatment of depression and mania, and as a means of delaying or preventing relapse of these conditions. Regular blood tests are necessary to ensure that appropriate blood levels are achieved as too high a dose of lithium can have serious side effects, such as kidney damage, while too low a dose is non therapeutic. The panel has concluded that in George Leigers' case, the lithium was being prescribed to maintain stability of mood and to prevent a relapse of depression. George Leigers' lithium levels were monitored at three monthly intervals and a renal function test was undertaken at six monthly intervals. Although it had been suggested at one stage by the Tees and North East Yorkshire NHS Trust that lithium monitoring could take place at six monthly intervals, Dr C had been keen to retain the three monthly check as this accorded with the recommendations set out in the British National Formulary. Dr C's practice records indicate that lithium levels were mainly found to be within the therapeutic range. There is a point in the summer of 1999 when the records show that from June to November the lithium

dose was decreased slightly, but this resulted in his lithium blood levels falling into the non therapeutic range and the previous dose was restored. At a care programme approach (CPA) meeting on November 22, 1999, it is stated that “George Leigers' mental state appeared to be stable, and he did not himself report any problems”.

3.63 Because the lower therapeutic levels can be related to the reduced dosage, there is no reason to suppose that George Leigers was experimenting with withdrawal from lithium at this stage. At this time the notes made by those seeing him regularly do not show any relapse or deterioration in his mental state. Indeed, there are regular comments such as “George Leigers his usual cheerful self” and “George Leigers was as usual welcoming. Nothing to indicate he was low or mood”, and “George Leigers continues to remain mentally well”, “George Leigers cheerful and said he was feeling mentally well”.

3.64 In Dr C’s view, the only thing which he regarded as unusual about George Leigers' use of lithium was that he took it in a divided dose, whereas other patients took it in a single night time dose. Dr C had inherited this arrangement, and saw no reason to change it. As has been referred to earlier, it appears that George Leigers may have stopped taking lithium in 2000 or 2001, but he continued to collect his prescription regularly and his lithium blood levels continued to fall within the therapeutic range, probably because he resumed taking the tablets in the period immediately before his blood test was due, according to his own report.

3.65 The consultant forensic psychiatrist who prepared the report for the Crown noted that George Leigers gave differing accounts of exactly

when he ceased to take lithium regularly. For example, he told the police in Inverness that it was a few weeks before the killing. When interviewed by the local police in Middlesbrough, he indicated that he had stopped taking it a few months prior to the offence. He indicated to Dr Z when interviewed by him at Holme House that he could not remember how long ago he stopped taking the lithium, and on another occasion, he indicated that it was two years since he had taken the drug. The panel noted, however that when his house was searched by the police, nearly 2000 lithium tablets were found. The panel is of the view that George Leighers' self report on this matter is unreliable.

3.66 The GP notes refer to lithium monitoring at regular intervals. Using the longest period mentioned by George Leigers as a frame of reference, namely two years since he stopped taking the drug, tests after August 2001 were carried out on the following dates, with the following results: November 15, 2001 (level 0.69 mmol/L); March 7, 2002 (level 0.64 mmol/L); July 11, 2002 (level 0.68 mmol/L); September 20, 2002 (level 0.8 mmol/L); December 24, 2002 (level 0.79 mmol/L); March 7, 2003 (level 0.84 mmol/L); May 29, 2003 (level 0.76 mmol/L). The therapeutic range was set at 0.4 to 1.0, the moderately toxic range was 1.0 to 2.0, and the severe toxicity level was >2.0. All of the tests over the period when George Leigers has alleged that he had withdrawn from taking lithium are seen to be within the therapeutic range.

3.67 The relevance of the impact of withdrawing from his lithium medication is heightened in this case by an entry which George Leigers made in his diary after the offence. It read, “Killed again.

Should have taken my medication". As he was regularly attending for his depot injections, this almost certainly refers to the lithium.

3.68 The panel has also given consideration to the impact of the withdrawal of lithium on George Leigers' mental state. If he had indeed stopped taking the medication two years before the offence, then there is little evidence of any discernable change in his mental state over that period even though he was in regular contact with a range of professionals who knew him well, and none of them discerned any deterioration in his mental state. The panel has also been informed by Dr J, the consultant psychiatrist with current responsibility for the care of George Leigers at Rampton, that although George Leigers was on lithium when admitted to Rampton, this has subsequently been stopped with no impact on his mental state.

3.69 The panel has taken account of the fact that after 1999 George Leigers was a voluntary patient, and under no obligation to comply with any particular regime. By that time, he was also living independently, and it seems clear that much of his social contact was in public houses, where he was a regular. His level of alcohol consumption may not have been out of the ordinary in the culture that existed locally, but George Leigers may have thought that there were choices to be made about withdrawing from lithium if he wished to drink socially.

3.70 **Panel comment.** In the view of the panel, the relevance of George Leigers not taking his lithium tablets has been overstated in many of the reports of this case. Given his absolute discharge in 1999, after which George Leigers was under no obligation to continue with any

regime of medication, it is difficult to know why he chose to stop taking it surreptitiously, although this may suggest that he did not fully understand his discharge. It is also difficult to know why he himself never raised the issue of stopping lithium with any of the professionals who were caring for him. The panel does not consider there to be any causal link between the alleged withdrawal from a regular regime of lithium medication and the second killing.

September anniversaries, self harm, and wandering off to remote places

3.71 There are references in various notes and reports about George Leigers to indicate that he suffers from lower mood regularly at the times of anniversaries such as his wife's birthday. There is also some apparent linkage between times of low mood and decisions by him to "take off" unexpectedly, often to quite distant locations. Although this is documented regularly at earlier stages, more recent notes and records do not make much of this feature.

3.72 The panel heard from a number of witnesses that the impact of anniversary dates had diminished. It was a feature of George Leigers' care that was highlighted for staff at the Avenue when he was discharged there in 1993. In the early stages of his stay at the Avenue, his behaviour would change and he would pace about and stay up all night. He might sleep with the light on. Latterly, this behaviour was less pronounced as his confidence increased. As low mood at the time of anniversaries had been flagged up to all the staff involved in his care, the panel considers it likely that staff would raise the matter with George Leigers, possibly giving a somewhat over emphatic view of the extent to which anniversaries continued to be a problem for him.

3.73 The panel is aware that there are numerous references in the notes and files to risk of self harm or to attempts by George Leigers to overdose on tablets. On occasions, this was identified by George Leigers himself, and there is not necessarily any external evidence of such an attempt. Some of these events occurred earlier in his history, connected with his unhappiness in the army, or the birth of his second daughter whom he feared might die as his first daughter had done, or in connection with his relationship with his wife. On one occasion, he overdosed on paracetamol, but he then telephoned his brother and was taken to hospital. When he was an inpatient in the Hutton Unit at St Luke's Hospital, suicidal gestures and threats were not uncommon, but by 1990, there is evidence in the notes that George Leigers was denying any suicidal feelings, there had been no recent attempts and this seems to have become less of an issue. The panel is aware that George Leigers had taken to keeping a bayonet which had belonged to his father under his bed. He claimed that it was there for the purpose of him committing suicide, but the panel considers this to be unlikely, given that there was no apparent deterioration in his mental state.

3.74 In 1992, George Leigers absconded from hospital while attending a day centre, travelled to Penzance and there took an overdose of drugs. This was at a time when he was involved in a relationship with a former fellow patient. He telephoned the woman, who advised him to present himself to the nearest police station, which he duly did. After this event in 1992, there is nothing in the notes and records available to the panel that give rise to any suggestion that George Leigers was at risk of self harm or suicide until after his arrest for the second killing.

3.75 Factors identified in the records as being cause for concern about George Leigers' behaviour included the need to monitor George Leigers' mood especially around September, which was the anniversary of the death of his wife. The CPN told the panel she looked for signs of deterioration such as isolating himself, excessive use of alcohol, wandering to remote places, and feeling low due to physical symptoms, such as back pain from which he appeared to be a chronic sufferer. Accounts of George Leigers being in low mood are often linked in the records to comments about his back pain, rather than to his mental state per se.

3.76 Although there are numerous references in the records to George Leigers going away for pre-planned weekends or holidays, there is only one well documented record of him "wandering in a remote place." On July 18, 1997, the manager of the Avenue alerted the CPN that George Leigers had not been seen for at least two days. She had originally been contacted by the GP, as George Leigers had failed to turn up at the surgery for an appointment. The CPN informed the Home Office, George Leigers' social worker, the consultant forensic psychiatrist, Dr N, and then arranged to attend at George Leigers' home, together with the social worker and the manager from the Avenue. The house was found to have been left secure.

3.77 The CPN then instituted a search of local public houses which George Leigers was known to frequent, but no information was found from them. In view of the lack of information as to George Leigers' whereabouts, the CPN called an emergency CPA meeting that same day. A comprehensive plan was put in place, including the potential

involvement of the emergency duty team. A further CPA meeting was scheduled for July 22. In the event, George Leigers turned up in the early evening and made contact with the Avenue. The CPN was informed, and spoke to George Leigers on the telephone. Her notes indicate that he stated that he had made a genuine mistake and that he had forgotten his appointment. She also notes that he sounded mentally well and there was no reason to give cause for concern. She arranged to visit him the following day, when he exhibited no evidence of mental health problems. Apparently George Leigers had walked to Helmsley, stayed overnight in bed and breakfast accommodation, and returned on the Friday.

3.78 This visit to Helmsley is the only documented example in a period of ten years of George Leigers wandering off to an isolated place. There is plenty of evidence of him joining walking trips with staff and residents from the Avenue, of going away on pre-planned weekends, often to Scotland, and of him joining residents and staff of the Avenue on longer summer holidays. He was known to be a keen walker, especially before he began to complain of back problems.

3.79 **Panel comment.** The panel accepts that low mood at September anniversaries, threats of self harm or attempts at suicide, and wandering off to remote places were all proper indicators of deterioration of mental state to be taken into account by the team who cared for George Leigers. However, the panel does not consider that any of these risk factors were present in the period leading up to the killing that would have alerted professionals to any change or deterioration in George Leigers' condition.

Alcohol abuse

3.80 Excessive use of alcohol was a risk factor identified regularly in earlier care plans for George Leigers. This was something which both the CPN and the social worker, each of whom had regular contact with him, were well aware of and which they kept under scrutiny. Sometimes, the CPN visited George Leigers first thing in the morning, but there was never any evidence of him being affected by excessive alcohol. It was a topic that was regularly discussed with him by the social worker, and his records show that he was always satisfied that George Leigers was not drinking excessively. The sister in the GP practice who administered his depot injections saw George Leigers at fortnightly intervals, when he was always keen to be seen first in the morning. She did not consider that he had ever manifested signs of being affected by alcohol.

3.81 It is clear from the range of evidence seen by the panel that much of George Leigers' socialising focused around a couple of pubs near his home. However, this would have been of greater concern if it had not been apparent that he had a structured life style, with other day time activities which he participated in regularly. During earlier periods when he lived at the Avenue, and subsequently when he first moved to live independently, he was a great walker, and for a period, he had a dog, which he exercised regularly. The pub appeared to provide a focus for his social activity, and he was a regular participant and sometimes organiser of pub quizzes.

3.82 George Leigers may not have presented as being affected by excessive alcohol use, but it would not be unusual for him to drink

several pints of beer each day. This appears to have been in keeping with the culture prevailing in the area in which he lived.

3.83 **Panel comment.** The panel has concluded that there was no obvious evidence to indicate that George Leigers' use of alcohol was problematic, and there was nothing to indicate that the professionals involved in his care needed to monitor this more closely. The panel does not consider that the level of George Leigers' alcohol intake is in any way connected with the killing.

Forming new relationships and consorting with prostitutes

3.84 Following the killing of his wife, a key concern for those working with George Leigers was to note his behaviour and attitude in relation to women. A number of those who met with the panel drew attention to his propensity to see women either as “mother figures” or as “sexual figures”. There is some evidence that on occasions, George Leigers made inappropriate remarks to women. At the point when he began to attend the GP surgery for his depot injections, there was a plan in place that female members of staff should always have a colleague present, although later when staff were more accustomed to his visits, this was not thought to be necessary.

3.85 In view of the murder of his wife, it might be thought that the formation of a new relationship by George Leigers would have been seen as a potential risk factor about which those working with him would have been concerned. There is evidence in the pre 1993 records that he attended relationship groups while he was an inpatient. In 1992 Dr F, in the course of seeking a psychological reassessment of George Leigers, noted that George Leigers was

scared that what had happened to his first wife could happen to the woman with whom he was having a relationship in hospital, and that was why they had split up.

3.86 However, in documentation seen by the panel relating to the time of George Leigers' conditional discharge and the period thereafter, the formation of new relationships is not listed as an explicit risk factor. The CPN told the panel that the formation of new relationships, whilst not identified as a destabilising factor, was nevertheless “on the team agenda” because of George Leigers' history, and was taken into account in his assessment. However, the GP reported to the panel that he was never explicitly alerted to the significance of George Leigers forming a new relationship, and this was not referred to in any of the letters written to him, including the letter discharging George Leigers to the care of the GP in 2003. The panel has found no entries in any of the notes available to it which would indicate any emphasis on this aspect of George Leigers care.

3.87 The CPN was aware that George Leigers was friendly with a young girl who worked in one of the pubs he frequented, which he would refer to as a “chatting relationship”. In evidence to the panel, one of the witnesses, Mrs B, indicated that so far as she was aware, George Leigers had no girlfriends. He had had a long term relationship at St Luke’s with a fellow patient, but that had ended. When he discussed possible relationships with women with her, he would say “When do you tell them?” She felt that he avoided commitment, and was not interested in a romantic relationship. The panel has considered whether any of the drugs that George Leigers was being prescribed would have had an effect on his libido. This is not a known side

effect of taking lithium, but it is a common effect of the depot injections.

3.88 **Panel comment.** If the CPN's recall is accurate that the issue of new relationships with women was on the agenda of the team caring for George Leigers, the panel is of the view that it is a significant omission that this risk was never identified in any documentation, nor brought to the attention of the GP. The panel considers that more attention should have been paid to this issue of relationships.

3.89 The panel has considered whether one of the drivers for George Leigers wishing to live independently might have been the freedom it would give him to associate with prostitutes if he so chose. There is evidence from statements given to the police after the second killing that he had used the services of a number of local prostitutes, with two of them describing him as a regular client. There is a suggestion in the statement given to the police after the killing by one of the prostitutes that she had had a conversation with the victim which indicated that she had previously been to George Leigers' house. The contemporaneous evidence of the prostitutes does not appear to suggest that George Leigers indulged in any particular fetishisms. They reported that George Leigers did not take them upstairs in his home, whereas he did take the victim of his second killing upstairs. The panel has reflected on the fact that George Leigers also had a bayonet, which he kept under the bed, but has been unable to reach any firm conclusion on his motivation for keeping it there.

3.90 It is clear to the panel that George Leigers was able to maintain a remarkably "compartmentalised" life. His use of prostitutes was not known to any of the professional staff who were working with him,

nor to any of his friends or acquaintances. George Leigers was not inclined to volunteer information to the professionals looking after him, and there was no particular trigger for them to probe this aspect of his life, so it is possibly not surprising that this part of his life was a closed book. His consultant psychiatrist indicated that he did not consider it necessary to explore sexual issues with George Leigers, as there was no suggestion of a need to do so or of any concerns.

3.91 The panel's particular concern relating to George Leigers' use of prostitutes was to establish whether those involved in his care would have approached the management of his care any differently if they had known about this. In seeking to establish views on this matter, the panel was mindful that George Leigers was latterly absolutely discharged, and continued on a voluntary regime of care, from which he was free to withdraw at any time.

3.92 **Panel comment.** In all the circumstances the panel considers that it is difficult to see how professionals could have approached this issue of consorting with prostitutes any differently, especially in the absence of any trigger in discharge documentation, risk assessments or care plans to alert them to its possible significance. '

Panel conclusions on possible deterioration in mental state

3.93 Overall, the evidence suggests that there was no deterioration in George Leigers' mental state in the months, weeks or days preceding the offence. He did not default on his depot injections, there were no signs or symptoms of relapse picked up by professionals in regular contact with him, he kept to his normal routines, his personal care remained good, he was still managing to live independently, his

friends and associates did not report noticing a changed mood, he was managing his resources effectively, he had a number of regular commitments which he fulfilled, he led an active social life including holidays and weekends away, he was an executive committee member of STAMP (a local advocacy service), there were no recent incidents of “wandering away from home”, and he had good contacts with his daughter and grandson.

3.94 The panel has taken account of George Leigers' self report subsequent to the killing that he was deteriorating during the months immediately prior to the offence. For example, in his report prepared for the Crown, the consultant psychiatrist states that George Leigers “reported to me a gradual deterioration in his mental state from the time he stopped taking his lithium medication”, and that he was constantly hearing his wife’s voice which “was getting worse – louder”. In the report prepared for the defence, Professor G indicates that George Leigers told him that “he had been getting increasingly depressed for some time but did not wish to admit this to anyone in case they readmitted him to hospital”.

3.95 The panel has carefully compared the statements made by George Leigers subsequent to the killing with the factual evidence before it and has concluded that the factual evidence is to be preferred to George Leigers' self report of the state of his health at that time. The panel has therefore concluded that George Leigers’ mental state had not deteriorated significantly in the months leading to the murder.

Term of Reference 1c – appropriateness of discharge to care of GP in March 2003

3.96 On September 24, 1993, when George Leigers was conditionally discharged from St Luke's Hospital, he remained under the psychiatric care of the consultant forensic psychiatrist, Dr N, and only came under the psychiatric oversight of the GP, Dr C, in March 2003. Dr N had taken over his care late in June 1993, a few months before his discharge. The Mental Health Review Tribunal which ordered his conditional discharge made it subject to a number of conditions, namely that he should reside at The Avenue, be under the psychiatric supervision of Dr N, under the social work supervision of TS, and that he continue medication under supervision. These arrangements continued, with various changes such as a move to independent living approved by the Home Office, until January 1999 when the Home Office directed that George Leigers should cease to be subject to section 41 restrictions under the Mental Health Act 1983. This meant that his continued association with mental health services was thereafter on a voluntary basis, and similarly he was no longer bound by a condition to continue medication under supervision.

3.97 From January 1999 until March 2003, S.117 aftercare arrangements were in place for George Leigers. In order to determine the appropriateness of the discharge to the GP in March 2003, the panel considered it important to trace what significance the S.117 arrangements had for George Leigers over this period, and to determine why those arrangements changed in March 2003.

3.98 During this period 1993 to 1999, a variety of professionals were involved in George Leigers' care, including the consultant forensic psychiatrist and his team at St Luke's (a CPN and a social worker), individuals from organisations such as New Horizons, and the staff at the Avenue, some of whom were registered mental nurses. During this time, George Leigers was registered with Dr C as his GP. Initially, George Leigers' depot injections were given at the Avenue, but after about a year, the GP practice took over responsibility for the injections.

3.99 The care team who looked after George Leigers was relatively stable over this period. There was a change of CPN and a change of social worker, but over a six year period, this represents good continuity of care. In consequence, he was well known to all the professionals involved, who had good open systems of communication between them. This was shown to have worked very effectively in 1997 when, as described above, George Leigers failed to turn up at the GP surgery for his regular depot injection.

3.100 Documentation available to the panel shows that CPA reviews took place at regular intervals as required by the CPA policy, and that George Leigers attended them regularly. Although the GP was always invited, there would usually be apologies for absence. This is not unusual, and after interviewing Dr C, the panel was satisfied that he would have attended if he had any cause for concern. Records indicate that all documentation about the CPA and its outcome were communicated to the GP.

3.101 A wider question about the practicability of GPs in general being able to attend CPA reviews as a matter of course was debated by the

panel. It was recognised that unless a GP has a very specific cause for concern, he or she simply does not have the time to attend, nor would attendance represent a good use of time. In these circumstances, the panel felt that it would be of benefit if a more proactive way for GPs to contribute to the process could be found, for example by inviting them to submit a record of all contact between the patient and the practice over the period since the last CPA meeting. Submission of such information might trigger a review of some of an individual's risk factors.

3.102 After his absolute discharge in January 1999, George Leigers continued as a voluntary patient under S.117 aftercare. It should be noted that cooperation with S.117 aftercare is entirely voluntary. It appears from the social worker's records that the impact of the absolute discharge was understood by George Leigers. He is reported to have commented that "he did not now have to consult with others about holiday plans or anything else for that matter". The notes record that George Leigers was continuing to see the CPN and also still had contact with staff at the Avenue, and with STAMP, the advocacy service for which he was an executive committee member. In February 1999, the social worker recorded that Durham County Council requested clarification of George Leigers' legal position under the Mental Health Act. George Leigers agreed that the social worker should respond, verifying that George Leigers was receiving voluntary supervision by the social worker and a CPN, and that he was also seeing the consultant, Dr N, on an outpatient basis. In fact, the panel has established that this latter point was not correct. Dr N was only seeing George Leigers at CPA reviews and he was not by that time seeing him at separate outpatient appointments, although George Leigers remained under his psychiatric care.

3.103 Aftercare services by virtue of S.117 of the Mental Health Act are regarded as being in the nature of a “safety net”. The CPA policy in place at that time indicated that it was a statutory duty of health and local authorities to provide aftercare services for service users who had been detained in hospital under S.37 of the Act, as George Leigers had been. These aftercare services must be appropriate to meet the identified needs of the individual for as long as it is considered necessary to prevent relapse or re-admission. The policy makes clear that there is no statutory obligation on the individual to accept such services.

3.104 By March 2003, a series of changes had taken place in the arrangements for George Leigers, all of which were reported at the regular CPA meetings. LA had ceased to be his CPN some time after March 2001, when she left for another job. At that point George Leigers indicated that he did not want another CPN, and in consequence BW, the social worker, became George Leigers' care co-ordinator. George Leigers was still receiving regular visits from DR from New Horizons. Over the period, some of the regular workers decreased the frequency of their visits in the light of George Leigers' stability and steady progress, and as indicated earlier, he was no longer seeing Dr N on an individual basis.

3.105 Once a discharge from the S.117 arrangements was planned, as it was in this case in March 2003, the policy stated that this should be with the agreement of both health and social services authorities, who must be satisfied that the individual is no longer in need of further aftercare services. Such a discharge should be discussed and jointly agreed at a formal CPA review meeting.

3.106 From the records available to the panel, it is not clear exactly why a move was made in March 2003 to discharge George Leigers from S.117 aftercare at this time. It appears from the CPA report for the previous October meeting that BW may have been unable to continue his involvement and noted that George Leigers did not want another social worker. There is also a note about this meeting in the records of DR, from New Horizons. She reports that George Leigers, Dr N, the social worker BW and herself were present at the meeting. She indicates that all present agreed that George Leigers was managing well overall. She also notes that BW stated he may no longer be able to offer support to George Leigers in the near future because of his workload, but asked whether New Horizons would continue to see him. DR confirmed that even when input was officially withdrawn, New Horizons would continue to offer their support.

3.107 None of the records available to the panel show any evidence of discussion about formal withdrawal from S.117 other than the note indicated above. The panel has concluded that the catalyst was the likely withdrawal of social work support from BW. The GP did not attend the meeting at which the decision was taken, and he is uncertain whether his view was sought in advance. However, he told the panel that he would have had little to contribute to that decision, given George Leigers' conformity to those aspects of his care with which he was involved, for example attendance for depot injections. The panel believes it likely that the GP would presume that George Leigers had been seeing the consultant psychiatrist on a one to one basis.

3.108 As indicated above, when the CPA meeting in question took place, it was attended by Dr N, BW, DR and George Leigers himself. These by now were the most significant persons involved with his care. The documentation records that George Leigers has no outstanding social or care needs. It also records that DR from New Horizons would continue to give social support and that Dr N would write to the GP with regard to the discharge from S.117.

3.109 **Panel Comment.** The panel accepts that this progression in care arrangements for George Leigers was not in any way unusual, given his progress up to this time. He had been stable for a considerable period, key personnel were about to change, and there was no obvious need for services. The panel is not critical of the decision to discharge to the care of the GP.

3.110 A brief letter from Dr N discharging George Leigers to the care of the GP was written on 18 March 2003. It simply states that George Leigers had done extremely well in the community for a prolonged period of time, and it was the conclusion of the CPA meeting that he no longer merited S.117 aftercare. The letter also records that George Leigers himself was in agreement with this, that he was well aware of how to seek help should he need it and that Dr N would be pleased to see George Leigers at the GP's request if it was considered appropriate. The letter notes that his formal contact with forensic services was therefore at an end, and trusts that George Leigers will do well in future. "There appears to be every reason to suppose that his previous good progress will indeed continue." The full text of the letter can be seen at *Appendix D.* No advice was given relating to George Leigers' further management, for example regarding medication, nor was any information provided in respect to

potential behaviours or circumstances that should alert the GP to the need for increased input.

3.111 **Panel comment.** In the circumstances of this case, the panel accepts that an appropriate point had been reached to discharge George Leigers fully to the care of his GP, ending the CPA arrangements. The panel is of the view that because of the stability of care George Leigers had enjoyed, and his experience and familiarity as a user of mental health services, he would have been aware of how to access services if he felt he was in need of support. The panel is also of the view that discharge to the GP was appropriate.

3.112 However, the panel is concerned that the level of information given to the GP was unsatisfactory. It should have contained a greater amount of detail to assist the GP to determine factors which might need to be watched in terms of possible future relapse or risk. It could be argued that the GP should have been well aware of this from all of the earlier CPA documentation that was copied to him, but the panel believes this should have been summarised in a document as significant as a discharge letter, which would be particularly important if there was a change of GP in the future. At a minimum, the letter should have made specific reference to the need to be aware of the implications of George Leigers forming a new relationship. The letter should also have indicated what approach the GP should take to on-going medication, and what he should be advised to do if he wished to vary it, or if George Leigers made such a request.

3.113 The panel also has concerns about George Leigers' own understanding of the process of being discharged from S.117

aftercare, and the extent to which the proposal was discussed with him in advance of the CPA meeting. George Leigers seems to have thought that it meant something similar to an absolute discharge. This is borne out by an entry in his diary saying “free at last” around the time of the S.117 discharge. However, the panel noted that at least one witness was of the view that this entry in the diary was made retrospectively. In any case, George Leigers appeared content about the situation, as was noted in DR’s notes for New Horizons – “taken off his 117 sections at his CPA today – George Leigers is happy about this”.

Term of Reference 1d - Psychiatric, psychological and social needs during the period 1993 – 2003

3.114 This term of reference has a number of strands to it. Before considering these in more detail, the panel considers it helpful to make some overall comment on the care arrangements in place over the period in question.

Care arrangements post September 1993

3.115 George Leigers was discharged to the Avenue, a care home looking after a number of residents who had been discharged from inpatient mental health care. A question was raised with the panel at an early stage in the inquiry whether the Avenue was an appropriate place for George Leigers to be discharged to. In consequence, the panel has made careful inquiry to ascertain the status of the Avenue, the qualifications of the staff there, and the kind of care and support which was offered to its residents.

3.116 When it was first proposed that George Leigers should be conditionally discharged to the Avenue, there was a legal issue with the Department of Health about its status. This accounted for some of the delay during 1993 in discharging George Leigers. Once this was resolved, his discharge there was a condition imposed by the Mental Health Review Tribunal in September 1993.

3.117 The Avenue opened in 1984. Its founder EB was a registered mental nurse, and had previously worked at St Luke's Hospital. The initiative for founding the Avenue was a model of caring for people with learning disabilities, where EB had seen that they could live like a small community. Initially, the Avenue housed eight residents, with all of them sharing in the domestic routines. Existing residents played a part in the selection of new residents. George Leigers made a number of visits there before his conditional discharge to determine if it was appropriate for his needs.

3.118 Once George Leigers took up residence at the Avenue, he gradually built good relations with staff and other residents. Over a period of time, his demeanour improved, and staff assisted him in re-establishing contact with his daughter. He was encouraged to participate in the communal life at the Avenue, and eventually he took on tasks connected with shopping and began to participate in outings and holidays with staff and fellow residents. He was regarded by staff as being supportive of other residents.

3.119 **Panel comment.** During his time at the Avenue, some of the staff made substantial efforts to assist George Leigers to rehabilitate back to a normal life. They were aware of his wish to live independently, and even after his move to Montrose Street, where he lived on his

own; he would regularly visit the Avenue. He went there to have his hair cut, and he continued to participate in outings and holidays. He was trusted by the staff, to the extent that he "house sat" for one of them. It was staff at the Avenue who felt that he would benefit from having a dog, and who found one for him. It was clear that the staff of the Avenue exercised a kind of collective responsibility to be a friend to George Leigers, to provide a listening ear and a shoulder for support. He spoke to staff regularly, and EB was instrumental in getting him involved in other activities, such as his work as an executive committee member of STAMP. EB maintained good, effective contact with the range of other carers and professionals who were involved with George Leigers. In the view of the panel, her input, especially after the departure of George Leigers from the Avenue, was above and beyond what might have been expected.

3.120 The panel has given consideration to whether it was appropriate for staff at the Avenue to take George Leigers to local pubs, and to encourage him to socialise there. The panel accepts that George Leigers did not appear to have an alcohol dependency problem and that it was likely that local pubs would provide a useful environment for helping him to socialise and establish local contacts. However, the panel is aware that the team caring for George Leigers appeared to focus quite strongly on alcohol consumption as a risk factor. This apparent mismatch between encouraging him to socialise in the pub, and yet monitoring this as a key risk factor, appeared somewhat contradictory.

3.121 **Panel Comment.** The status of alcohol use as a risk factor never changed over the period under review, which emphasised to the panel the lack of a detailed review of risk factors and risk

management in this case. This further highlighted for the panel the fact that those working with George Leigers may have been focusing on factors not particularly relevant to his risk while failing to monitor other potential risk factors, such as the formation of a new relationship.

Continuity of care

3.122 The panel considered the range of professionals who had been involved with the care of George Leigers over the period 1993 – 2003. What is striking is the continuity of care which he received from people who were very familiar with his history and his progress. Throughout this period there was input from the same consultant psychiatrist, the same GP, the same surgery staff, and the same staff at the Avenue, while there was only one change in CPN and one in social worker. This had the benefit that these people were all familiar with other team members, and knew whom to contact when necessary. There is evidence in the records that this worked well and effectively, to the benefit of George Leigers, for example on the occasion when George Leigers failed to turn up at the GP surgery for his depot injection.

3.123 **Panel comment.** The panel considers that George Leigers received good continuity of care from a team who were liaising well with each other. The panel does however consider that where such continuity of care exists over a long period, it is important for teams not to become complacent. This could result in lack of rigour in processes. In this particular case, the panel believes that such lack of rigour is evident in the absence of a review of medication, and in the limited

explicit risk assessment that was undertaken which is commented on further in paragraphs 3.150 to 3.164.

Were George Leigers' social needs understood and addressed?

3.124 George Leigers social needs can be taken to encompass matters as diverse as his housing, his financial arrangements, the possibility of returning to work, friendship and family contact, hobbies, external interests and activities, and his sexual needs.

Housing arrangements

3.125 The panel has seen evidence in many of the records that show great attention to matters such as George Leigers' housing requirements, including settling him in initially to independent living, providing furnishing and equipment, watching out for the state of tidiness and cleanliness of his home, and adaptations which were needed to take account of his physical problems of a bad back. George Leigers received support from New Horizons, and had regular visits from one of their workers, which are well documented.

Financial arrangements

3.126 So far as George Leigers' financial position is concerned, he was in receipt of disability living allowance, which the panel believes was awarded because of his mental health problems. George Leigers does not appear to have had financial problems, or to have had difficulties with budgeting or debt. He had sufficient resources to enable him to drink socially, to go away for weekends and holidays, and to socialise with his daughter and grandchild.

Return to paid employment

3.127 On the question of George Leigers' social needs in relation to a return to paid employment, the panel found little evidence of any steps taken to explore this idea or seek to promote activity that would support a return to work. On his part there did not seem much desire by George Leigers to undertake paid work. There was a view expressed to the panel that it would have been difficult for him to hold down paid work, partly because of his appearance and partly because in the main, he only functioned well in small groups. However, the panel also heard evidence that he was a committed and regular participant in the range of support work required at STAMP, where he attended regularly twice a week, and where he assisted at an external venue once a week. These activities required him to be reasonably smartly turned out, and to be reliable in terms of timing and attendance, which he appeared to manage without trouble. He also participated as a tenant member of the New Horizons forum, routinely helped the Avenue with their weekly shopping, and was a regular helper at the coffee bar in St Luke's on Friday evenings.

3.128 There was also a view that paid work would have been difficult for George Leigers because of his chronic back pain and associated pain in his legs, which was considered to be a bar to any manual work. The panel has some difficulty in identifying the true level of difficulty caused by his back problems, but it was certainly not sufficiently severe to prevent him from assisting with the unloading, carrying and assembly of the volunteer stand for STAMP each week. The panel also noted that at Rampton back problems have not been an issue for George Leigers.

3.129 There is some limited evidence to indicate that George Leigers enrolled himself on an employment training scheme while still at St Luke's Hospital in 1991. However, apart from this, there is nothing in the notes to show that any consideration was ever given to whether George Leigers could undertake paid work, whether he should be encouraged to try to do so, and whether he would require support or training to be able to do so.

3.130 **Panel comment.** The panel is unclear why no opportunity was ever taken to discuss the prospect of returning to paid employment for George Leigers. He was able to perform satisfactorily as a volunteer in a number of settings, which required him to attend regularly, to be turned out appropriately, and to perform tasks reliably. It appears to the panel that the amount of benefit being received by George Leigers may have contributed to his lack of motivation to get back into employment.

Friendships and family contact

3.131 There are a number of records which contain references to the scope of George Leigers' friends and acquaintances, his colleagues at the various activities he participated in, and the increasing contact he appeared to have with family members. Some of his social contact was through attendance at local public houses. However, his range of activities over the course of the week at the Avenue, STAMP, New Horizons, St Luke's Hospital and the callers who regularly visited him at home ensured that George Leigers had regular and sustained social interactions. There was also a period when he was very

friendly with a bar maid in one of the pubs he frequented, but she moved away from the area.

3.132 George Leigers' contact with his daughter increased, although at times this was intermittent, caused by factors such as her car being off the road, or the birth of her baby. The records indicate that George Leigers had contact with other family members, including a brother and a sister. His range of friends and associates was something of which his social worker and CPN were aware, and which they followed up. Both recognised that he could be somewhat lower in mood if he was too isolated or lonely.

3.133 **Panel comment.** The panel has concluded that George Leigers had a good network of supporting friends and acquaintances, as well as the professional team who were involved in his care. In addition, the nature of his socialising was monitored appropriately and documented.

Significant relationships and consorting with prostitutes

3.134 The panel saw virtually no references in George Leigers' notes and records to relationships with other women, although the CPN referred in evidence to this being “on the team agenda”. In 1992 while George Leigers was still an inpatient, he had a brief relationship with another patient, which was clearly significant for him, as its breakdown caused him to abscond to Penzance from inpatient care. His clinical notes indicate that there was a marked deterioration in his mental state at this time, which in the view of the Panel reinforces the importance of relationships as a risk factor. Moreover, George

Leigers himself was concerned then that what happened to his first wife might happen to the woman in this relationship, which was the reason for the relationship ending.

3.135 When BW first took over as George Leigers' social worker, he must have discussed relationships with him, as his notes made in February 2001 indicate that George Leigers did not have a regular female partner, nor did he inform BW of any platonic relationships with females. He told us that he did not believe George Leigers was looking for other relationships. He believed that George Leigers liked living alone with his dog and near the town, to be close to the facilities he wanted. In 1997, at a CPA meeting, there is limited reference in the notes of the meeting to the possibility of George Leigers forming another relationship as something that would require careful monitoring. Other than this brief comment, however, none of the documentation which the panel has seen makes reference to the potential significance of relationships.

3.136 The panel sought to identify if any of those regularly in contact with George Leigers were aware that he was consorting with prostitutes. None were, but it was accepted that George Leigers was unlikely to volunteer this information to any of them. His consultant psychiatrist was never alerted to problems of a psychosexual nature, and he felt that there was no reason to explore sexual issues as there was no suggestion of any need or concerns.

3.137 There was a view advanced by one of his professional carers that George Leigers' libido may have been reduced by the medication he was taking. The panel recognises that impotence is a common side effect of depot injections, but as there was no systematic review of

his medication, this possible side effect was never explored with him. If it had been, it may have triggered wider discussion of George Leigers' sexual needs.

3.138 **Panel comment**. The panel accepts that professionals working with George Leigers were not aware of the fact that George Leigers was using prostitutes. However, this lack of awareness may in itself be an indication of the limited work that was undertaken to understand George Leigers' sexual needs and his attitude towards new relationships. It is possible that in the context of a discussion about the side effects of medication, or explicitly about his views of forming a new relationship and whether he was lonely, sexual issues may have emerged. The panel recognises that it would not have been possible for professionals to prevent George Leigers from having contact with prostitutes, but knowledge of this may have influenced his management. CPA meetings were not appropriate forums for such discussions, but the panel considers that if one to one outpatient consultations had still been taking place, these could have provided a suitable setting.

Social need for hobbies and external interests and activities

3.139 The evidence before the panel on these matters is extensive, and shows that George Leigers developed a range of interests and activities which gave an effective structure to his week. His interests included walking, either alone or in groups, and the notes record some of his achievements such as twice completing the Lyke Wake Walk. He helped out at a local day centre, on a ward at St Luke's Hospital, at the Avenue, at STAMP and at New Horizons. He was a regular at two local pubs and enjoyed pub quizzes. He had weekend

trips away and longer holidays at other times. With EB from the Avenue, he house sat for a friend of hers. He was encouraged for a period to keep a dog. The notes record events such as his fortieth birthday, which he celebrated at the Avenue, and his activities at times like Christmas and New Year.

3.140 The panel has also considered evidence about how George Leigers spent his time at home. There were periods when he was a keen watcher of sport on TV. There is also a limited amount of evidence in relation to his possession of books and videos, as well as a bayonet, which could be called “Nazi memorabilia”. Taking into account George Leigers' family background, in that his father had been a German prisoner of war in England, and that one of his sisters had been brought up by German relatives, his possession of these items did not appear to be morbid, nor linked to a motivation for the murder. In considering this matter, the panel has taken account of the weapon used in the killing, a bayonet which had belonged to George Leigers' father.

3.141 **Panel comment.** The panel considers that there was a good structure of external activities and contacts for George Leigers, which were well monitored and encouraged by professionals working with him. The panel has taken the view that material found in his house relating to the Second World War was part of a general interest or hobby, and was of limited significance.

George Leigers' psychiatric needs - were they fully understood and addressed?

3.142 Two matters relating to George Leigers' psychiatric needs give the panel some concern. First, although psychiatric outpatient review was commented on in all of the CPA meetings, outpatient appointments appear to have stopped by 1999, with George Leigers reviewed by Dr N only in the context of the CPA meetings themselves. George Leigers does not even appear to have been seen by the psychiatrist to discuss his discharge from psychiatric care in 2003. It is difficult, therefore, for the panel to conclude that his psychiatric needs were fully understood or addressed.

3.143 Second, at no point after his discharge does there seem to have been a systematic review of the medication he was regularly being prescribed. There may have been a good rationale for the long term prescription of lithium and flupentixol, but given the working diagnosis of depression, with no relapses over 10 years, this rationale is not discernable from the medical records, nor does the continuing need for these medications seem to have been considered. The view appears to have been that as George Leigers was doing well, it was safer to leave the regime in place. The panel accepts that George Leigers himself never raised the possibility of discontinuing the depot injection or the lithium, but nor was this issue ever raised with him.

3.144 **Panel comment**. The panel is concerned about the lack of direct psychiatric review of George Leigers by the psychiatrist responsible for his care. It does not consider the second hand reports of others to be a satisfactory means to monitor an individual’s psychiatric condition. In addition, the panel considers that a more proactive approach to George Leigers' medication could have been pursued. Once it was clear that George Leigers was functioning in a fairly stable way, it would have been appropriate to have raised this matter

for discussion. The panel believes that the lithium medication might well have been discontinued, and the dose of the depot reduced.

George Leigers' psychological needs – were they understood and addressed?

3.145 This is an area of some concern for the panel, in view of the fact that as early as November 1987, while George Leigers was an inpatient at St Luke's Hospital, he had been referred by Dr MS to a consultant psychotherapist, Dr Wh. In his report, Dr WH indicated that in terms of personality, George Leigers could best be described as schizoid, as this describes the profound splitting of himself and objects that takes place in his internal world. He concluded that "moving George Leigers from a paranoid-schizoid position to a depressive position would be a major task requiring interviews over three or four years".

3.146 Dr MS asked Dr Wh to provide psychotherapy for George Leigers but this proved to be impossible because of Dr WH's commitments. However, the panel has noted the internal inquiry report, in which Dr G concluded that George Leigers received substantial, apparently beneficial, psychological intervention and support programmes during the period of his inpatient stay. This included weekly psychotherapy sessions, some involvement in a relationship group, supportive therapy, and counselling sessions including bereavement counselling.

3.147 At the point when George Leigers was conditionally discharged in 1993, it appears that there were still significant unresolved psychological issues, especially in relation to grief and relationships. It is also apparent that the psychological basis of his absconding the

year before was not understood, although this behaviour bore similarities to his behaviour at the time of the killing of his wife. Several of these issues are commented on in the inpatient records, but there is no evidence that further consideration was given to them, nor do they appear to have been carried forward when George Leigers was discharged to the Avenue. None of the records available to the panel show any indication that these matters were known about or discussed thereafter. The panel has noted that the CPA team did not include a psychologist, and can only speculate whether such issues would have received more attention if there had been one on the team.

3.148 **Panel comment.** The panel considers it unfortunate that no emphasis was placed on the need for psychological input for George Leigers after his discharge, as it seems apparent from the records that he had severe grief reactions to the death of his premature first daughter and other family bereavements. Taken together with the voices he was hearing, and a recent episode of absconding in 1992, the panel considers that further thought should have been given in 1993 to securing psychotherapy input. The lack of such input may have contributed to a continuing unresolved pathological grief reaction that was never adequately addressed.

3.149 The panel has therefore noted with interest the work that has been undertaken at Rampton Hospital in relation to psychological progress and treatment needs. For example, in a report by Dr Br, a clinical and forensic psychologist, it was stated that George Leigers had a very high score in relation to state anger, suggesting that he habitually suppresses anger and tries to avoid showing others how angry he may be feeling. The report also indicated that George

Leigers has a poor range of coping skills particularly in relation to extreme emotional content. In retrospect, this is not surprising, and has been a feature of much of the evidence, namely that George Leigers led a highly compartmentalised life, in which he was able to bottle things up and chose to reveal only very partially certain aspects of his activities and feelings. This may have been due to what Dr Br describes as an inability or difficulty in trusting others to discuss his feelings, which may be a potential difficulty in therapeutic engagement. It is recognised that much assessment work is based on a person's self report, and where a patient is unable to discuss his feelings, this would be a major hindrance to the risk assessment process.

Term of Reference 2 – risk assessments and risk management provided between 1993 and 2003

3.150 The starting point for the panel's review of risk assessments and risk management was to consider the CPA policy during the time George Leigers received psychiatric treatment. The version which the panel was provided with by the Trust related to the period from 1999. It is not clear how this may have differed from earlier versions of the policy.

3.151 Risk assessment and risk management is considered at section 9 of the policy, which is reproduced in *Appendix E.* According to the policy, teams must "regularly consider risk issues" and should "record these considerations clearly". The policy also encourages the "need for positive, supportive and therapeutic risk taking". The assessment and management of risk should be "based on detailed evidence of a person's psychiatric and social history, together with information

regarding their current mental state and functioning". The policy also suggests that the risk assessment procedure and documentation/tool should be jointly agreed between the specialty and relevant social services department.

3.152 This latter comment would seem to imply that some specific documentation or tool should be used for risk assessment. In their survey of all the records available, the panel found no evidence of such a specific tool being used.

3.153 Section 10 of the CPA policy, reproduced at *Appendix E,* also indicates that a risk and relapse management plan should exist, which should be readily available and which should be capable of being accessed through the relevant area duty manager, who would have access to CPA records. The plan should indicate how individual risk may increase, and should detail the action to be taken in response to deteriorating mental health. The panel can find no evidence of such a risk and relapse management plan in relation to George Leigers.

3.154 **Panel comment.** The panel considers that adherence to the CPA policy was poor, in that neither the risk assessment procedure and documentation/tool, nor the risk and relapse management plan appear to have been completed in this case.

3.155 As relevant documentation required by the CPA process was lacking, the panel considered the extent to which risk assessment and risk management formed a central part of the CPA review process, and any evidence to show that review of risk was central to the care of George Leigers. Early documents maintained by the social worker,

dating from 1996 indicate that the main risk factor of concern was the potential for a “deterioration in mental state”. The social work records from that time also state that in relation to George Leigers, there was no significant risk of suicide or violence to others, nor was there a significant risk of severe self neglect or serious self harm. In a full note written by the social worker, dated May 7, 1996, he comments that George Leigers' mental state gives no rise to concern, and overall his situation was satisfactory and he was maintaining excellent progress. The social worker also commented that George Leigers placed little demand on his carers and was almost totally self sufficient within the hostel environment.

3.156 The records of later CPA reviews were available to the panel, and on examination, it is evident that these meetings took place regularly, at six monthly intervals. There is a clear record of who was invited and who attended. It was common for George Leigers himself to be present. The CPA review records also clearly indicate who was the care coordinator, that George Leigers was on full CPA and subject to S.117. A care needs assessment was completed at each review, as were minutes of each meeting summarising the verbal reports given, including George Leigers’ own views. Where a Care Plan is included in the notes, (for example December 16, 1998, or February 28, 2001), it identifies that the CPN will observe George Leigers for the “identified risk factors”. The assumption must be that a list of factors had been identified in CPA meetings and was an agreed list, decided by the team caring for George Leigers. This list (which does not appear to have changed over that period) related to indicators of a deterioration in mental state, isolating himself, excessive use of alcohol, wandering in remote places, lack of motivation to get out of bed and feeling low due to physical symptoms, that is, back pain.

3.157 There are also examples of documents titled “Care Plan Review” in the records. For example, in one dated April 22, 2002, at a time when there was some concern that George Leigers’ drinking may have increased, the care plan was revised in that the social worker was to increase his visits from monthly to fortnightly. This change to the care plan is recorded in the minutes of the CPA meeting. One dated March 17, 2003, on the occasion of George Leigers' formal discharge from S.117 aftercare, notes that there had been no revision to the care plan.

3.158 Taking the CPA records overall, there is evidence from both the minutes and various pieces of documentation that some risk factors were taken into account. The minutes frequently record comment on George Leigers’ physical health, his social contacts, his mental health, his family contact and his use of alcohol.

3.159 Throughout the documentation, however, the panel has not been able to find evidence of any rigorous re-assessment of risk in relation to George Leigers. It is noteworthy that at no time does the risk of George Leigers committing another violent offence appear to have been considered. However, the panel has also taken account of the fact that over a lengthy period of time, he was a very stable patient, with little change in his routines or his presentation. Small changes, for example a slight increase in his use of alcohol, were picked up and the care plan modified accordingly. Given the risks which were identified in the documentation, it could be said that there was nothing of which carers could be aware that would give rise to concern, and which would trigger a more fundamental review of risk. It is difficult to know how George Leigers' carers could, for example,

have been alerted to his use of prostitutes. In evidence to the panel, however, some of those caring for George Leigers did agree that they would have regarded the formation of a new relationship with a woman as a significant event, although this risk was not identified in any of the documentation that the panel has seen.

3.160 **Panel comment.** Overall, the panel considers that those caring for George Leigers were reactive in their approach to risk. At no time does the risk of George Leigers re-offending appear to have been expressly considered, nor the risk of him forming a new relationship. It is disappointing that at key points in the care of George Leigers, for example at the time of his conditional discharge and at the time of the decision to discharge him from S.117 aftercare, a more rigorous reassessment of risk was not made.

3.161 Two further issues concerning risk assessment and risk management concerned the panel. First, after his discharge from St Luke's Hospital, George Leigers was seen by Dr N as an outpatient on a regular basis, in addition to the CPA reviews. As already commented above, there appears to have come a time when these outpatient appointments ceased, and were instead subsumed into the regular CPA meeting from January 1999. The panel considers that the cessation of separate outpatient appointments was unfortunate, as this would have provided a regular opportunity for a more clinically based assessment as well as affording George Leigers a more enclosed and confidential opportunity to open up and share information; it could have afforded Dr N and the team a different perspective on George Leigers' progress.

3.162 **Panel comment**. The panel is strongly of the view that regular outpatient contact should have been maintained up to the point of absolute discharge, as this would not only accord with good practice, but it would also be in line with the requirements of the CPA policy, and indeed with the management plan as stated in the CPA documentation.

3.163 The second point of concern for the panel on the matter of risk assessment and risk management was the limited information contained in the discharge letter written by Dr N to the GP. That letter dated 18 March 2003 which has been previously referred to in paragraph 3.110, is, in the view of the panel, inadequate to support the GP in his care of George Leigers. In particular, it does not give the GP any indication of the risk factors that might prompt him to want to re-refer George Leigers. No doubt the GP had been copied in to all the minutes and documentation arising from the regular six monthly CPA reviews, but the panel has already noted that some key risks were not identified or documented in the CPA papers, particularly risks in relation to the formation of a new relationship. The lack of a clear statement regarding follow-up would be especially important in the event of a change in GP.

3.164 **Panel comment**. The panel is strongly of the view that the discharge letter should have given a clear summary of key indicators of risk to which the GP should be alert.

Term of Reference 3 – to draw on the findings of other relevant investigations and reports.

3.165 An internal inquiry led by Middlesbrough Primary Care Trust was set up in September 2003, as the murder by George Leigers was treated as a serious untoward incident. That inquiry reported to the Strategic Health Authority in June 2004. Its terms of reference were appropriate to the incident that had occurred, and the inquiry was established with a team that had wide and relevant experience.

3.166 The work undertaken by the internal inquiry was detailed, and the review of the paper evidence was in depth, although in the view of the panel it sometimes lacked in critical analysis. Its conclusions highlight certain issues, which have also been of direct concern to the present independent inquiry panel, particularly in relation to risk assessment. Although the internal inquiry report did not identify the specific aspects of risk assessment that were lacking, the panel was pleased to see a recommendation in the internal inquiry report that consideration should be given to strengthening the documentation of the risk assessment process undertaken during CPA meetings. In this respect, the panel has also taken note of a report commissioned by SANE, *"A Review of 69 Inquiries of Homicides" (March 2001)* which states at page 8 that "seventy five per cent of inquiries blamed a lack of adequate risk assessment and poor risk management".

3.167 The panel does however wish to draw attention to a number of aspects of the internal report. First, the internal inquiry included a report carried out by a consultant forensic psychiatrist who worked alongside Dr N. In the view of the panel, it is not appropriate for a

close associate to be providing an opinion on the quality of care provided by his colleague, as happened in this report.

3.168 The panel is also concerned that in the executive summary to the report, an opinion is expressed that those charged with the care of George Leigers could not have predicted the second homicide. The panel notes that the terms of reference for the internal inquiry did not require such an opinion to be expressed. Moreover, such comment is irrelevant, as a repeat offence can rarely be predicted. Their terms of reference were focused more on patient management, and in the view of the panel, it would have been more useful to concentrate on whether better risk assessment and different management of George Leigers might have prevented the second homicide.

Term of Reference 4 – to consider the extent to which the care and treatment of George Leigers between 1993 and 2003 complied with relevant legislation, local and national policies and agreed good practice.

3.169 Some aspects of this term of reference have already been covered in the panel's criticisms about adherence to the CPA policy, in relation to review of medication, and in respect of the detail in discharge letters, which did not conform to good practice.

3.170 In other respects, the panel is content that the care and treatment of George Leirgers over this period was in conformity with legislation, policies and good practice, although examples have been identified where a more proactive and imaginative approach would have been welcome.

3.171 The panel has found evidence of numerous examples where staff involved in George Leigers' care showed themselves to be thoughtful, responsive, caring and effective. In particular, the members of the panel were impressed by the extent to which staff of the Avenue Nursing Home continued to support George Leigers long after he had moved out and ceased to be their direct responsibility. The panel was also impressed by the support and interest shown in George Leigers by the manager of the advocacy project, STAMP.

Term of reference 5 – to examine aspects of communication between the various professional team members and between organisations.

3.172 The panel has concluded that communication in this case, both between professional team members and between organisations, was good. Although the records are extensive over the extended period of time covered by the inquiry, the clarity of entries is in conformity with good practice.

3.173 Communication was no doubt aided in this case by the fact that the team caring for George Leigers was stable for long periods of time. When any untoward circumstance arose, the evidence shows that there was speedy contact made with relevant persons, for example in July 1997 when George Leigers failed to attend for his depot injection.

3.174 Elsewhere in this report, the panel has been critical of the information contained in the discharge letter to the GP.

Term of reference 6 – to consider such other matters as the public interest may require.

3.175 One matter for debate among panel members was whether a patient such as George Leigers, who had committed a homicide and who had been sentenced under the provisions of S.37 and S.41 of the Mental Health Act 1983, should ever be given an absolute discharge, or if so, the manner in which such a discharge should take place. A comparison was drawn with those imprisoned for murder, who may be released after serving a number of years in prison but who remain under a lifelong licence.

3.176 In the view of the panel, consideration should be given at policy level in Government as to whether patients who have committed a very serious offence and who receive restriction orders should remain under supervision for the rest of their lives. Alternatively, if such patients are to receive absolute discharges, consideration should be given as to whether this should only be via a Mental Health Review Tribunal rather than by administrative action by the Home Secretary. In making a decision, the Home Secretary is usually wholly reliant on reports prepared by the team caring for the patient, and as such is dependent on the quality of their assessments and conclusions. In contrast, a Mental Health Review Tribunal is able to carry out a much more extensive, and independent, review of a case, including information obtained from interviews carried out by its own medical member. Although such a change would not have had much relevance to the case of George Leigers, in general the panel believes it would increase public confidence in how such decisions are reached.

Chapter 4

Conclusions and recommendations

4.1 The panel regards George Leigers, and the reason for the killing, as a conundrum. Panel members are of the view that this second killing by George Leigers was not caused by a mental illness or personality disorder as would be recognised in psychiatry. This is not to say that George Leigers did not have psychological difficulties that contributed to his behaviour, but his ability for compartmentalisation and detachment, as well as the unreliability of his self report, makes it difficult to find an explanation for what took place. Although he has a history of severe mental illness, the panel found no evidence to suggest that this had relapsed at the time of the killing; his psychological difficulties and the personality traits that underlie them do not amount to a personality disorder. We have concluded that abnormalities in his current mental state requiring treatment in Rampton Hospital occurred subsequent to the killing.

4.2 In reaching its conclusions, the panel gave consideration as to whether there was anything of significance that could be drawn from similarities between the offence in 2003 and the earlier killing by George Leigers of his wife. It was noted that in both cases the killings took place in the bedroom, in both cases George Leigers covered the body up, both were killings of a sexual partner, in both cases George Leigers cleared up after the killing then left home, and in each case George Leigers gave himself up to the police and gave them an account of what took place. However, differences between the two cases are more extensive than the similarities. In the first

case, George Leigers was undoubtedly in an unstable period in regard to his mental state, and all the contemporaneous evidence in relation to that killing points to George Leigers suffering from a depressive psychosis, whereas in the second case he appeared to be extremely settled, both in terms of his mental state and in his life generally, with much to give him greater fulfilment, including regular contact with his daughter and his grandchild.

4.3 In concluding that George Leigers did not suffer from a mental disorder at the time of the offence, the panel is not saying that he is "normal". The view of the panel is that his problems cannot be classified. He himself has an extreme tendency to hide, disguise and compartmentalise parts of his life, and the panel has noted his inability to cope effectively with grief and bereavement. However, we simply do not know George Leigers' motivation for the killing, nor the thought processes that led up to it. In terms of his management, while the panel has made criticisms in the body of this report that could contain lessons for the future, we cannot be certain that different management of his case would have resulted in a different outcome.

4.4 A number of additional matters have arisen from discussion with witnesses during the inquiry, on which the panel wishes to express a view.

4.5 First, on the question of whether George Leigers should have been discharged from hospital in 1993, and if so, whether discharge to the Avenue nursing home was appropriate, the panel has concluded that a conditional discharge was appropriate at that time, and the choice of the Avenue nursing home was entirely appropriate. Staff at the

Avenue were well qualified and proved to be highly supportive to George Leigers. In addition, as his discharge was conditional, he could have been recalled to hospital at any time if there were concerns about his mental state or behaviour.

4.6 Next, the relevance of his failure to take lithium has attracted much attention. However, the panel questioned the need for lithium in any case and has expressed its view that its prescription should have been reviewed. Regardless, its role was to prevent a relapse of depressive illness, and as there is no evidence to suggest that George Leigers had such a relapse, we do not believe that his intermittent use of lithium in any way related to the killing.

4.7 An issue was also raised about the discharge of George Leigers to the psychiatric care of the GP in March 2003. The panel has concluded that this was appropriate given George Leigers' lengthy stability and cooperation. Although the panel has raised issues about the limited amount of information provided to the GP on discharge, the lack of detailed information was not related to the killing.

4.8 The panel has also given extensive consideration to George Leigers' self report that "voices" prompted the second killing. This explanation was not accepted by the court at his trial, nor is it accepted by the panel. The panel considers that a more likely explanation about the "voices" was George Leigers' wish to avoid being sent to prison, so hindering attempts to establish his true motivation and state of health.

4.9 In view of the circumstances of the killing, the panel has considered the possibility that George Leigers is a sexual sadist, speculating that these tendencies were normally kept in check, but became manifest perhaps because of an inability to sustain an erection and attempts by him to maintain arousal. George Leigers explicitly denied such a possibility to the panel, and evidence given at the time of his arrest by other prostitutes does not indicate such sadistic tendencies. However, it may also have been the case that failure to maintain an erection whilst attempting intercourse with his victim in combination with other factors may have made him more volatile, for example if the victim had in any way “annoyed” or “provoked” him. Again, George Leigers himself denied that this was the case to the panel, and it is a matter on which the panel is unable to draw firm conclusions.

4.10 The panel has also considered the possibility that the impact of the removal of S.117 aftercare arrangements, thereby leading George Leigers to perceive himself to be liberated from supervision, may in some way have “freed” him to behave in ways which previously he had only fantasised about. Given the very limited impact of S.117 aftercare following George Leigers' absolute discharge in 1999, the panel has concluded that although this is a possibility, it is unlikely that this of itself would have been a major factor in the second killing. Furthermore, the panel considers that the discharge from S.117 aftercare was entirely appropriate given that he had been followed up as an outpatient for 10 years, and a voluntary patient for four years who was wholly compliant with his depot injections, and had no symptoms causing any concern over this extended period.

4.11 In conclusion, based on what was known about George Leigers, the panel considers that there was nothing to indicate that a second killing was imminent. Different management of this case, however, might have produced further information that may have had the potential to change the risk assessment, influence his on-going treatment and lead to different therapeutic interventions.

4.12 In forming its conclusions, the panel is mindful that the primary focus was on George Leigers' mental state rather than on his earlier offending behaviour. Where someone has committed a crime as serious as the killing of his wife, as in this case, the panel has concluded that more emphasis should have been given to work relating to the earlier offence, not just in terms of assisting him to "get over it", but in better understanding its causes, and therefore identifying potential triggers in the future. Such work may have provided valuable insight into the management of his care, as well as providing a firmer basis on which to establish a cause for the killing in 2003.

Recommendations

4.13 The panel makes the following recommendations:

1. When discharging patients to the psychiatric care of a GP, the discharge letter should give full information with regard to the future management of the patient, including a review of significant issues of which to be aware, all relevant risk factors that may trigger relapse, steps to take in case of relapse, and advice about review of medication and treatment.

2. Where patients have been receiving long term care from a multi disciplinary team, and where there has been little apparent change in the condition of the patient, the team should consider whether there would be benefit in a periodic independent review in order to avoid complacency or a purely reactive approach becoming established.

3. In relation to risk assessment and risk management, there should be mechanisms in place to ensure that risk factors are explicitly identified, with rigorous reviews of risk at appropriate stages in the care of a patient, particularly where steps such as conditional discharge or discharge of S.117 arrangements are being planned. Where patients have committed serious offences, risk assessment should take account of the risk of re-offending as well as the risk of deterioration in mental state.

4. Patients who are being treated in the community should receive regular reviews in psychiatric outpatients (which in the case of well stabilised patients could be limited to three or four appointments per year). Contact in the context of CPA reviews or other larger meetings is no substitute for a psychiatric outpatient appointment.

5. Where CPA arrangements are in place, all documentation specified in the CPA policy should be completed, and full adherence to the CPA policy should be verified by audit. In the present case, this may have identified the fact that separate psychiatric outpatient appointments had ceased, and that no risk and relapse plan had been drawn up. Consideration should also be given to a more effective method for GPs to make input to the CPA review process, for example by requesting them to submit a note of recent contacts of the patient with the GP practice.

6. Consideration should be given at policy level in Government to two alternative issues. First, whether patients who have committed a very serious offence and who have received restriction orders under the provisions of S.41 of the Mental Health Act 1983 should remain under supervision for the rest of their lives. Second, if such patients are to be absolutely discharged, whether this should be undertaken only by a Mental Health Review Tribunal rather than by administrative action taken by the Home Secretary, as a tribunal would have the benefit of its own more independent assessment compared with what is available to the Home Secretary, who is dependent on information obtained almost wholly from the team caring for the patient.

Appendix A

Terms of Reference

Independent Inquiry into the Care and Treatment of George Leigers

1. To examine the circumstances surrounding the care and treatment of George Leigers by mental health services, primary care, social services and non statutory organisations, from 1993 when he was discharged from hospital, up until he committed a murder in August 2003. In particular:

    a. To investigate whether there is evidence that George Leigers had a mental disorder at the time of the offence

    b. To investigate whether there is evidence of deterioration in George Leigers' mental state in the months preceding the offence

    c. To determine whether George Leigers' discharge to the care of his GP was appropriate, and if so whether re-referral to mental health services would have been appropriate

    d. To review whether George Leigers' psychiatric, psychological and social needs were fully understood and addressed during the period 1993-2003.

2. To review the risk assessments and risk management provided in the course of George Leigers' care and treatment between 1993 and 2003.

3. To draw on the findings of other relevant investigations and reports.

4. To consider the extent to which the care and treatment of George Leigers between 1993 and 2003 complied with relevant legislation, local and national policies and agreed good practice.

5. To examine aspects of communication between the various professional team members and between organisations.

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

7. To prepare a report with recommendations to County Durham and Tees Valley Strategic Health Authority.

Appendix B

Bibliography

Medical and nursing notes and records relating to GL from Tees & North East Yorkshire NHS Trust and other NHS secondary care organisations

Social services files relating to GL from Middlesbrough Borough Council

Primary care files relating to GL from the Endeavour Practice, Middlesbrough

All medical history (brief summary of consultations with Endeavour Practice, Middlesbrough)

Documents and notes obtained from file on GL from New Horizons, Middlesbrough

Serious Untoward Incident report 2003/1464, Middlesbrough Primary Care Trust, June 2004

Care Programme Approach Policy, Tees & North East Yorkshire NHS Trust and local authorities social services, including Middlesbrough, 2003

Case Summary on behalf of the Crown

Mitigation and sentencing remarks

Psychiatric reports prepared for Teesside Crown Court

Appeal Judgement No:2005/0036/A1

Independent investigation of adverse events in mental health services, Department of Health, 2005

HSG(94)27 Guidance on the discharge of mentally ill disordered people and their continuing care in the community, NHS Management Executive 1994

Fakhoury, WKH & Wright, D “A Review of 69 Inquiries of Homicides” research conducted at the mental health charity, SANE, 2001

Szmukler, G “Homicide inquiries What sense do they make?” Psychiatric Bulletin (2000) 24, 6-10

International Classification of Diseases, 10th Edition (ICD 10)

Diagnostic and Statistical Manual, 4th Edition (DSM-IV)

Press cuttings

Appendix C

Standard Letter Requesting Attendance at Hearing

The following is the general core text that was used. There were some personalised variations, depending on the witness concerned.

CONFIDENTIAL

Dear **(Name),**

Independent Inquiry – Mr George Leigers

As you'll be aware the County Durham and Tees Valley Strategic Health Authority has established an independent inquiry relating to the care of Mr George Leigers. The members of the Inquiry Panel are: Mrs Anne Galbraith, Chairman, Professor Don Grubin (Psychiatrist), Mr William Morgan (Social services) and Mrs Rachel Morphew (Psychologist). In addition a GP, who has been retained as an advisor to the Panel (Dr David Smart who works in the Durham and Chester-le-Street PCT area), will be present.

I'm writing to confirm the time for you to meet with the panel:

Time: (personalised for witness)
Date: (as above)
Venue: Teesdale House, Westpoint rd., Thornaby, TS17 6BL

Travelling and access arrangements
I enclose a map giving directions to the venue. If you are travelling by car a reserved space will be allocated for you in the car park. You will see from the map that the venue is close to Thornaby railway station and there is access from the Stockton High street bus stop area through the Castlegate shopping centre across the footbridge.

Two rooms have been set aside for the Inquiry, one to act as a waiting room and a second room for the panel to meet with you. On arrival please note that there is an intercom link to reception who will be expecting you.

About the Inquiry
I would be grateful if you would please note the following points:

- You may bring with you a friend, relative, member of a trade union, solicitor or anyone else whom you wish

- It is to you that the members of the panel will address questions and invite an answer; the person accompanying you will not be able to address the Inquiry panel

- When you give your evidence, the chairman will ensure that you are given an opportunity to raise any matter which you may feel is relevant to the Inquiry

- Notes will be taken of the proceedings of the Inquiry. You will be given an opportunity to see these notes in draft and to comment on the accuracy of the content.

- You are welcome to bring any documentation with you that you think would be useful for reference purposes during the discussion

- All sittings of the Inquiry will be held in private

- The findings of the Inquiry and its recommendations will be made public

- The Inquiry will not make public any of the evidence submitted either orally or in writing or attribute any statements to individuals within the report

- The Inquiry terms of reference are enclosed

The panel is allowing an hour for the interview, but obviously, it is a little difficult to predict exactly how long any discussion will take.

If you have any further queries in the light of reading this letter, my direct line number is (01642) 666778.

Thank you for your cooperation,

Yours sincerely,

Avril Rhodes (Mrs)
Administrative Support to Inquiry
County Durham and Tees Valley Strategic Health Authority
Enclosures:
Directions
Terms of Reference

Appendix D

Text of Discharge Letter

The following is a reproduction of the text of the discharge letter. Addresses of the sender and recipient and the typist's reference are omitted.

"18 March 2003

Dear

Re: George H Leigers – d.o.b. 25/08/1956
11 Montrose Street, Middlesbrough TS1 2RU

A CPA was held on the above this morning (17 March 2003). He has done extremely well in the community for a prolonged period of time, and it was the conclusion of the meeting that he no longer merited Section 177 aftercare. Mr Leigers himself is in agreement with this, and although he will continue to have some support in the community from DR of New Horizons, it is not proposed to follow him up further psychiatrically or indeed by the Social Work Department. Mr Leigers is well aware of how to seek help should he so need it. I would be pleased to see him at your request in the future if you felt this to be appropriate. His formal contact with the Forensic Services is therefore at an end. I trust he will do well in the future. There appears to be every reason to suppose that his previous good progress will indeed continue.

Yours sincerely,"

Appendix E

Care Programme Approach – Sections 9 and 10

The following is an extract from the Care Programme Approach policy, published in February 2003, to which Tees and North East Yorkshire NHS Trust and the Local Authority social services departments of Teesside and North Yorkshire were party.

"9 RISK ASSESSMENT AND MANAGEMENT

9.1 Risk assessment is an essential element of good mental health practice and is not regarded as, or fulfilled simply by, an exercise of completing a "risk assessment" form. It is an ongoing process that team members and other involved agencies must carry out. It is their responsibility to regularly consider risk issues and record these considerations clearly.

9.2 After the initial risk assessment, further assessments will be undertaken, by the MDT for those on Enhanced CPA, as a minimum, prior to leave, prior to discharge from hospital and at every review. Any major life event should trigger a review and further risk assessment.

9.3 The need for positive, supportive and therapeutic risk taking is essential to effective care delivery and a key element of the CPA process.

9.4 Risk assessments and its management must be based on detailed evidence of a person's psychiatric and social history together with information regarding their current mental state and functioning. This must also involve consideration of the person's social, family and

welfare circumstances, and include the views of the carer and any significant others. (See 'No Secrets' Protecting Vulnerable Adults From Abuse'.)

9.5 Professionals involved in the risk assessment process will utilise all sources of information available to them and will be responsible for communicating to others involved any relevant information/details that they are in possession of, or that they receive, in a timely manner.

9.6 In certain cases, risk assessment may involve public protection strategies e.g. public protection meetings, child protection, adult protection.

9.7 The risk assessment procedure and documentation/tool will be jointly agreed between the locality/speciality and the relevant social services department.

10 RISK AND RELAPSE MANAGEMENT PLANNING

10.1 The risk/relapse management plan will include information, wherever possible based on previous knowledge/experience, that indicates how individual risk may increase, together with details on the action that is to be taken in response to the individual becoming very ill or when their mental health is rapidly deteriorating. This information, at a minimum, will include:

- Previous incidents
- Signs, symptoms, behaviour suggestive of potential risk/relapse
- Action to be taken if signs of potential risk/relapse

- Previous successful strategies/interventions
- Action to be taken if the service user is non compliant with the plan
- Action to be taken if there is loss of contact
- Action to be taken if the carer is no longer able to provide support

10.2 The risk/relapse management plan will be documented separately from the care plan and will be easily accessible outside of normal office hours. Out of hours crisis staff/liaison staff/emergency duty team/on call medical staff etc. will be able to access this information by contacting the relevant area duty manager who has access to central CPA records or who can access the CPA electronic system.

10.3 Referrals to out of hours services, i.e. crisis, due to potential problems that may arise, for example, over a weekend/bank holiday period, should include information regarding the risk/relapse management plan.

10.4 The risk and relapse management plan will be entered onto the electronic CPA system and recorded using agreed documentation."