REPORT OF THE INDEPENDENT PANEL REVIEWING THE CARE AND TREATMENT PROVIDED FOR MRS RITA SALMON BETWEEN MAY AND JULY 2002 [EDITION FOR GENERAL RELEASE]

THE MEMBERS OF THE REVIEW PANEL, INTRODUCTION AND TERMS OF REFERENCE

1. The Review Panel consisted of:

Dr John Bradley FRCP., FRCPsych., Emeritus Consultant Psychiatrist, Camden and Islington CMHS NHS Trust and Honorary Senior Lecturer, University College London, a Member of the Parole Board 1992-1998 and a Member of the Mental Health Review Tribunal since 1971. Chairman of the Panel;

Ms Angela Flaye, RMN, Lead Nurse (Mental Health), Barnet/Hertsmere, Barnet, Enfield and Haringey Mental Health NHS Trust; and

Mr Colin Brown, a Solicitor (now retired from active legal practice), who sits part-time as a Costs Judge of the Supreme Court Costs Office and whose experience in practice included 26 years' work in the medico-legal field, both within the NHS and in private practice.

2. Introduction.

We were appointed by the Essex Strategic Health Authority in October 2003 to provide an independent review of the care and treatment provided for Mrs Rita Salmon between May and July 2002. Our review has been carried out in consequence of Mrs Salmon's conviction at Chelmsford Crown Court on the 27 June 2003 for the murder of her late husband, Mr Derek Salmon.

We were asked to carry out the review under the provisions of the National Health Service Executive's Guidelines HSG(94)27.

3. Our Terms of Reference:

A. To examine and review the report of an internal review by North Essex Mental Health Partnership NHS Trust including:
i) the quality and scope of Mrs Salmon's health and risk assessment;
ii) the appropriateness of her care, treatment and supervision, having regard to her assessed health and social care needs, her risk assessment of potential harm to others, her previous psychiatric history (if any) and the nature, extent and relevance of any previous criminal involvement or convictions; and
iii) the extent to which her care corresponded with statutory obligations, in particular the Mental Health Act 1983, and relevant guidance from the Department of Health (including Care Programme Approach HC(90)23, LASSL (90)11, Discharge Guidance HSG(94)27 and local operational policies).

B To examine the inter-agency relationships in this case, including the links between the GP and secondary psychiatric services.

C To consider any other facts that appeared to be relevant and

D To produce a report and to make recommendations to the Essex Strategic Health Authority.

DEFINITIONS AND ABBREVIATIONS

4. In this Report, the words or phrases listed below have the meanings respectively ascribed to them:

"the Act" or "MHA" means the Mental Health Act 1983;

"RS" means Mrs Rita Salmon;

"the Trust" means the North Essex Mental Health Partnership NHS Trust, which was the statutory body within the National Health Service immediately responsible for the provision of the care and treatment to RS;

"ASW" means a social worker appointed to act for the purposes of the MHA; and

"CMHT" means Community Mental Health Team

OUR APPROACH TO OUR TASK

5. We were initially provided with copies of RS's psychiatric records, her General Practitioner's records and the local care and treatment protocols and policy documents of the Trust mentioned in paragraph 61 of this Report. In addition we were given copies of press reports published at the time of RS's trial, which provided us with some background information about the case. Subsequently we were also provided with RS's medical records from the St Andrews Centre, Broomfield Hospital, Chelmsford, where she received treatment for her self-inflicted wrist injuries and where her mental state was assessed on two occasions, as mentioned below.

6. Following our initial consideration of those documents but before receipt of the St Andrews Centre notes, we had meetings with the following members of the Trust's staff involved in RS's care and treatment:-

The Consultant Psychiatrist and a medical practitioner approved for the purposes of Section 12 of the Act (referred to herein as "the Consultant Psychiatrist"), who assessed RS on the 31 May 2002;

The ASW (referred to herein as "A"), who assessed RS with the Consultant Psychiatrist on the 31 May 2002;

The Community Psychiatric Nurse (referred to herein as "B"), who assessed RS on the 30 May 2002), accompanied by her manager;

The Community Psychiatric Nurse (now retired) (referred to herein as "C"), who assessed RS on the 12 July 2002 in company with the next mentioned Community Psychiatric Nurse;

The Community Psychiatric Nurse (referred to herein as "D") who assessed RS on the 12 July 2002 in company with C and who further assessed RS on her own on the 15 and 25 July 2002; and

The Community Psychiatric Nurse and member of the Criminal Justice Mental Health Team (herein referred to as "E"), who only saw RS after she had been taken into custody by the Police.

7. From the initial consideration of RS's psychiatric and general practitioner records, it was apparent to us that she had no history of mental disorder prior to late May 2002 nor was there any evidence to suggest that she had any previous criminal record. The members of staff listed in paragraph 6 above were all the people involved in Mrs Salmon's care and treatment during the relevant period, apart from a Psychiatric Staff Nurse who saw RS during the night of the 28/29 May 2002, and a locum Staff Grade Psychiatrist (referred to herein as "F"), who saw her on 30 May 2002 with B. We have not met this Staff Nurse and F because we do not feel that they can add anything material to the information available to us from the psychiatric and general practitioner records and our meetings with the members of staff listed above. The Staff Nurse did not actually assess RS's mental state and F is no longer employed by the Trust and is, we are told, unable to recall RS.

8. Usually in such a case it would be our practice to offer to meet the members of the family of the patient concerned, but in this case we received information to the effect that Mrs Salmon's son and daughter would not be likely to wish to meet us and accordingly we have not taken any steps to contact them.

9. Since our meetings with the staff, Dr Bradley has discussed RS's care and treatment with her General Practitioners by telephone and their comments are reported in paragraphs 58 and 59 below. Also Mr Brown has discussed certain points arising from the St Andrews Centre notes, which were not available when we met them, with A and B over the telephone and has also followed up two aspects of the case with D by telephone.

THE HISTORY OF THE MATERIAL EVENTS AND THE PSYCHIATRIC CARE AND TREATMENT OF RS WHICH WE HAD TO CONSIDER

10. As already stated, no evidence was put before us to suggest that RS had any history of mental disorder or criminal record prior to the 27 May 2002.

11. On the 27 May 2002 at approximately 10.30 p.m. RS, a known epileptic, attended the Accident & Emergency Department at Colchester General Hospital after having taken an overdose of Hedex Extra tablets and phenobarbitone and a large amount of alcohol. The staff in the Accident & Emergency Department consulted the Poisons Unit at Guy's Hospital about the appropriate treatment regime but shortly before 1 a.m. on the 28 May 2002 RS discharged herself from the Hospital in spite of the fact that the potential complications of a

phenobarbitone overdose and the need for blood tests and a period of observation were explained to her.

12. This incident resulted from the discovery by RS on the 20 May 2002 that her husband, Derek, was having an affair with another woman. Mr Salmon had left the matrimonial home at RS's insistence on the 25 May 2002.

13. At 00.15 a.m. on the 29 May 2002 RS attended the Accident & Emergency Department at Colchester General Hospital again, after having cut her own wrists and taken an unknown quantity of alcohol. On this occasion her husband appears to have attended with her. The tendons in both of her wrists were damaged and after emergency treatment was given, arrangements were made with the St Andrews Centre (the specialist plastic surgery and hand unit at Broomfield Hospital, Chelmsford) for RS's further treatment to be undertaken there. An ambulance was ordered for after 6 a.m. on the 29 May 2002 for RS's transfer there.

14. At 2.18 a.m. on the 29 May 2002 the Accident & Emergency Department staff contacted the Lakes (the psychiatric unit at Colchester which shares the same site as Colchester General Hospital) and RS was seen by the Psychiatric Staff Nurse mentioned in paragraph 7 above. However, no assessment of RS's mental state was possible at that time due to the need to secure RS's medical fitness first and the continuing effect of her intake of alcohol. The Staff Nurse gave Mr Salmon the telephone number of the Mental Health Assessment Team to contact, if necessary, when RS's wrist injuries had been treated and also advised about the alternative option of a referral being made through RS's General Practitioner. The Staff Nurse recorded the position and the action taken by him in a Fax sent by him at 04.33 a.m. on the 29 May 2002 to an unidentified addressee. For the sake of completeness, we should mention that the date printed by the Fax machine on the copy of that Fax in the documents supplied to us is the 2**8** May 2002, but it seems to us that that is an error, whatever its cause, as (if correct) it would be entirely incompatible with all the other relevant dates shown in the contemporaneous records.

15. RS was admitted to Ward B27 at the St Andrews Centre by 10 a.m. on the 29 May 2002 and she underwent surgery between 10.00 p.m. and 11.00 p.m. that evening for the repair of the division of the palmaris longus tendon in her left wrist. The injuries to her right wrist did not require any surgical repair.

16. During the morning of the 29 May 2002 a member of the counselling team at the St Andrews Centre, saw RS, her husband, her son and her daughter and advised that she be seen by the Liaison Mental Health Team. B, a member of that Team, came to see RS on the 30 May 2002. RS was reluctant to speak to B at first but then did so. B concluded that RS was suffering from a severe reaction to the breakdown of her marriage; that her safety could not be guaranteed; and that she required admission to a psychiatric unit as an in-patient. In accordance with normal practice, B arranged for RS also to be seen by F, a locum Staff Grade Psychiatrist, who diagnosed severe adjustment disorder and concluded that there was a significant risk of self-harm or suicide and a need for RS to be assessed for possible admission as an in-patient at a psychiatric unit in Colchester. F also advised the ward staff at the St Andrews Centre on RS's future management on the ward.

17. The conclusion reached by B and F that RS might have to be admitted to hospital compulsorily under the Act made it necessary for her to be assessed by a medical practitioner

approved by the Secretary of State for Health under Section 12 of the Act as having special experience of the diagnosis or treatment of mental disorder and by an ASW. Accordingly, RS was seen on the 31 May 2002 by A and the Consultant Psychiatrist.

18. Precisely how the arrangements were made for A and the Consultant Psychiatrist to assess RS is a matter which we examine in more detail in paragraphs 33 to 37 of this Report, but for the purposes of this history of the relevant events, we can pass directly on to the result of their assessment.

19. A and the Consultant Psychiatrist saw RS at 3.15 p.m. on the 31 May 2002. They were told by RS of the circumstances leading up to her recent actions and she said that she had never harmed herself or felt suicidal in the past. She added that she then had no thoughts of self-harm or suicide and that she did in fact feel that she had acted foolishly and impulsively. A recorded in her written report of the assessment - a report with which the Consultant Psychiatrist fully agreed - that "She *(RS)* talked about the marriage and her husband's infidelity *(and that)* she was rational, calm and displayed few emotions during interview. She related to her work as a technician and said she wanted to return , when her wounds have healed." This assessment was carried out in the presence of RS's adult son and daughter, both of whom said that they would be moving in with their mother and would provide support to her and both of whom were opposed to her compulsory admission under the Act

20. The conclusions reached by A and the Consultant Psychiatrist were that RS had a good insight into the difficulties she faced in the next few months and that she did not require formal (i.e. compulsory) admission to, and detention in, a psychiatric unit under the Act. The Registrar on the Plastic Surgery ward is recorded as having agreed with these conclusions. It was agreed that on discharge RS would be given the telephone number of the 24-hour Access Team at the Lakes in Colchester in case she wanted to contact them.

21. The form of Report by an ASW on MHA assessments then in use contained a specific section for Risk Assessment. A completed the form to show RS as being a risk in terms of suicide and self-harm, but she and the Consultant Psychiatrist told us that at the time of the interview RS no longer presented with suicidal thoughts and the risks of suicide or self-harm had reduced. Accordingly, RS was discharged home, where her son and daughter would be staying with her. RS also said that she would accept help and would telephone the 24 hour access team at the Lakes if she required support. Her son and daughter also said that they would contact the Lakes, if they were concerned.

22. Following the assessment carried out on the 31 May 2002 RS was not in touch with the Psychiatric Services in North Essex again until the 11 July 2002. We should mention at this stage that later newspaper reports published at the time of RS's trial for the murder of her husband on the 28 and 30 June 200**3** reported that two incidents of aggression involving RS and her husband occurred in the meantime. First, Mr Salmon was said by the Evening Gazette on the 30 June 2003 to have gone to RS's house on the 11 June 2002 and kicked a door down when demanding his passport. Second, the Evening Gazette of the 30 June 2003 and the East Anglian Daily Times of the 28 June 2003 reported that in late June 2002 RS had slashed her husband's car tyres and had poured brake fluid over the bonnet of his car. It is important to record that neither of these incidents came to the attention of the Trust's staff while they were treating RS.

23. Also during the period between the 31 May and the 11 July 2002 RS went on holiday to Turkey with members of her family. She is believed to have returned to England from Turkey on or about the 7 July 2002. On Thursday, the 11 July 2002 RS telephoned the 24 hour Access Team in Colchester. The information which she gave to the officer taking the call was that she was not coping after her husband had left her, even with the support of her family, and that she had taken three overdoses, the most recent one having been taken in Turkey while she was on holiday there. Apparently she had been admitted to an Intensive Care Unit there. In the course of this conversation RS was tearful and she said that she felt severely depressed. Her General Practitioner was away until the following week and she needed help before he returned.

24. The officer passed the details of the call on to the Community Mental Health Team at Holmer Court, Colchester for them to assess RS's condition and RS was seen at Holmer Court on the following day by D and C, Community Psychiatric Nurses. The interview was conducted mainly by D. Her Community Care Event Report recorded a brief history. As to the current position, D noted that RS remained low in mood and tearful but denied any plan to harm herself at that time. RS did not wish to take any medication or to be admitted to hospital. She did, however, accept the offer of a follow-up visit on the following Monday, the 15 July 2002. D also ensured that RS had the telephone number of the CMHT 24-hour team, the North Essex Resource Information Line number (a help line) and that of the Samaritans, with whom RS had been in contact previously and whom she had found to be helpful.

25. As arranged, D called on RS at her home on the 15 July 2002. The Community Care Event Report of the visit recorded that RS said that she would not kill herself. She was, however, tearful and she talked about feeling lonely and being afraid of living on her own for the rest of her life. RS's eye contact with D was good and she had no difficulties in expressing her feelings. A further visit was arranged for the 25 July 2002 and D agreed to telephone her over the intervening weekend in case RS needed a visit.

26. That further visit duly took place on the 25 July 2002. On that occasion RS was dismissive and lacked the eye contact she had shown previously. She told D that she did not want to talk to anyone that day and D left. The Community Care Event Report records that D told RS that she was going on leave for the next two weeks and that she would contact her again on her return.

27. At our meetings with D and C we explored in more detail the substance of these three meetings between D (and C on the first occasion) and RS and we deal with those discussions in paragraphs 52 to 57 below.

28. As stated, that last meeting between D and RS took place on the 25 July 2002, which was a Thursday. D then went on two weeks' leave and on Sunday, the 28 July 2002 RS killed her husband.

29. After that tragic event RS was seen on two occasions by E, a member of the Colchester Criminal Justice Mental Health Team, first at Colchester Magistrates Court on the 30 July 2002 and then on the 6 August 2002 at Chelmsford Crown Court. As these interviews occurred after the killing of Mr Salmon and the arrest of RS, they were concerned more with the risks posed by RS to herself and/or others while in custody and although for the sake of completeness we met E, we do not think it necessary for us to deal with these two interviews,

apart from recording E's confirmation to us that RS had never said to her that she (RS) wanted to harm her husband..

MATTERS ARISING FROM OUR INQUIRIES

30. We now address in more detail a number of matters, which we have had to consider in order to satisfy our obligations under our terms of reference. The matters in question are now listed below one-by-one in underlined text, followed in each case by our commentary and conclusions on each of them. Our conclusions are set out in bold type.

The availability of in-patient accomodation on the 30 May 2002.

31. This question arose because a "Postit" sticker was annexed to the record of B's assessment of RS on the 30 May 2002, which noted that no psychiatric beds were available in Colchester that day. However, at our meeting with B, she confirmed that the availability or otherwise of a bed did not influence the course of RS's care. That is consistent with the fact that in any event RS was receiving in-patient treatment for her wrist injuries until the 31 May 2002, when A and the Consultant Psychiatrist concluded that RS was not in need of in-patient care anyway.

32. Accordingly, the availability of in-patient accomodation was not a matter which we had to pursue any further.

The procedures for arranging an assessment of a patient for the purposes of the Act after that patient has already had an assessment of his or her mental state.

33. B and F did, of course, carry out an assessment of RS's mental state on the 30 May 2002, when they concluded that she was in need of compulsory admission to hospital under the Act. For that purpose RS needed a further assessment by a doctor and social worker approved for that purpose to determine whether the conditions for such an admission laid down by the Act were fulfilled. That assessment ("the MHA assessment") was carried out by the Consultant Psychiatrist and A at 3.15 p.m. on the 31 May 2002.

34. We did, however, hear inconsistent evidence as to how the MHA assessment was arranged. When we met her, B told us that she had requested the MHA assessment, though it must be remembered that our meeting with her took place about twenty-one months after she had seen RS and that B said that she did not then actually remember RS . On the other hand the Consultant Psychiatrist and A told us that the referral of RS to them for the MHA assessment came from the ward (Ward B27) at the St Andrews Centre where she was receiving treatment for her wrist injuries.

35. At the time of our meetings first with B and then with the Consultant Psychiatrist and A jointly we did not have the records from Ward B27 available to us. We did, however, obtain them after the two meetings and they reveal the following sequence of events:

Date	Time	Event
30.05.02	1.30	B visited the ward to see RS, who was initially reluctant to see her. B then

	p.m.	made arrangements for a doctor to attend with her to assess RS as she was not happy that RS be discharged.
Ditto	3.30 p.m.	By this time RS had been seen by B and F, who both felt that she was in need of in-patient assessment.
Ditto	5.15 p.m.	A ward nurse rang B who said that she was trying to contact the on-call Consultant.
Ditto	5.25 p.m.	Further telephone call in which B reported that she had contacted the psychiatrist who said that RS would be assessed the next morning.
31.05.02	8.00 a.m.	The Ward tried to contact the Liaison Team at the Linden Centre (the psychiatric unit in Chelmsford) to find out what was going to happen, but nobody was available to deal with the query.
Ditto	9.05 a.m.	Further call to the Liaison Team, who said that the case was now nothing to do with them and that the Ward would have to contact the Approved Social Workers' Assessment Office.
Ditto	9.10 a.m.	The Ward tried to ring the Assessment Office, but without success.
Ditto	9.20 a.m.	The Assessment Office returned the Ward's call, took details of the case and said that they would be passed on to the on-call Approved Social Worker/Assessor.
Ditto	10.00 a.m.	The Ward was advised by telephone that it was agreed that the assessment seemed to be necessary but was told that it could be "hours" before the attendance of the appropriate personnel to deal with the matter could be arranged.
Ditto	12.10 p.m.	Further telephone conversation between an ASW/Assessor and the Ward, in which the Ward was advised that the case had been handed over to A, a member of the Criminal Justice Team at the Linden Centre.
Ditto	12.15 p.m.	The Ward rang the Criminal Justice Team to be told that A was in Court but that she had spoken to the Consultant who would not be available until after 2.00 p.m.
Ditto	3.15 p.m.	MHA assessment carried out by the Consultant Psychiatrist and A (N.B. This time is taken from the assessment record and not from the Ward nursing notes).

36. In our view the contemporaneous nursing notes are not only likely to provide the most reliable account of the material events two years after they occurred but also they may well go some way towards reconciling the inconsistencies in the recollections of B on the one hand and A on the other. It is clear that B started off the process of arranging the MHA assessment but it is equally clear that after the referral passed from the Liaison Team to the ASWs' Assessment Office and then successively to another ASW/assessor and A, the final arrangements in the referral process were made directly between Criminal Justice Team/A and the Ward.

37. In any event, RS was duly assessed for the purposes of the MHA on the 31 May 2002 and so nothing now turns on the different evidence about how that assessment was arranged given to us by B and A respectively, except perhaps for a need for the Trust to review the procedure for arranging MHA assessments to ensure both that the process is as efficient as it reasonably can be and that it is clearly understood and applied by all officers involved in arranging MHA assessments.

38. This matter is also linked with the next matter which we consider.

<u>The arrangements for officers conducting a second or subsequent assessment to have available to them all records of previous attendances on, and assessments of, the patient in question.</u>

39. When the Consultant Psychiatrist and A assessed RS on the 31 May 2002 for the purposes of the MHA they did not have available to them the record of the mental state assessment carried out on the previous day by B and F. Indeed, they had not seen it, until we produced it to them at our interview with them.

40. When we met B, she told us that usually the team carrying out the MHA assessment would come to the office and read through the paperwork of any previous assessment or there would be a meeting on the ward, though "usually it is better for them to come into the office". In addition, the first team to see the patient will write something in the ward notes to give an overview to the team carrying out the MHA assessment. Otherwise, contact between the two teams depends on whether a member of the first team is on duty when the second team makes its assessment.

41. On the other hand, A told us that normally the Liaison Team (or 24-hour Team) would fax any information in their possession through to the ASW carrying out the MHA Assessment.

42. It may be - though we can come to no definite conclusion on this point without extending our enquiries unnecessarily - that the records of the assessment carried out on the 30 May 2002 or information regarding that assessment were not available to the Consultant Psychiatrist and A simply because the referral for the MHA assessment had to pass through the Liaison Team, the ASW's Assessment Office, another ASW/assessor and the Criminal Justice Team before it ended up with A. In any event, once A and the Consultant Psychiatrist had made their own assessment of RS and had concluded that she was not in need of admission and indeed did not satisfy the conditions for it laid down by the MHA, there was no necessity for them to seek any information or records of the previous day's assessment.

43. In that connection we should record that the Consultant Psychiatrist told us expressly that "I do not think that I could have actually recommended detention under a section of the Mental Health Act at the time." Furthermore, his view about compulsory detention is wholly consistent with the views of A as expressed in her Social Circumstances Report. His findings at that time are set out more fully in paragraphs 46 to 50 below.

44. When we interviewed A and the Consultant Psychiatrist, we did, of course, have B's record of her assessment of RS's mental state on the 30 May 2002 available to produce to them. We duly produced it and both of them confirmed that it did not contain anything which would have caused them to alter the conclusion reached by them on the 31 May 2002 that RS did not then require compulsory admission to hospital under the MHA, because she did not meet the criteria for such admission set out in the Act and had adequate support from her family.

45. It follows from the points made in the last two preceding paragraphs that the fact that the Consultant Psychiatrist and A did not have B's notes of her assessment of RS on the preceding day available to them when they assessed RS had no effect on the

subsequent course of RS's care and treatment. In another case that may not be so. Therefore, we would recommend the Trust to review their procedures for the transmission of a patient's previous history and supporting documentation to an approved doctor and social worker making an MHA assessment, in order to ensure that thee latter have before them all the information that they may need to carry out their statutory tasks properly and that those procedures are fully understood and implemented by all officers concerned. Where, as in this case, the patient is already receiving in-patient treatment in a surgical or medical ward, those procedures need to take account of the fact that the records from that ward may be of assistance to the officers carrying out an assessment.

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The compatibility of the conclusions about RS's mental state and needs reached at the assessments carried out on the 30 and 31 May 2002 respectively.

46. As a result of their assessment on the 30 May 2002 B and F concluded that RS should be admitted to the Colchester Psychiatric Unit and for that purpose should be assessed under the MHA. One day later the Consultant Psychiatrist and A carried out that MHA assessment and decided that RS did not need formal (i.e. compulsory) detention in hospital under the Act.

47. As stated, the Consultant Psychiatrist and A had not seen B's records of her and F's assessment when they assessed RS. When we met the Consultant Psychiatrist and A, we asked them about the basis for their conclusion. In reply the Consultant Psychiatrist told us that he did not note any evidence of any mental disorder in RS, either in terms of mental illness or a personality disorder. What had precipitated the recent incidents of self-harm was a huge stress response which, however, was not giving rise to any on-going danger of self-harm by the time he assessed RS. The Consultant Psychiatrist also told us that by that time RS was "very unequivocal that she had no intention of harming herself or of suicide." Moreover, her son and daughter, who were present at the assessment, supported RS fully and were going to stay with her on her discharge. This family support was a very important factor in the Consultant Psychiatrist's view. A's notes of the assessment essentially confirm the absence of suicidal thoughts by that time, the reduction in the risk of self-harm and the availability of 24-hour family support.

48. In essence, the Consultant Psychiatrist and A did not think that the statutory conditions for compulsory detention under the MHA, namely the presence of mental disorder of a nature or degree warranting hospital admission and the need for detention in the interests of the patient's own safety or with a view to the protection of others, were satisfied.

49. As stated, we gave the Consultant Psychiatrist and A the opportunity of reading B's notes of the assessment which she and F had carried out on the 30 May, which included an entry by F, and after reading them, the Consultant Psychiatrist and A confirmed that nothing was revealed by the notes which caused them to alter the decision reached by them on the 31 May 2002 that RS was not in need of, and did not qualify for, compulsory detention under the Act. Indeed, the Consultant Psychiatrist commented that the patient described in the notes seemed to be a different patient from the one whom he had seen. In his assessment RS had been "....remarkably different in terms of the thoughts about the future, what she was going to do about her marriage, about her positiveness, that the children were going to be there and with their help and the mother-in-law's help she was going to rebuild her life."

50. In answer to the express question whether there was any information emerging from B's assessment which might have led him to a different conclusion, the Consultant Psychiatrist said that "At the time when I assessed her I do not think that I could have actually recommended detention under a section of the Mental Health Act at the time. What I might have done is try to pursue with her and her family for her to take shelter in the mental health unit at the Lakes in Colchester, perhaps for a few days, so that more support services could be tied up, such as she could be linked to her own catchment area consultant psychiatrist and a community mental health team; that they would be on stand-by to try and assist her in any way they could. That is probably the extent of it.....at the time I saw her, given her mental state and given..... the way her children and her mother-in-law supported her version of events, I could not have recommended a Mental Health Act detention."

51. We accept the Consultant Psychiatrist's comments, supported as they are by A, and insofar as there may appear to be a possible inconsistency between the results of the two assesments made on the 30 and 31 May 2002 respectively, any such inconsistency is explained to our satisfaction by the Consultant Psychiatrist's comments to us.

<u>The adequacy of the arrangements for RS's continuing care made first on the 12, 15 and 25 July 2002 respectively.</u>

52. We pass now to the second part of RS's care, namely that provided for her on three occasions in July 2002 after her return from holiday in Turkey, in the course of which RS had taken a third overdose. This part of her care is summarised in paragraphs 24 to 26 above. In essence D's three meetings with RS were part of a continuing attempt on her part to achieve a sound professional relationship with RS rather than a period of active care and treatment.

53. At our meeting with D she described her three meetings with RS to us in considerable detail. She told us that the first meeting, on the 12 July 2002, was not a usual one because all that RS could talk about was her husband's affair. Nevertheless, D felt that she was bonding with RS and fixed another meeting with her in three days because she (D) felt that it was important to get RS to engage with her. D was going on holiday herself in about two weeks and thought that she needed to get RS involved with the mental health services so as to be able to leave her in good hands when she left for her holiday.

54. On the second occasion (the 15 July 2002) D spent a longer time with RS than normal and again felt that she was achieving good eye contact and rapport with her. RS was pre-occupied with the fact that her husband had run off with someone who was not her social equal. D told us that they talked about how RS felt mentally, about what had happened in the past and if she was going to harm herself again. In that last respect RS was adamant that she would not harm herself again. She remarked that her husband had taken every thing else from her and he was not going to have that. In answer to Dr Bradley, D confirmed that RS had expressed anger but more in the sense of being incredulous about what her husband had done. D added that on this second occasion RS was much more positive, wanting to move on with her life.

55. After that second meeting RS was much more withdrawn. D tried to make contact with her by telephone on several occasions without success and RS did not return her calls.As she was about to go on leave, D went to visit her but was only admitted reluctantly. Indeed, within

about 15 minutes RS said "Look ! I really do not feel like talking. Can you leave ?" The Community Care Event Report of that last visit contained no indication of what (if any) action D took to cover the case while she was on holiday. However, she told us that the third visit took place on a Thursday, which it did, and on Thursdays her Team had regular meetings at which any matters of concern could be raised and at that particular Thursday meeting she arranged for a colleague to look after RS while D was on holiday. D told us that the plan was that her colleague would contact RS on the following Monday but RS did, of course, then attack her husband on the following Sunday, the 28 July 2002, before that contact could be made.

56. After D gave us this information, Mr Brown spoke to the colleague in question by telephone when she confirmed that D had spoken to her, though she could not recall whether D had asked her to initiate contact with RS or whether it was a case of D having given her (the colleague's) name to RS in case RS wanted to contact someone for help while D was away on holiday.

57. Whilst it would have been preferable for that arrangement to have been recorded, the omission to record it had no bearing whatever on subsequent events in this case. Apart from that point, we believe that D's approach to RS during the latter half of July 2002 was entirely responsible and that there was no reason for D to intervene more actively or urgently. In that respect it is important for us to stress that at all material times in this sad sequence of events the potential risk indicated by the evidence, and which the officers had to address, was that of RS doing further harm to herself rather than her being a danger to any one else.

Liaison between Mental Health Services and RS's General Practitioner (the only other "agency" involved).

58. The care and treatment required by RS between the 30 May and 28 July 2002 was all provided by the staff of the Trust. Reports of RS's care and treatment, both for her wrist injuries and her psychiatric problems, were sent to her General Practitioner in the normal way. Also, during the period in question a member of the practice saw RS on one occasion after she had injured her wrists and on another occasion another doctor in the practice had taken a telephone call from D on the 25 July 2002, the object of which was to advise the practice of D's concern about RS whilst she (D) was on holiday, in which respect the practice's representative confirmed that RS would be seen by them whenever she wanted to be.

59. We did not think it necessary to ask the members of the practice to meet us but Dr Bradley spoke to two of them over the telephone and was assured that they were very pleased with the quality of care provided for RS by the Community Psychiatric Nurses.

Compliance with statutory obligations affecting RS's care and treatment.

60. RS was never admitted to hospital under the MHA and so there are no issues in this case about compliance with the Act or with the Department of Health's discharge guidance.

Compliance with the Trust's protocols and policies.

61. We asked to see the Trust's relevant protocols and policy documents on matters such as Risk Assessment and the Care Programme Approach. In response to that request we were given the Risk Assessment Tools Handbook of the predecessor North East Essex Mental Health NHS Trust (the April 2000 Edition), the Trust's own Risk Assessment Tools Handbook (undated) and the Trust's Care Programme Approach Policy dated October 2001. It has been confirmed to us that the Trust's undated Risk Assessment Tools Handbook was not in use at the time of these events and so we have not had any regard to it for the purposes of our inquiries and this report.

62. The Trust assumed responsibility for Mental Health Services in a catchment area which includes Chelmsford and Colchester with effect from the 1 April 2001. The report of the Trust's own serious, untoward incident inquiry into this matter states that ".....the risk assessment tools in use at the time of (these events) were those used in the predecessor Trusts, use of which was explicitly advisory rather than mandatory. The incident pre-dates the introduction by the Trust of a Clinical Risk Management Protocol with its single mandatory risk assessment/screening tool. Staff at the East Area 24 hour mental health assessment team (from whom Mrs Salmon was receiving care prior to the incident) have all received training in risk assessment and risk management." We understand that that is also the position in Chelmsford, which is not in the East area.

63. The relevant parts of the North East Essex Risk Assessment Tools Handbook are as follows:

i. A form of Chronology of Risk Assessments:
We do not know whether or not this form was actually in use in the period May to July 2002 but we have not seen it or any similar form in RS's records.

ii. The Screening Protocol for Accident & Emergency Departments:
Certainly there was liaison between the A & E Department in Colchester and the Lakes early in the morning of the 29 May 2002, though the Staff Nurse from the Lakes was unable to assess RS then due to her intake of alcohol and her physical injuries. In addition, it is clear that Ward B27 at the St Andrews Centre, though not an A & E unit, maintained contact with the CMH Teams in Chelmsford after RS's transfer to that ward.

iii. Guidance on Risk Assessment of Suicide and Self Injury:
The Handbook contains a considerable amount of guidance on the risks of self-harm and/or suicide. There is little indication from the records that that guidance was specifically applied in RS's case but we are satisfied that all the officers involved in her care and treatment were fully alert to the risk of further self-harm and/or suicide by her from her very presentation and history since May 2002 and we do not feel that we need to consider the use of these parts of the Handbook any further.

iv Guidance on Risk Assessment of Dangerousness in Clients:
We would first comment that the records regarding RS do not contain any written assessments of the risks posed by her to others. However, B confirmed to us in her oral evidence that she does as a matter of routine

consider whether a client is a risk to others at the same time as she is considering the risk of self-harm. B and her present manager also told us that there would have been a risk assessment form (the Worthing Risk Indicator) in use in 2002, which leads an assessor to explore evidence of risks of both self-harm and danger to others.

The records produced to us do not contain any such form but we have no reason to reject B's recollection that such a form would have been completed, and our joint experience of medical/psychiatric record-keeping makes us aware of the possibility that on occasions forms simply do not find their proper "homes". More importantly, however, in RS's case all the evidence available to the officers involved in her treatment pointed towards self-harm as the risk and none towards her being a danger to anyone else. Therefore, if a form had been completed, the great probability is that it would have done no more than reflect that position.

Then, on the 31 May 2002 the Consultant Psychiatrist and A concluded that the main risk for them to consider was that of self-harm and/or suicide, albeit at a reduced level, and not that of dangerousness to others. This is borne out by A's completion of the relevant section of her Social Circumstances Report in which she ticked the "Suicidal" and "Self Harm" boxes but not the "Danger to Others" box. We asked them whether dangerousness to others was something which they considered as a matter of routine and were told that they had asked specifically about RS's feelings towards her husband and were told by her "very categorically" that she had finished the relationship with him; that she knew there was nothing left in it; and that even if he were to return, she would not take him back. The Consultant Psychiatrist also told us that he discussed with RS both the question whether she drank excessively and the possibility that her epilepsy might have caused her to think that she was a kind of handicapped or ill person and thus might feel more aggrieved by the desertion, without being given any reason by her to believe that she was a danger to others.

By the time D saw her on three occasions in late-July 2002 RS had apparently taken a third overdose of drugs while on holiday in Turkey, which had necessitated intensive care there. If anything, this accentuated the risk of self-harm rather than that of danger to others and when we discussed that latter danger with her, D confirmed that there had been no indication whatsoever that RS might harm anyone else. D's comments to us about risk assessment were to the effect that formal risk assessments were updated only when a change in the client's circumstances required and that in the case of RS the accent throughout was on self-harm without there being any other risk. Indeed, the reports of RS's behaviour on the weekend of the 27/28 July 2002, which reached D after her return from holiday, made RS appear as a different person from the one D knew on her three meetings with her earlier in the month. D added that RS's actions on that weekend simply made no sense to her.

64. Accordingly, we not consider that there were any factors in RS's presentation on the 30 and/or 31 May 2002 which justified B, the Consultant Psychiatrist and A in concluding that RS was a risk to others, nor do we feel that there were any indications that RS was a danger to others, which D could or should have recognised in July 2002.

65. Overall, therefore, whilst written risk assessments are obviously to be encouraged, both to ensure that officers consider the whole spectrum of risks that a patient might pose and to alert all concerned to any risks that are actually recognised, in this particular case the great probability is that no such assessment would have identified any risk of danger to any other person apart from RS herself anyway.

66. As the Risk Assessment Tools Handbook in force at the time of these events was only used on an advisory, and not mandatory, basis we do not feel that it would be right for us to take this matter any further, save to express the hope that the Trust now has a clear Risk Assessment policy and supporting literature in mandatory use throughout its area.

The Care Programme Approach

67. In the context of this Review the North Essex CPA Policy states in paragraph 1.2.3 on page 3 that the CPA applies to all service users accepted by specialist psychiatric services. The provision of a service for RS on the 12, 15 and 25 July 2002 and the intention, apparent from the records and evidence given to us, that that service was intended to continue both during and after D's holiday indicates to us that the CPA was applicable to RS by the 25 July 2002. On page 5 of the Trust's Serious Untoward Incident Inquiry report the sparse nature of the CPA documentation in this case was noted, and certainly we have not seen evidence of any more CPA documentation than that listed in Finding No. 2 on page 4 of the Trust's own report. In particular, we have already commented in paragraph 57 above on the desirability of the arrangements for cover during D's holiday having been recorded - an omission which D herself acknowledged in our meeting with her - though we repeat that, important though the objective of keeping full and accurate patient records undoubtedly is, we do not think that the unfortunate outcome in this particular matter was affected by any omissions in the keeping of records for RS.

Co-ordination and the establishment of common procedures throughout the Trust

68. This is something of a side-issue but in our meetings with the officers involved in RS's care and treatment a number of them mentioned to us that those working in one part of the Trust's area, for example Chelmsford, did not know about the practices applying in another part of the area, such as Colchester.

69. We are mindful that the Trust, as one entity, began to operate on the 1 April 2001 and was faced with the inevitable problems of unifying the working practices of a number of predecessor trusts or departments. That process of unification would inevitably have taken an appreciable period of time and even if the process remained incomplete in the Summer of 2002, much more work towards its completion is likely to have been undertaken over the intervening two years.

70. Accordingly, we mention the point merely in case it is a matter which Management in the Trust is still having to address, as of course, they will know as well as we do, if not better, that practices unified throughout the whole Trust, known to and understood by all staff, greatly facilitate the delivery of services to the clients of the Trust.

Our consideration of the Trust's Internal Review of the case

71. Our Terms of Reference require us to examine and review the Trust's internal review of the case. The major questions covered by the Trust's internal review have been covered by the preceding sections of this Report. We should, however, make the following additional points in connection with the Trust's internal review:

72. The chronology of the material events set out in the report of the internal review is not fully consistent with those events, as we understand them to have occurred. Indeed, there was one substantial misconception in that the final paragraph of the section entitled "The Incident: Chronology" on page 2 concludes with the statement that "This means that there was in fact probably just one attempt *(of self-harm),* that took place on 27.05.2002 and involved an overdose and cut wrists", whereas we now know that there were two separate attempts in May 2002, apart from the further one in Turkey in July 2002.

73. In paragraph 1 of the section entitled "The Inquiry: Findings" reference is made to the complete absence of formal risk assessments or risk management plans, whereas B told us that she had completed one, though it has not been traced, and A did complete the part of her Social Circumstances Report form dealing with Risk Assessment.

74. Paragraph 5 on page 4 of the report of the internal review, entitled "Supervision of junior staff", contains the comment that Supervision arrangements within the team *[in Colchester]* are that G grades supervise E grades and discuss all their cases with them, but this is not underpinned by robust documentation of this process." Both C and D described to us how they received clinical supervision from a named, senior supervisor in their team. We certainly agree that the keeping of proper records of such supervisory sessions is good practice but again, since the Trust had already explored the matter of record-keeping, we did not feel it necessary to re-visit that point.

75. In the penultimate paragraph on page 5 of the report of the internal review attention is drawn to the absence from the MHA assessment documentation of any opportunity to provide for a management plan for a patient not admitted to hospital. We do not see that provision should be made for such a plan in the MHA assessment documentation, as the formulation of such a plan is surely the responsibility of the appropriate CMHT, unless the ASW and Section 12 Doctor are also the members of the CMHT who will be treating the patient.

Other matters arising from our inquiries

76. At the time of RS's trial for the killing of her husband the Press reports contained a suggestion by a Dr Gillian Mezey that as a matter of good psychiatric practice it would have been proper to have admitted RS to hospital for care and treatment, though Dr Mezey added that she had reached that view with the benefit of hindsight. All that we can say in this respect is that Dr Mezey did not see RS at the time of the events in question; that it is clear from the

evidence that we received that RS presented differently on a number of the occasions when she was seen by the Trust's staff; and indeed that when RS was seen on the 31 May 2002 by the Consultant Psychiatrist and A, they were both satisfied - on grounds which we find to be convincing - not only that RS was not in need of compulsory admission to hospital under the Act but also that the requirements of the Act for such admission were not fulfilled. It is also material that RS was not agreeable to voluntary admission.

77. Our second point under this heading is that several relevant matters did not come to the attention of the Trust's officers while RS was in their care. In this connection, we have already referred to two incidents of aggression in late-June 2002 in paragraph 22 above. In addition, the Press reports published at the time of RS's trial referred to the turbulent nature of Mr and Mrs Salmon's marriage - something which was never mentioned to the officers involved in RS's care and treatment.

OUR OVERALL VIEW OF THE QUALITY OF THE CARE AND TREATMENT PROVIDED FOR RS

78. We are satisfied that, apart from one or two apparent omissions in record-keeping, the care and treatment provided for RS between the 30 May and the 29 July 2002 was of a good standard in all respects. Moreover, in our opinion there were no untoward acts or omissions occurring in the course of that care and treatment which caused, or contributed to, the killing of Mr Derek Salmon on the 28 July 2002. Generally we were favourably impressed by the way in which the members of staff whom we interviewed explained to us the background to, and reasons for, their decisions as to the care and treatment provided for RS and we see no grounds for criticising any of the individual staff members concerned.

Dated the day of January 2005

.....
Dr John Bradley, Chairman of the Review Panel

....
Ms Angela Flaye, Member of the Review Panel Mr Colin Brown, Member of the Review Panel

REPORT OF THE INDEPENDENT PANEL REVIEWING THE CARE AND TREATMENT PROVIDED FOR MRS RITA SALMON BETWEEN MAY AND JULY 2002

ADDENDUM LISTING THOSE OF THE REVIEW PANEL'S CONCLUSIONS AND RECOMMENDATIONS REQUIRING, OR POSSIBLY STILL REQUIRING, FURTHER ACTION

For various reasons a considerable period of time has elapsed since the unfortunate events which gave rise to this review occurred. During that intervening period the North Essex Mental Health Partnership NHS Trust may already have addressed some or all of the matters which the Review Panel identified, on the evidence received by it, as being matters which require, or might still require, further attention from the Trust's management.

Those matters are listed below. This addendum does, however, need to be considered in the light of any relevant action already taken by the Trust in the intervening period to address the matters in question. Moreover, those matters also have to be considered in the light of the Review Panel's full report to put them into proper context.

The matters in question are:

1. **That the Trust should review the procedure for arranging assessments under, and for the purposes of, the Mental Health Act 1983 (''MHA assessments''), to ensure both that the process is as efficient as it reasonably can be and that it is clearly understood and applied by all officers involved in arranging MHA assessments.**

2. **That the Trust should review its procedures for the transmission of a patient's previous history and supporting documentation to an approved doctor and social worker making an MHA assessment, in order to ensure that the doctor and social worker have before them all the information that they may need to carry out their statutory tasks properly, and should ensure that those procedures are fully understood and implemented by all officers concerned. Where, as in this case, the patient is already receiving in-patient treatment in a surgical or medical ward, those procedures need to take account of the fact that the records from that ward may be of assistance to the officers carrying out an assessment.**

3. **That the Trust should ensure that it has a clear Risk Assessment policy and supporting literature in mandatory use by its staff throughout its area.**

4. **That, as certain of the Trust's officers whom we met told us that staff working in one part of the Trust's area, for example Chelmsford, did not know about the practices applying in another part of the area, such as Colchester, the Trust should ensure that, wherever possible, its working practices are unified throughout the whole of its area and are known to and understood by all staff, as unified practices greatly facilitate the delivery of services to the clients of the Trust.**

.....

Colin Brown,

Member of, and Secretary to, the Review Panel

January 2005