Oxfordshire Mental Healthcare NHS
NHS Trust

Strictly Private and Confidential

Senior Panel Review into the care and treatment of BS

For presentation at Trust Board Workshop October 2005

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Draft confidential report into the care and treatment of BS

1. Introduction

On the 5th of January 2005 Mr S was arrested on the suspicion of murdering his estranged wife.

Mr S was receiving community care from the Oxfordshire Mental Healthcare NHS Trust Crisis Resolution and Home Treatment (CRHT) Team at the time of his arrest.

Mr S was charged with murder and was remanded to HM Bullingdon Prison. The case is due before HM Crown Court in October 2005.

With the agreement of Thames Valley Strategic Health Authority the Executive Team of the Trust commissioned a joint Health and Social Service panel to undertake a review of the care and treatment of Mr S.

2. Investigation Process

The Executive Team of the Trust tasked the Head of Risk to manage and support the process of the investigation.

The Executive Team and the Strategic Health Authority agreed terms of reference for the investigation.

The terms of reference were that the panel report on:

- The history of mental illness of Mr S
- His treatment and care by Oxfordshire Mental Healthcare NHS Trust
- The panel were also asked to determine the adequacy of the support offered to Mr S and his family and to consider any questions or concerns raised by either the family of Mr S or that of the victim.

3. Membership of the Panel

- Mr Larry Sanders, Non Executive Director, Oxfordshire Mental Healthcare NHS Trust (Chair)

- Dr Mike Hobbs, Medical Director, Oxfordshire Mental Healthcare NHS Trust

- Mrs Alison Bussey, Director of Nursing, Buckinghamshire Mental Health NHS Trust

- Mr Graham Whitwell, Social Care Director, Oxfordshire County Council

- Ms Maureen Tierney, Secretary to the panel

The panel were most grateful for the information received from the victim's parents and wish to express their appreciation for their involvement with this investigation, particularly as they were also trying to absorb the death of their daughter as well as caring for her young children.

The family of Mr S did not respond to invitations by the panel to participate in the investigation but were informed about the progress of the investigation.

Sources of Information used by the Panel

- Clinical case notes
- Forensic assessment report following alleged offence
- Policies and procedures relating to:
    - The Care Programme Approach
    - Clinical Risk Assessment and Management
    - Crisis Resolution & Home Treatment (CRHT) Team Operational Document
    - FACE Risk Profile document

Interviews with the following

- The parents of the victim
- Crisis Resolution & Home Treatment Team Manager
- Dr B, Consultant Psychiatrist for Mr S
- Practice Development Nurse for CRHT Team
- Dr M, Consultant Psychiatrist linked to CRHT Team
- Senior Practitioner (Social Worker), CRHT Team
- Community Psychiatric Nurse, CRHT Team

Liaison with Thames Valley Police occurred both at the beginning and end of the process.

The panel were impressed with the willingness of all those professionals interviewed to aid the investigation process. All staff interviewed demonstrated the ability to reflect upon current practice and make comments where they thought improvements could be made.

4. Background to Incident

At the beginning of December 2004 Mr S left the family home following the breakdown of his second marriage. He continued to live in Oxford, staying with his brother.
He was referred on the 15th December 2004 to the Crisis Resolution & Home Treatment (CRHT) Team after presenting himself that same day to the John Radcliffe Hospital A&E department, asking for help because he felt low and thought that he might present a risk to himself.
Mr S was assessed on the 16th of December 2004 by a Community Psychiatric Nurse from the CRHT team and by a senior house officer.
The assessment indicated that he was experiencing a depressive episode with suicidal ideation following the breakdown of his marriage.

Mr S engaged with the CRHT team over the next four weeks.

At approximately 7pm on the 5th of January 2005 Mr S visited his estranged wife at the family home. He had consumed alcohol earlier that day and is alleged to have taken between 12 and 15 tablets of Nurofen and 12 to15 tablets of either Temazepam or Lofepramine. He had taken a knife with him.

His wife and three small children were alone in the house.
It is alleged that he stabbed his wife, more than once, wounding her fatally. The children were in the house but not present in the hallway where the alleged attack occurred.
Mr S is said to have alerted neighbours to the incident; Emergency services were called and police and ambulance attended.

Mrs S was pronounced dead at the scene.

Mr S was arrested and, following assessment at the local A&E department to establish his fitness, he was detained for questioning by the police.

5. Personal History of Mr S

Mr S was born in 1965 and brought up in Oxford. There is no history of problems with his mother's pregnancy or his early development. His mother was unmarried and said to be unable to cope with him, so for the first three year his maternal grandmother cared for him.
At aged three he went to live with his mother who was now married. Mr S had six half siblings (four brothers and one sister from his mothers marriage to his stepfather). He also had a sister who was adopted; this sister was not the stepfather's child.
Mr S reported his childhood as fairly happy but he did recall some incidents where his stepfather had been physically violent to his mother and to himself.

Mr S left school at 16yrs with 4 'O Levels' and went on to complete a Diploma of Higher Education in Ophthalmic Optics for two years before beginning work in Rochdale.

At age 22yrs he met his first wife and moved with her to Scotland to work as an optician. They returned to Rochdale 18 months later and Mr S held down a number of jobs over a few years.

This marriage produced two sons, aged 10 & 13yrs at the time of the alleged offence. However by 1996 the couple parted following the breakdown of their relationship and were divorced in 1997.

Mr S started another relationship, despite a brief period when he and his first wife decided to try again. He did not end this relationship and eventually in 1998 his ex-wife asked him to leave for good.

Following this final separation from his first wife and children, Mr S was admitted to Littlemore Hospital complaining of suicidal ideation and low mood (see previous psychiatric history).

Mr S met his second wife in 1998; they lived together for 6 years before marrying in 2004. There were three children from this relationship, 2 sons and a daughter, aged 5, 3 and 2 years at the time of the alleged offence.

Despite qualifying as a Rehabilitation Officer for the visually impaired Mr S stayed at home caring for the children in order that his wife could undertake an access course enabling her to undertake training as a midwife.

From September 2004 Mr S worked as a Rehabilitation Officer for the visually impaired spending the weekdays away in Hertfordshire and returning home at the weekends.

This second marriage ended in December 2004 when Mrs S found that Mr S had begun a relationship with another woman.
Mrs S began a friendship with a local man. Mr S was aware of this and is said by the family of his wife to have been jealous, spending time watching the house for signs of this man's presence.

Mr S lived with his brother in Oxford following the breakdown of his marriage. He continued to have access visits to his children, although he showed a marked preference towards his daughter which his wife found unacceptable. She had begun to set out conditions for access a few days before her death requesting that her husband have equal access to all the children.

There was no known history of violence in the relationship, although since the death of Mrs S her family have become aware (through reports from friends and neighbours) of three incidents of Mrs S having bruised and cracked ribs, a black eye and a chipped tooth. Mrs S had not confided in her family and they had been unaware of these alleged injuries. The family had noted a marked change in the relationship after the marriage, alleging that BS became possessive and demanding of their daughter. They saw less of her and she appeared to take much less interest in herself and her appearance following the marriage.
Mr S denies that he was ever violent towards his second wife.

6. Previous Psychiatric History

Mr S was referred to psychiatric services in April 1998 with low mood and suicidal ideation following the break down of his first marriage.

He was admitted as an informal patient for a period of one month. During this time Mr S was treated with Sertraline 50mg each day for a reactive depression secondary to his relationship breakdown.

He was discharged, having arranged accommodation and found work in Oxford.

Mr S declined follow up by a Community Psychiatric Nurse (CPN) and was discharged in July 1998 having failed to respond to offers to meet with the CPN.

There was no further contact with psychiatric services until he was referred on the 15th of December 2004.

7. Psychiatric Contact: this episode

On the 15th of December 2004 Mr S had seen his GP, complaining of low mood and suicidal ideation following the breakdown of his second marriage. The GP had commenced treatment of Lofepramine 70mg nocte and also referred Mr S to the catchment area Consultant Psychiatrist, Dr B.

On the **15th of December 2004** Mr S also self-referred to the A&E department at the John Radcliffe Hospital, complaining of low mood and suicidal ideation. He was seen by a senior house officer (SHO, psychiatry) who referred Mr S to the Crisis Resolution and Home Treatment (CRHT) Team.
The SHO noted in his assessment that Mr S had no thoughts of homicide, but was a risk to himself.

Mr S was assessed on the **16th of December 2004** by a community psychiatric nurse (CPN) from the CRHT team and a psychiatric SHO, Dr H.

He was found to be mildly to moderately depressed with suicidal ideation in the context of his recent relationship breakdown.
He was prescribed Lorazepam 1mg PRN up to 2mg per day and Temazepam 10mg at night. He was to continue the Lofepramine. The CRHT team agreed with Mr S that they would meet with him daily until the period of crisis was abated.

Mr S continued to stay at his brother's home in Oxford.
Mr S had daily contact with the CRHT team and on the **23rd of December 2004** he was seen by Dr B and a CPN from the CRHT team. His antidepressant medication Lofepramine was increased to 140mg nocte. He was referred to the day hospital and daily contact with the crisis team was to continue.

He was thought to be at risk of self harm but was willing to continue to work with the CRHT team in addressing his suicidal ideation.

Throughout his assessment and treatment the risk that Mr S posed was thought to be only to himself. There was no known history of violence, he was not living with his second wife and at no time did BS express thoughts of harming his second wife or others.

The CRHT team linked with Mr S's brother, with whom he was staying, but the team had no contact with his estranged wife or other members of his family.

Mr S reported that he was looking for housing. He said he had also secured employment with Social Services in Lewisham which was due to start in 2-3 months time.

On the **24th of December 2004** Mr S reported that he felt better, his mood was improving and he was making plans for the future. He was successfully using distraction techniques for intrusive thoughts.

Mr S said that he continued to have contact with his children and reported that his daughter had stayed with him for a few days and that this visit had had a positive impact on his mental state.

It was agreed that he would not have a daily visit from the CRHT team on Christmas Day as he was spending this with family. Mr S contacted the CRHT team on the **26th of December** asking that the next visit not be planned until after the **28th of December** as friends and relatives were visiting.

29th of December 2004. Mr S was seen by Dr B. He was reported to be improving, with no suicidal ideation. He was concordant with medication. The agreed plan was that Mr S would continue with medication at the current dose. He was to have a weekly visit from the CRHT team after which he would initiate contact if required.
It was arranged that he would see Dr B in one week after which, if his improvement was maintained, the CRHT team would withdraw.

31st of December 2004 - Mr S reported, when contacted by phone, that he was feeling well and declined a home visit.

1st January 2005 - Mr S reported during telephone contact initiated by the CRHT team that he was feeling" not too bad". He agreed to a home visit on the 4th of January. He also agreed that he would contact the CRHT team if necessary before the 4th of January 2005.

4th of January 2005 - home visit by CS, senior Social Worker from the CRHT team.
Mr S reported that he had been increasingly low in the past few days. He reported that he had some suicidal ideation. He spoke of weighing up whether

or not to die but was also continuing to work out a new future for himself with prospects of moving to the new job.
CS recorded in the case notes that Mr S's presentation was incongruous in that Mr S was maintaining good eye contact and rapport and was laughing and smiling when he was talking about his suicidal ideation. Mr S agreed to attend a review the next day with CS and Dr B.

5th January 2005
The CRHT team received a telephone call from Mr S cancelling his appointment with Dr B later that day, saying that he didn't feel like attending and would contact his GP if he needed more medication.
The CRHT team member who took the call offered to call back later and said they would rearrange the appointment with Dr B.
Several attempts were made to contact Mr S by phone over the course of the day as Dr B had agreed to rearrange the appointment and see him on 7th of January 2005.

6th of January 2005, 09:25hrs
The CRHT team received a telephone call from Mr S's brother informing them that Mr S had been arrested following an incident with his estranged wife the previous evening.

8. Good practice points identified

The CRHT team made efforts to provide Mr S with a flexible service enabling him to engage as far as possible with the team.

Following his cancellation of appointments he was diligently followed up and alternative appointments were offered.

The team sought to engage with the brother with whom Mr S was staying at the time of his referral and throughout his treatment.

There was excellent liaison between the consultant responsible for Mr S and the CRHT team.

The CRHT team manager organised a team debrief following the incident and all efforts were made to support staff who were distressed following the incident.

The CRHT team manager and Dr B made contact with Mr S's brother and offered to meet to provide ongoing support following the incident.

The CRHT team manager maintained contact with the brother and made several offers of continued support.

9. Issues of Concern

The CRHT team operates on a medical/problem-solving model with the role of staff being to monitor the impact of prescribed medication on the mental state of the patient and to assist in addressing and identifying any immediate practical problems.

Adherence to this model precludes in-depth work to aid understanding of the psychosocial needs of patients. Indeed team members stated that deeper work needed to be carried out by generic CMHTs once the patient was discharged from the CRHT team.

In line with the medical/problem-solving model used, the CRHT team did not attempt to engage with Mrs S to develop a more in-depth picture of the family dynamics that had led to the breakdown of the marriage, despite this being the stated reason for Mr S's current crisis. This also means that in-depth understanding of the individual psychodynamics which might have linked this experience with Mr S's previous experience of separation and loss was not fully developed/explored.

There is third party evidence that Mrs S may have been assaulted in the past. If the team had made contact with her she may have disclosed this, which would have had an impact on the assessment of risk that Mr S posed.

Although they would have needed Mr S's consent to do so, it was clear from our interviews that staff did not consider this aspect of Mr S's life to fall within their remit.

The team did not address the needs of the three small children in terms of their relationship with their father and what the potential loss of contact with this second family may have meant for Mr S.

Root Cause Analysis

10. Individual patient factors

Mr S was undoubtedly in crisis following the break down of his second marriage. At the time of initial assessment he had no known previous history of violence to others and was not thought to pose a risk to others.

Mr S had had a previous breakdown in a marital relationship. It may be that the loss of this second family compounded his sense of loss, particularly in the light of his own experience in his family of origin.

It appears from conversations with the family of the victim, the police and from the forensic report that Mr S had consumed alcohol prior to the assault on his second wife. It is well know that alcohol use often increases the propensity of violence occurring. He also claimed to have consumed significant numbers of

Ibuprofen (Nurofen) and Temazepam or Lofepramine tablets, all of which may have contributed to his disinhibition.

11. Team Factors

The Crisis Resolution and Home Treatment Team in the Trust follows a model partially adopted from DoH guidelines (*DoH Mental Health Policy Implementation Guide; 2001*). The model used varies from the DoH guidelines in that the team do not provide gate-keeping to inpatient beds over a 24hr period and they do not have an integrated consultant in the team.

The model used basically sets out that the crisis team will engage with those who are presenting with acute mental health problems or crisis. The stated aim of the team is to provide a flexible, responsive and comprehensive service for working age adults who are experiencing acute mental health problems or crisis.

Outside of normal working hours the team is involved in all assessments and their role is to provide a safe, effective alternative to admission where possible. Team members are on call at night and will attend assessments throughout the on call period wherever possible. They are also available to provide ongoing support to current CRHT team patients out of usual hours.

The team is predominantly made up of Nursing and Social and Healthcare staff. There is a consultant psychiatrist who provides a “virtual” medical role within the team. He meets with team members weekly regarding the development of case management plans and care coordination. He also takes a role in the development of the long term strategic vision of the team.

The consultant responsible for a patient’s care remains the responsible consultant whilst the CRHT team is involved, and liaison between the CRHT team and the consultant is an essential component of the crisis team’s work. Patients who are referred from generic CMHTs remain on the CMHT’s case load whilst the crisis team is involved, and the care coordinator role is retained within the generic team.

The team follows a medical/problem-solving model which means primarily the role of staff appears to be to monitor the concordance with and effectiveness of medication on the patient’s mental state and to address current practical problems. This model allows little space for a psychosocial understanding of the patient to be developed.

12. Environmental/work factors

Mr S was separated from his family and was living with his brother, having recently vacated the family home. He had stated that he was looking for permanent housing in order that he could have access visits from his children.

The loss of his usual environment may have added to Mr S's sense of isolation and loss.

13. Organisational and Management Factors

The agreed medical/problem-solving model of the crisis team is such that it was unlikely that they would have been able to make any real impact on the psychological processes that Mr S was experiencing.

The medical/problem-solving model of the service might in the short term aid Mr S, but there was no therapy occurring that may have led Mr S to a deeper understanding of his reaction to the loss of his second marriage.

14. Conclusion

The panel was impressed by the level of engagement with Mr S achieved by both the CRHT and medical staff. Having reviewed the care and treatment of Mr S, the panel's opinion is that it was not possible to predict that Mr S would react in such a catastrophic manner to the breakdown of his second marriage.

His risk assessments had taken into account past as well as present indicators of risk and as such he was deemed to present a risk to himself rather than to others.

Once the team had agreed that the risk he posed was to himself they made no effort to contact his wife in order to ensure that she shared that view. Much of what Mr S said was taken at face value and there was no apparent attempt to understand him within a psychosocial context.

However it must be stated that his wife's family have said that they did not believe that their daughter was frightened of Mr S and indeed she spoke to her mother on the phone moments before the incident and talked of Mr S being present in the house without any evident concern.

The CRHT team operated within their agreed operational policy and adhered to Trust policy in terms of risk assessment and the care programme approach. Staff attempted, very actively, to engage with Mr S within the agreed terms of the team. There was excellent liaison with Mr S's consultant throughout his contact with the CRHT team.

The panel were concerned that the medical/problem-solving model operated by the CRHT may not meet the needs of all those who require support when in crisis.
Clearly medication and problem-solving have an important part to play in the treatment of acute psychiatric disorder or crisis but it is by no means the only intervention that is required.

15. Recommendations

15.1 The Crisis Resolution and Home Treatment Team need to develop its Risk Assessment / Risk Management practice and processes to hear and understand the risks that Carers and family members may want to report and contribute to the overall balances of Risk and Risk Management.

15.2 That the CRHT review the assessment procedure to include input from significant others and **not** just those people who are/were directly involved in an individual's day to day life

15.3 CMHT and CRHT clinicians must ensure they enquire about the potential for domestic violence when carrying out an assessment.

15.4 The Crisis Resolution and Home Treatment Team needs to develop a psychosocial model of assessment and psychiatric care which actively assesses the social network of the Service User, seeking to understand the Service User in as wide a historical and social context as possible to maximise the depth and breadth of clinical interventions.

15.5 In working with the above two recommendations the Crisis Resolution and Home Treatment Team will need to develop practice on working with Service Users' consent to sharing and collecting information on a routine level.

15.6 The model of the Crisis Resolution and Home Treatment Team operates without a dedicated operational Consultant Psychiatrist integrated into the team. Whilst in this inquiry there was no concern about the role of the particular Consultant Psychiatrist in this case, strong evidence was presented highlighting the need to strengthen and develop the model and integrate Consultant Psychiatric and medical time into the team. The panel recommend this be explored and implemented.

15.7 The panel recognises that in working cases like Mr S, who do not necessarily meet Crisis Resolution and Home Treatment criteria but do need urgent responses, there is a need for CMHTs and other teams to work effectively in transferring patient care across team interfaces. Where there is disagreement between teams there appears to be no system for decision-making resolution and arbitration. The panel recommends that the Service Management and Clinical Lead Consultant roles be developed to arbitrate and decide upon creating operational seamlessness between teams.

15. Recommendations continued

15.8 Existing assessment and treatment models should be reviewed to ensure that there is scope for a variety of treatments to be put into place.

15.9 The Crisis Resolution and Home Treatment Team needs to develop its Risk Assessment / Risk Management practice and processes to routinely check with Child Protection systems to ensure the safety of children. In Risk Management this may then involve joint working with Child Protection Teams to provide family based approaches in the management of the whole family.