Report to:	Strategic Health Authority Board
Title:	Independent Inquiry into the Care and Treatment of Dr S
Author:	Robert Robinson, Chair of the Independent Inquiry Panel
Lead Director:	Richard Samuel, Assistant Chief Executive
Purpose:	To report on the background to the Independent Inquiry into the Care and Treatment of Dr S and to outline the content of the report, its recommendations and the action plan developed as a result of the Inquiry
Decision Sought:	To formally receive the Independent Inquiry Report and accept the recommendations listed at Chapter 5 of the report and agree the action plan and monitoring arrangements.

1. Background

The Independent Inquiry is concerned with the circumstances surrounding the death of VS who was killed on 23 February 2000 by her husband Dr S. At the time he was receiving treatment for mental illness. Dr S was charged with murder and on 14 July 2000 he pleaded guilty at Winchester Crown Court to manslaughter on grounds of diminished responsibility. His plea was accepted and he was made subject to an unrestricted hospital order under section 37 of the Mental Health Act 1983.

As a consequence of organisational configuration and the dissolution of Health Authorities, the commissioning of the inquiry was unfortunately delayed. As the successor organisation, the Hampshire and Isle of Wight Strategic Health Authority has apologised to the relatives of VS for this delay and has sought to progress the inquiry as swiftly as possible.

The Inquiry was therefore established in March 2003 by the Hampshire and Isle of Wight Strategic Health Authority as successor organisation to the Isle of Wight, Portsmouth and South East Hampshire Health Authority. The Inquiry was commissioned under the terms of Health Service Guidance 94/27 The Discharge of Mentally Disordered People and their Continuing Care in the Community.

An Inquiry Panel was established comprising Robert Robinson, a mental health solicitor and Panel Chair and Dr Lindsey Kemp, Consultant Psychiatrist. The Strategic Health Authority provided administrative support to the Panel.

2. **Approach**

On 11 March 2003, the Strategic Health Authority Board approved the terms of reference for the independent inquiry. The terms of reference set out a two stage approach to the Inquiry:

Stage 1 - Fact Finding

- To report on what care, treatment and services were provided by the wider NHS and any other organisations in respect of RS and what assessments and professional judgements were made about his condition and needs in the period prior to February 2000;
- To establish what communication there was between those caring for Dr S and those caring for VS.

Stage 2 – Evaluation

- To report on whether the assessments, care, treatment and services planned and/or provided (by the services individually or liaison with each other) were suitable and appropriate given Dr S's needs. To report on the appropriateness and adequacy of the communications between those caring for Dr S and those caring for VS;
- To report on whether the assessments, care, treatment and services met statutory obligations, national guidance and local policies and practices;
- To present findings and make recommendations as to how services can be improved in the future.

3. **Conclusions and Recommendations**

The Panel concluded that "in our judgement those directly involved in Dr S' care and treatment acted conscientiously and with professional competence. To the extent that we have identified areas where practice could have been better, particularly in relation to recording information and adherence to the local CPA policy, we do not suggest that these shortcomings are casually relevant to VS's death. Indeed, we do not believe that there is anything Dr P, or anyone else, could reasonably have done to have prevented Dr S from killing VS."

The Inquiry Panel did, however, make a total of seven recommendations, and so two action plans have been drawn up in response to these recommendations: the Hampshire and Isle of Wight Strategic Health Authority Action Plan (attached at Annex A) and the West Hampshire NHS Trust Action Plan (attached at Annex B).

During the course of the Inquiry the panel made some observations with regard to the care and treatment of VS specifically that relating to the experiences she had when accessing medical services in secondary care. These observations were considered by the panel to be important, but were outside the remit of the Inquiry Panel's terms of reference. Consequently, they have not been included in this report. However, they will be subject to a different process of scrutiny by the Strategic Health Authority and the relatives of VS will be kept informed of progress.

4. Action

The Strategic Health Authority would like firstly to note with regret the tragic events of February 2000 which prompted this Inquiry. The Strategic Health Authority would also like to extend its sincere apologies to the family of VS on behalf of the NHS for the delay in the commissioning of the Independent Inquiry. In so doing, the Strategic Health Authority would like to thank the family of VS for their contribution to the Inquiry, which the Strategic Health Authority recognises must have been a very difficult and emotional process for them.

The Strategic Health Authority would like to reaffirm its commitment to ensuring that the NHS continues to learn all it can from tragic events such as this in order to make sure that such events can, if possible, be avoided in the future.

The Strategic Health Authority would also like to extend a vote of thanks to Robert Robinson and Dr Lindsey Kemp for their work, and to the clinical and managerial staff of Hampshire Partnership NHS Trust (formerly West Hampshire NHS Trust) who contributed to the Inquiry for their commitment to and support of the work of the panel.

The Strategic Health Authority is asked to:

- Receive and accept the Independent Inquiry report into the Care and Treatment of Dr S
- Accept the action plan and the means by which the action plan is to be progressed and monitored
- Note that in the course of the investigations issues have been raised around the provision of acute care to VS. These issues will need to be progressed, but fall outside the Terms of Reference for this Inquiry. Therefore these issues will be shared with the Trust concerned and any actions arising from these observations will be taken forward in a separate process and the relatives of VS will be kept fully informed of progress.

REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF DR S

ROBERT ROBINSON
DR LINDSEY KEMP

Commissioned by Hampshire and Isle of Wight Strategic Health Authority

Published April 2004

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Chapter 1: Introduction

1.1 This inquiry is concerned with the circumstances surrounding the death of VS who was killed on 23rd February 2000 by her husband Dr S. At the time he was receiving treatment for mental illness. Dr S was charged with murder and on 14th July 2000 he pleaded guilty at Winchester Crown Court to manslaughter on grounds of diminished responsibility. His plea was accepted and he was made subject to an unrestricted hospital order under section 37 of the Mental Health Act 1983.

1.2 The inquiry was established in March 2003 by the Hampshire and Isle of Wight Strategic Health Authority, as successor organisation to the Isle of Wight, Portsmouth and SE Hampshire Health Authority. It was commissioned pursuant to Health Service Guidance 94/27: *The Discharge of Mentally Disordered People and their Continuing Care in the Community*. The inquiry's terms of reference were:

Stage One – Fact finding

a To report on what care, treatment and services were provided by the NHS and any other organisations in respect of Dr S and what assessments and professional judgements were made about his condition and needs in the period prior to February 2000. The inquiry will also establish what communication there was between those caring for Dr S and those caring for VS.

Stage Two – Evaluation

b To report on whether the assessments, care, treatment and services planned and/or provided (by the services individually or liaison with each other) were suitable and appropriate given Dr S's needs. To report on the appropriateness and adequacy of the communications between those caring for Dr S and those caring for VS.

c To report on whether the assessments, care, treatment and services met statutory obligations, national guidance and local policies and practices.

d To present findings and make recommendations as to how services can be improved in the future.

1.3 The members of the inquiry panel (the panel) comprised Robert Robinson, solicitor and Lindsey Kemp, consultant psychiatrist.

1.4 We have great sympathy for VS's two children, MD and AS. They lost their mother in shocking circumstances at a time when they obviously had not expected her to die. The nature of the criminal proceedings meant that the evidence, and specifically Dr S's version of what happened, was not tested through an adversarial procedure. Their understandable sense that the criminal process had

failed to answer many questions about the circumstances of their mother's death was compounded by the regrettable delay in establishing this inquiry.

1.5 In this report, within the constraints of our terms of reference, we attempt to answer a number of the questions which they have raised concerning what was known at the time about Dr S's state of mind and whether more could have been done to prevent VS's death. We are conscious that what we have to say will provide little comfort to VS's family and is unlikely to assuage the sense of injustice which would be felt by anyone in such circumstances. We hope, however, that they will accept our judgement that mental health professionals responded in a considered way to Dr S's mental illness and the risks to which it gave rise. That the threat he represented to VS was not properly understood is not in itself evidence that those directly involved in Dr S's care were at fault.

Chapter 2: Dr S's personal and psychiatric history

2.1 The sequence of events with which we are mainly concerned began when, at the end of December 1999, Dr S was instrumental in getting VS admitted to the Meadows, an in-patient psychiatric unit serving Fareham and Gosport. This chapter of the report deals briefly with Dr S's life prior to those events and in particular with his psychiatric history.

Personal history

2.2 Dr S was born at Ickenham in Middlesex on 27th March 1940. He was one of two brothers.

2.3 In 1962 he married for the first time. The relationship lasted until 1977 when his first wife left him. He met VS in 1978 and they married in 1980. They remained together until her death.

2.4 There is evidence from a variety of sources that in his domestic life Dr S was prone to angry outbursts. There were also episodes of physical violence towards both his wives but these were exceptional. He was very dominant in the relationship with VS, to the extent that she appears to have been excessively anxious not to do anything of which he would have disapproved.

2.5 Dr S does not have any children but he helped VS bring up her two children, MD and AS, after they came to live with their mother in 1982.

2.6 Dr S left school at the age of 15. He found employment and remained in work until being made redundant at the age of 35. Soon afterwards he went to Oxford University as a mature student where he took a first degree in history. This was followed by a PhD at Southampton University, which he completed in 1988. Thereafter he worked as a part-time history lecturer at the Open University until his arrest in February 2000.

Psychiatric history

2.7 Dr S has suffered a number of episodes of depressive illness and related anxiety during his adult life. The first followed the breakdown of his marriage in 1977. In 1978 he was referred by his general practitioner to a consultant psychiatrist and received treatment for depression over several months. This included a brief admission to a psychiatric hospital in September 1978 which was followed by attendance at a day hospital.

2.8 Throughout most of the 1980's Dr S received treatment from his general practitioner with antidepressant medication and was also prescribed a beta blocker for chronic anxiety. In 1985 he was again referred to a consultant psychiatrist who noted his obsessional and ruminatory traits. Advice was given on antidepressant medication and cognitive therapy was recommended. Dr S attended as an

outpatient over the following months and his condition improved. In 1988 he became unwell again, describing a two month history of being irritable with loss of control, his mind being over active, difficulty in concentrating, disturbed sleep and waking at night with anxiety. He was again prescribed an antidepressant and a beta blocker, and his condition improved.

2.9 His next contact with specialist psychiatric services was in May 1993 when he was reported to be finding it difficult to cope because VS had experienced a breakdown in her mental health. He was found to have symptoms of anxiety secondary to VS's illness and a minor tranquiliser was prescribed.

2.10 In February 1994 Dr S suffered another episode of mental illness and, following treatment with antidepressant medication prescribed by his general practitioner, he was referred in September 1994 to Dr P, consultant psychiatrist. He was assessed by Dr P in October 1994 when he described symptoms of depression with early morning wakening, loss of appetite, diurnal variation in mood, increased feelings of anxiety and aggression, loss of libido, tearfulness, sweats and panics waking him at night and morbid thoughts. Dr P recommended continuation of the antidepressant medication prescribed by the general practitioner.

2.11 He was next referred by his general practitioner and seen by Dr P in February 1995. He was described as being *"extremely vulnerable indeed in the presence of stresses related to his wife"*. He was treated with antidepressant medication. He remained under review until March 1995. It appears that he recovered from this episode and thereafter remained well until 1999.

2.12 In Dr P's opinion Dr S's mental health problems resulted from the difficulties he experienced when VS's mental health was unstable. Treating Dr S was further complicated by the fact that he did not tolerate SSRI antidepressants and was treated instead with flupenthixol. In his evidence to us, Dr P commented as follows on his experience of treating Dr S:

"Our experience was that antidepressants didn't actually help … medication made little difference. He didn't tolerate it, in fact. What became very clear was that when his wife got better so did he. All his problems went away and he dropped out of treatment".

Chapter 3: December 1999 – February 2000

VS's care and treatment

3.1 VS had suffered from mental illness since the birth of her second child. This was diagnosed as bipolar affective disorder. For most of the time her condition was well controlled by lithium and she was able to lead a full life. But she did occasionally experience relapses of her mood disorder. The last such occasion was in 1995.

3.2 During 1999 VS suffered episodes of severe lumbar back pain. The pain was such that on 27th December she went to the Accident and Emergency Department at Queen Alexandra Hospital, Portsmouth. She described having a two to three month history of low back pain, which had been worse over the past three days with spasms of severe pain at night. On physical examination no abnormal neurology was found and she was prescribed diazepam to relieve muscle spasm and dihydrocodeine for pain relief. Because of the evident high emotion of the situation she was admitted overnight to an observation ward where she was treated with Voltarol intramuscularly for pain relief. She was seen again by a doctor the following morning who formed the view that her anxieties were contributing to a hysterical response to mechanical low back pain.

3.3 Had it not been for Dr S's intervention VS would then have been discharged home. He was extremely dissatisfied with the approach taken by the Accident and Emergency Department. Having failed to persuade them to carry out further investigations or to admit VS to an orthopaedic ward, he went on 28th December to the Meadows psychiatric unit to try to get VS admitted onto an acute psychiatric ward. He explained to a nurse that she was at the Accident and Emergency Department and he told the nurse that he was fearful she would be discharged back home. He said that she had been keeping him awake at night because she was in such pain and that he would not be able to cope if she were to return home.

3.4 Following confirmation from Queen Alexandra Hospital that they did not intend to admit her to an orthopaedic ward, VS was transferred to the Meadows where she was seen straight away by a psychiatrist. She gave a history of severe back pain and expressed concern about the impact of her condition on Dr S, saying that he was run down and needed a rest. There was no evidence of active mental illness or of suicide risk; although VS did say that she and Dr S had agreed that if *"one goes in future"* they would *"want to go together"*.

3.5 The decision was made to admit VS to the Meadows not because she was acutely mentally ill but as respite for Dr S who was clearly not coping well. The same psychiatrist also assessed Dr S and formed the impression that: *"they appeared to have an enmeshed relationship in that they appeared to be unhealthily close"*.

3.6 VS remained as an in patient on a psychiatric ward under the care of Dr P, consultant psychiatrist, from her admission on 28th December 1999 until 19th January 2000 when she was transferred to an orthopaedic ward at Royal Haslar Hospital in Gosport. The transfer was arranged by a consultant in accident and emergency medicine who was on a study attachment at the Meadows during January 2000 and was fortuitously present on 14th January when Dr S was seen by

Dr P as an outpatient and expressed concern about his wife's back problem. While she was in hospital, Dr S visited VS every day, both at the Meadows and after she was transferred to Royal Haslar Hospital.

3.7 There is no suggestion that VS needed to be in hospital for treatment of her bipolar disorder during her three weeks at the Meadows. As Dr P expressed it to us:

"There was no psychiatric reason for her to be in hospital at all. In a sense, the reason for that admission was to address Dr S's needs rather than anything else".

3.8 At Royal Haslar Hospital VS's back condition was thoroughly investigated. She was found to have a spondylolithesis of the low lumbar spine and urine retention caused by compression of nerves in the spine. She received treatment which appears to have been successful in reducing the pain. By the middle of February the decision had been made that VS would not require an orthopaedic bed clinically for much longer and, in consultation with Dr P, arrangements were put in hand for her discharge from Royal Haslar Hospital.

3.9 Dr P was concerned about the impact that VS's precipitate return home would have on Dr S, and the possible risks to her safety arising from Dr S's anxiety about not being able to cope. He therefore decided that she should return to the Meadows before going home. As a first step in the discharge process, Dr P arranged for VS to be assessed by a community psychiatric nurse while she was still at Royal Haslar Hospital. The assessment, which had originally been arranged for 16th February, took place on 21st February 2000. VS told the community psychiatric nurse that she felt much better than when she had been admitted to the hospital, but her back still troubled her and it was necessary for her to take breaks during the meeting and to walk around as a way of relieving the pressure on her back. While she said that she was looking forward to returning home, she told the community psychiatric nurse that she would require a great deal of help and support. She accepted the need to return to the Meadows as a transitional step and requested an ambulance to take her there because she had found travelling by car to Royal Haslar Hospital extremely painful. The community psychiatric nurse told VS that she would arrange this and she also reassured her that support would be offered when she did finally return home.

3.10 Following the meeting with VS on 21st February, the community psychiatric nurse spoke by telephone to Dr S. Her recollection, when she made a statement to the police on 25th February 2000, was that he said: *"Oh that's marvellous, that's what we hoped would happen".*

3.11 VS told several people, including her two children, that she was feeling better and looking forward to returning home. According to AS, her daughter, when she saw her on 18th February VS said she was not very happy about the suggestion, which she believed came from Dr S, that she should be rehabilitated via the Meadows. But it appears that by the time she was assessed by the community psychiatric nurse on 21st February she was reconciled to this.

3.12 VS remained a patient at Royal Haslar Hospital until her death.

Dr S's care and treatment

3.13 Prior to December 1999 Dr S had not consulted his general practitioner about his mental health since the last episode of depression in 1995. He was not on any medication for mental illness.

3.14 When he went to the Meadows on 28th December seeking help for VS, Dr S's demeanour and some of the things he said gave cause for concern. He was seen that day by the same psychiatrist who assessed VS. In her opinion he was low in mood and upset. She asked him screening questions for depression. He said he felt low and that there was no point in things when he was not with his wife, and that he felt useless at home by himself even though he knew he was not useless. He mentioned fleeting suicidal thoughts but said he could see a future if VS was alright. The psychiatrist concluded that Dr S appeared to be depressed and she advised him to see his general practitioner for antidepressants.

3.15 Dr S followed this advice and saw his general practitioner, Dr C, on 30th December. Dr C's notes record that he was tearful and agitated but not suicidal. Dr C prescribed flupenthixol, the drug which Dr S had taken during previous depressive episodes.

3.16 On the afternoon of 31st December Dr S visited VS at the Meadows. A nurse noticed him standing in a corridor leaning against the wall. He was crying. The nurse invited him into an office where they could speak privately. Dr S spoke about the pressure he felt under because his brother was in prison and he said he was angry because of what he felt was the inadequate treatment VS had received in the Accident and Emergency Department. He went on to talk about how worried he was that she might return home while still in pain and that he would not be able to cope. The nurse recorded him as saying: *"if she came home in such a state or in such a way that I couldn't take care of her, I would have to kill her and take my own life"*.

3.17 The nurse was so concerned about Dr S that he asked him to see the duty psychiatrist. Dr S agreed to this and when, in the presence of the nurse, he was asked by the doctor whether if VS was discharged he would harm her, he replied that he did not know. Dr S was calm during the meeting and was able to articulate his problems adequately. The doctor concluded that there was no immediate risk to VS because she was not about to be discharged. He arranged for Dr S to see Dr P in the New Year. An appointment was made for 14th January 2000.

3.18 Before the consultation with Dr P took place, Dr S went on 7th January without an appointment to the Osborn Centre, which is a mental health resource centre in Fareham. There he was seen initially by the duty nurse and then by the same doctor with whom he had spoken on 31st December. He was distressed and unhappy about what he saw as the lack of treatment being given to VS for her back condition, as she continued to be in pain. He was worrying and unable to sleep at night. He wanted VS to be moved to a general hospital and to have scans and an x-ray of her back. He said that if these things were not done he would take matters into his own hands. The doctor did not interpret this as a threat to harm her. He decided that he would arrange an x-ray and a reassessment of VS's pain

relief. When he told Dr S that this was what he intended to do Dr S appeared pleased and he was very grateful. Dr S repeated that he would not be able to cope if VS was discharged home in her present state.

3.19 On 14th January Dr S was seen by Dr P at the Osborn Centre. Prior to the meeting Dr P had spoken to the referring doctor and to the duty nurse who had seen Dr S on 7th January. As already noted, a consultant in accident and emergency medicine was also present during the consultation on 14th January. Dr P's findings were set out in a letter dated 17th January addressed to Dr C:

"I saw Dr S at the Osborn Clinic on 14 January. He told me that he is struggling to cope at the moment but that the main thing that would help him cope would be for VS, his wife to be better. He exceeded [sic] that he had also been under considerable stress as his brother was convicted of manslaughter last year and is likely to be released from prison within the next few weeks".

3.20 In his evidence to us, Dr P said:

"My impression was of a man who was anxious and mildly to moderately depressed, and whose concerns were very clearly focussed on his wife and his wife's illness. He was angry about the treatment that she had had, as he saw it, at the local general hospital. He was very worried about her physical health. Indeed the interview drifted more towards talking about her and his concerns about her than it did on his own health".

Dr P did not make any changes to Dr S's medication. He concluded his letter to Dr C: *"We will keep you informed of the progress here"*. This was understood by both Dr P and Dr C as meaning that for the time being Dr S would remain a patient of Dr P's, but no further appointment was made at that stage.

3.21 It is necessary to record that Dr S came to the appointment with a letter he had received from his brother. He had it in his hand. At that time his brother was in prison, serving a sentence for the manslaughter of his wife, and the letter said he was soon to be released. Dr P told us that he did not attach much importance to the letter at the time:

"What I made of that and what he indicated within that was that his brother was actually being released from prison quite soon and was coming his way to be rehabilitated. This was another thing for him to be coping with. It was another stress for him really".

As we have seen, shortly after that consultation VS was transferred to Royal Haslar Hospital.

3.22 Dr S next saw Dr C on 20th January. His mental state had not improved since the previous consultation in December and Dr C prescribed the antidepressant sertraline in place of the flupenthixol. As had happened in the past, the sertraline caused increased agitation and Dr S stopped it after a week. On 31st January he saw Dr C again and flupenthixol was restarted.

3.23 On 17th February Dr S requested to see Dr P and was given an outpatient appointment on 3rd March. The reason why Dr S wanted to see Dr P is not known. It is possible that he was concerned about deterioration in his mental health but it is just as likely that he wanted to satisfy himself that, in planning VS's discharge home, Dr P was taking account of his worries about not being able to cope.

3.24 On the evening of 22nd February Dr S visited VS's daughter AS and her husband JS. According to the statement AS made to the police on 24th February 2000: *"He seemed alright but his voice shook when he spoke at times. He said that he had been told that mum would soon be transferred to the Meadows before being allowed home. He kept asking why he was not happy about her coming home. He said he was very fearful about how he would cope and afraid it would not work out. He also asked who would do the cooking, cleaning and shopping. I explained that someone from social services could help. He did seem worried and added that he had arranged to see his own doctor …".* JS, in a statement he gave to the police on 25th February 2000, describes Dr S's state of mind that evening as follows: *"I know he felt he could confide in us and [he] spoke of his anxieties of VS returning home. Dr S has had trouble at times coping with VS's illness and was often tearful when speaking of it. However, on this day he seemed much calmer. He spoke for the first time about their relationship saying that there needed to be changes in him supporting VS more. He said they would have to talk more and be honest with each other. He said he was pleased that VS was improving but questioned why he was feeling increasingly anxious about her returning home. When he left Dr S seemed calm and in control of his emotion".* In her evidence to us, AS spoke about Dr S's state of mind at that time in the following terms:

"The last time we saw him he was really tearful and he just said to us, 'I can't understand the way I feel', he said, 'I know she's getting better, I can see how mobile she is'. He said, 'I know that social services or an OT will hopefully help her out, why do I feel so worried things aren't going to turn out?' I just challenged him and said, 'Look, Dr S, you've got to do your bit, you've got to help mum, you've got to take her to the shops or do her shopping'. I think that just frightened him, the thought of doing that. I think he was confused internally himself with the way he felt. It's like a cry for help, isn't it, really, that's how I see it."

The events of 23rd February 2000

3.25 On the morning of 23rd February Dr S saw Dr C again. Dr C recorded that Dr S was complaining of early morning wakening for one or two nights, diurnal variation in mood and increased anxiety with VS about to return home. He said his concentration was alright but his weight was down slightly. Dr C prescribed supplementary diazepam for anxiety. He noted that Dr S was due to see Dr P on 3rd March. In his evidence to us, Dr C said that Dr S was agitated but not apparently depressed:

"The guy was as normal as I'd ever seen him, in some senses probably not as flat as when he first came back in December".

3.26 After seeing Dr C, Dr S went to the home of VS's son, MD. He arrived there at about 11.30am and stayed for lunch. MD recollection is that he seemed happier than on recent visits and less preoccupied with his worries about not being able to cope when VS returned home. This is consistent with his reported reaction to what he had been told by the community psychiatric nurse on 21st February following the assessment of VS. On leaving, he agreed that he would come for a meal the following week and would drop in for coffee prior to that.

3.27 At about 3.30pm MD went to Royal Haslar Hospital to visit his mother. His impression was that:

"There was nothing at all about what she said or her tone of voice or manner that was out of place. She seemed fine and looking forward to coming home".

MD left at about 4.30pm. As he was driving home he passed Dr S coming in the other direction on his way to the hospital to visit VS.

3.28 Dr S arrived on the ward between 5.00 and 6.00pm. He spent fifteen minutes or so talking to VS while she ate her evening meal and they then went out together. They walked off the ward together arm in arm, as was usual when he visited. They then went to a disused ward on the Royal Haslar Hospital site, and while VS sat on a chair Dr S strangled her with a cord which he had with him for the purpose. He had apparently been carrying it in his pocket for several days. The two forensic pathologists who prepared reports in connection with the criminal proceedings found nothing to suggest that VS had been forcibly restrained or that there had been a struggle.

3.29 After killing VS he walked around the Royal Haslar Hospital site for approximately an hour before going to the main gate of the hospital where he told a security guard that he had killed his wife. He gave the following explanation:

"she asked me to do it, she's been asking me to for some time, and tonight I did. She's been in pain for a long time over a year … ".

Dr S's account

3.30 Following his arrest, Dr S was assessed by two doctors at Gosport police station before being interviewed by the police. He was first seen by a forensic medical examiner on 23rd February who recorded that:

"Dr S told me that he had been feeling depressed for the last four or five months and said that he had felt particularly tearful around Christmas time as his wife was in a lot of pain. He told me that he had lost a stone in weight over the past eight weeks and had not been sleeping well, going to bed around 11pm and waking up at about 3am and was usually very restless the rest of the night." The following day he was seen by a consultant psychiatrist who recorded Dr S as saying: *"I was tearful and distressed … it got worse at New Year. Very depressed – waking during the night – thinking about suicide – I thought I would take tablets and use the car exhaust – I have lost weight".*

The consultant psychiatrist considered him fit to be interviewed and recommended that he be admitted to psychiatric hospital.

3.31 Dr S was extensively questioned by the police over a period of 5 hours on 24th February. He maintained his position that at the time of the killing he believed that he was doing what VS wanted:

" …my wife has been asking me to end it because she has had this back problem [which] has been very stressful, she has also had mental health problems over many years, she was frightened of going back to the Meadows, she didn't think she would be able to carry on at home because of her condition she didn't think she was going to get better and the pain was still there in her legs and she was frightened that she was going to be as bad as she was back near Christmas when she was screaming out with the pain, and she was asking me to end it all, she had been on and off for some weeks, three weeks probably and last night because she was near moving it sort of came to a head and that's why I did it, that's it in a nutshell".

3.32 He went on to say that when he visited on 23rd February VS had talked about ending her life. He had a cord in his pocket, which he had been carrying about for several days with this in mind. He described how VS sat on the chair while he applied the ligature:

"She sat on there, and I got the cord out of my pocket and I strangled her, there was no discussion much there at all, I just did it and she put up no resistance or no argument at all, she was ready".

3.33 He made a connection between what his brother had done and his own actions:

"I don't know if I would have done it if he hadn't done it whether it had put the thought there, the seeds there you know I just don't know". In relation to his brother he also said: *"I mean the thing is there was that affair with my brother you see, I mean I didn't realise probably just how much that had taken a toll".*

3.34 In describing his own state of mind at the time he said:

"[I was] hardly responsible for what I did last night I was so uptight and so tense and not myself, I'm not sure how rationally, well I didn't rational [sic] think it through did I, that must be obvious". When he was asked whether thinking about killing his wife had been playing on his mind he replied: *"The time that it [was] playing on my mind was when I woke up in the early hours of the morning, not just yesterday but for (inaudible) cos I hadn't been sleeping well."*
He went on to say:
"Well, I was pretty worked up into a state and I thought I was do … at the don't tell me now tonight but I thought at the time I was doing the right thing because of … alright my judgement was clouded horribly mistaken and all the rest of it I know but I thought with the complete honesty in the state I was in that I was doing the right thing that she wanted".

3.35 According to Dr P, who was responsible for Dr S's treatment following his transfer to the Meadows in October 2000, where he subsequently remained for over a year as an inpatient, his consistent account of the offence was that his action was justified because it was what VS had requested. Dr P told us:

"His account was that it was the right thing to do, but a distressing thing to do… that actually he viewed this as a rational decision taken with himself and his wife involved with it. That was information that came from interviews well after the event, and at times when he was really not giving us any indication of any psychiatric illness at all".

3.36 The same point was made by GH, who was Dr S's named nurse for much of the time that he was a patient at the Meadows. He told us:

"He never showed any remorse for killing his wife; he always seemed fully justified in what he had done. His only regret was that he hadn't taken his own life at that time".

Was there a suicide pact?

3.37 One matter which needs to be brought out in considering the background to VS's death is the suggestion made by Dr S when he was interviewed by a psychiatrist after the homicide, that he and VS had discussed a suicide pact. Clearly, what he did was not consistent with a suicide pact, because he did not attempt to take his own life. However, it would appear that his belief that they had at least discussed a suicide pact played some part in his thinking at the time. But when the question of a suicide pact was raised in the course of the police interviews Dr S's answers lacked conviction.

Q: Did you ever discuss how you would end it?
A: No we didn't, no we didn't.
Q: So it was totally your idea to use this piece of cord?
A: How, yes.
Q: Had you thought of any other ways of doing it?

A: If she had been discharged then we thought we, there was a possibility of doing it in the car at home.
Q: You've discussed doing that?
A: No, no didn't discuss it, I thought of it.
Q: You thought of it, and you say by doing it in the car at home did you mean the exhaust pipe?
A: Yes.
Q: Hose pipe to the car?
A : Hose pipe yeah, yeah, yeah.

3.38 It was put to Dr S that it would have been possible on 23rd February 2000 to have taken VS home from the hospital and to have put the supposed suicide pact into effect:

Q: Right, you could've, she was dressed, you could've walked out that hospital last night, got into your car, driven somewhere and done that?
A: No.
Q: Why?
A: Because she would've been missed at the hospital, long before we done it.
Q: No, I can't accept that.
A: Just never thought about it. That was something which was a possibility for the future if she came home, and I just didn't see it as a possibility last night.

3.39 While there is no evidence to suggest that he and VS had at any time entered into a suicide pact, there is some corroborating evidence that in the past they had discussed the possibility that if they were not able to cope they would "end it together". There is, however, no independent evidence that VS had made that decision on or before 23rd February 2000. As we have seen, there is considerable evidence which points the other way and suggests that she was in fact looking forward to returning home.

The psychiatric evidence relied on at trial

3.40 Dr S's plea of diminished responsibility was supported by psychiatric reports which were prepared in connection with the criminal proceedings. He was assessed separately by three psychiatrists, all of whom concluded that his responsibility was diminished and that the appropriate disposal was an unrestricted hospital order under section 37 of the Mental Health Act. We are not concerned with the disposal, but the views of the three psychiatrists on the nature and degree of Dr S's mental disorder at the time he killed VS are relevant to a consideration of the adequacy of the care and treatment he had received. It is important to record that when assessed after the homicide Dr S's mental state was undoubtedly worse than it had been prior to the event. Specifically, following his arrest he started experiencing auditory hallucinations. These had not been present prior to the homicide.

3.41 With regard to mental illness, the doctors concluded that at the time of the killing Dr S was suffering from a depressive illness. Dr C. Sh, consultant psychiatrist, and Dr J. O'G, consultant forensic psychiatrist, described it as *"a severe depressive*

illness" and Dr J. O'G also used the phrase *"major depressive disorder"*. Dr B. B, consultant forensic psychiatrist, described it simply as *"depression"*.

3.42 All three doctors considered the depression was a relevant explanatory factor:

Dr C. Sh:

"Bearing in mind the severity of the depression, it would be my opinion that his thinking would have been far from clear, that he would have felt extreme anxiety, despair and fear."

Dr B. B:

"In my opinion at the time of the offence Dr S suffered from such an abnormality of mind (induced by depression) as substantially impaired his mental responsibilities for his act at the time of the alleged offence. Although Dr S knew that it was unlawful to kill his wife he saw it as the only solution to relieve her suffering. At the time of the alleged offence Dr S lost his ability to exercise will power to control his physical acts and decided that the only option was to kill her."

Dr J. O'G:

"In my opinion, the depressive illness from which he suffered had significant and profound effects upon his thinking, judgement and perception such that it altered in a morbid way his appreciation of his wife's illness, the prognosis of her illness and his appreciation and judgement concerning her apparent wish to die."

Personality disorder

3.43 Given that Dr S was sentenced on the basis that his belief at the time that he was justified in killing VS was evidence of his abnormal mental state, it is paradoxical that, as we have seen, this belief was not modified when he later recovered from mental illness after receiving treatment in hospital. It is perhaps surprising, in the light of all the evidence, that he continued to believe his action was justified. Part of the explanation lies in features of his personality to which the psychiatrists drew attention in their reports.

3.44 Dr C. Sh described Dr S's personality as follows:

"He seemed to have few, if any, close friends apart from his wife and he seemed to have particular difficulties in relating to women. In relationships, especially with women, he has a great need to be in control and becomes extremely angry when this sense of control is threatened. He can be stubborn and seems to pay little regard to the effect this might have on others. In his recollections he grossly distorts the nature of relationships painting himself in a much more positive light than would objectively appear to be the case. In certain circumstances he demonstrates a considerable flare in his temper and this can give rise to physical violence, both it would seem to his first and second wife."

3.45 Dr C. Sh concluded that:

"Killing his wife was also a supreme act of power and to do so on someone who was allegedly begging to be killed had the added merit of being a selfless and merciful act. In a setting of Dr S's severe depression and very abnormal personality I believe he had distorted reality to the extent that his actions seemed to him to be justified, moral and magnanimous."

3.46 Dr J. O'G described Dr S's personality in the following way:

"Dr S presents as a man with personality traits which would make him vulnerable to the development of depression. Independent of depressive symptoms, he exhibits a behavioural pattern of rigidity, over control and obsessional traits which in interpersonal relationships have led to attempts to control relationships and, at times, to utilise aggression to achieve this."

3.47 Dr J. O'G saw Dr S again in November 2001 when there were no longer any signs or symptoms of mental illness. At that time Dr O'G commented on Dr S's personality as follows:

"Dr S has, in my opinion, exhibited abnormal personality traits over many years, of obsessionality, rigidity, over control and difficulty maintaining reciprocal friendships. Nevertheless, he has had two long-term relationships and a stable work record without criminal offences, significant substance misuse or other abnormal behavioural patterns. Up to the committing of the offence, in my opinion it would have been difficult to conclude that he showed evidence of personality disorder reaching thresholds of clinical diagnosis. Since his depressive disorder has resolved, these personality traits have been accentuated and are causing major problems in his management in the Meadows. I think this is best understood … as the uncovering of such personality traits in the context of a complicated bereavement reaction to the death of his wife."

Chapter 4: Discussion and recommendations

Introduction

4.1 Our terms of reference require us to report on whether the assessments, care, treatment and services planned and/or provided (by the services individually or liaison with each other) were suitable and appropriate given Dr S's needs; the appropriateness and adequacy of the communications between those caring for Dr S and those caring for VS; and whether the assessments, care, treatment and services met statutory obligations, national guidance and local policies and practices. A discussion of these issues now follows, together with our recommendations.

The Meadows assessment and referral to Dr P

4.2 We consider that the response of clinical staff at the Meadows to Dr S's presentation in December 1999 was responsible and compassionate. The advice he was given on 28th December to consult his general practitioner was appropriate and timely, as was the action taken on 31st December by the nurse who referred him to the duty psychiatrist, following Dr S's disclosure of his thoughts of killing VS and himself. The duty psychiatrist assessed the risk in the light of what Dr S had said to the nurse. It was reasonable to conclude there was no immediate risk while VS remained in hospital. The decision of the psychiatrist on that date to arrange an appointment for Dr S to see Dr P was undoubtedly correct, given what had been said to the nurse and Dr P's previous clinical involvement.

4.3 We do, however, criticise the fact that the medical entries relating to these assessments were made in VS's notes and not copied into Dr S's own notes.

We recommend that where a person is assessed by mental health services and information of clinical significance, including matters with a bearing on risk assessment, concerning a person who is not currently receiving treatment from the service is disclosed to clinical staff, a record should be made. This should be sent either to the person's general practitioner, where the person has a general practitioner, or where the person concerned is a patient of specialist mental health services, to the consultant psychiatrist in charge of the patient's care and should form part of the person's medical records.

Dr S's visit to the Osborn Centre on 7th January 2000

4.4 We are impressed by the responsiveness of the doctor who saw Dr S on this occasion. The clinical situation in relation to VS was difficult for everyone involved in her care at that time. Portsmouth Healthcare NHS Trust ('the Trust') cannot be criticised for the way in which this came about. It was clearly desirable that further efforts were made to investigate her back condition and it was therefore appropriate for the doctor to have responded to Dr S's continuing concerns by undertaking to arrange an x-ray and reassessment of VS's pain relief.

Dr P's assessment on 14th January 2000

4.5 In considering this assessment we are mindful that Dr P had treated Dr S before and that he was also VS's consultant psychiatrist. In the past, the breakdown in Dr S's mental health was associated with health problems which VS was experiencing. As we have seen, Dr S's previous episodes of mental illness had been treated with antidepressant medication. But Dr P's opinion was that Dr S's depressive illness was a reaction to the stresses in his life arising from VS's health problems and that medication had made little difference in the past. Dr P's previous experience was that Dr S's health improved spontaneously once VS started to get better.

4.6 When Dr P was consulted by Dr S in January 2000, the context was one in which VS was unwell and her poor health had again impinged on Dr S, causing him to become anxious and depressed. Dr P's clinical response to this episode was informed by his previous experience of treating Dr S and by the immediate concerns arising from Dr S's reaction to VS's back condition. Dr P told us that he assessed Dr S's mental state and formed the impression that his depression was less severe than he remembered from previous occasions when he had seen him as an outpatient. Dr P was clear in his own mind about what Dr S was seeking from him:

"*What he was trying to do was expedite his wife's wellbeing. He was pressing me to get something done about it. That is something that had repeatedly been happening over the weeks after that, and he was saying things like, 'If you don't do something I am going to take matters into my own hands', whatever that means. Again that is an ambivalent statement. He was pressing for VS to be re-assessed at the casualty department, or what have you, at QAH [Queen Alexandra Hospital] at some point in the intervening weeks as well. That was what his pressure was all the time, concern for her needs."*

4.7 The fortuitous presence on 14th January of a consultant in accident and emergency medicine, who took it upon himself to arrange for VS to be transferred to Royal Haslar Hospital, meant that Dr P was able to respond effectively to Dr S's demands. As Dr P explained to us:

"*we spent some [time] talking about how we would be able to get her investigated much more quickly. He seemed to be pleased about that and content with that".*

4.8 In relation to the treatment of Dr S's mental illness, Dr P did not change the antidepressant which had been prescribed by Dr C. He was aware that Dr S had not in the past tolerated other antidepressant drugs and, given his opinion that medication was of limited efficacy in treating what was a reactive depression, it was entirely appropriate not to have changed the prescription. It was also right in our opinion that when he wrote to Dr C on 17th January following that consultation he made it clear that he would retain clinical responsibility.

4.9 We have considered whether Dr P underestimated the severity of Dr S's depression at this time and thereby failed adequately to assess the risk to VS. This

question arises because, as has been highlighted in the previous chapter, the psychiatrists who assessed Dr S after the homicide described his depressive illness as *"severe"* and as a *"major depressive disorder"*. It is right to point out that they were referring to the time immediately before the homicide, which occurred nearly six weeks after the consultation at with Dr P formed the opinion that Dr S was only *"mildly to moderately depressed"*. While it does seem possible that Dr S deteriorated somewhat during the ensuing period, if there was such a deterioration it was not apparent to Dr C on 23rd February. It therefore seems reasonable to conclude that the apparent inconsistency cannot be explained simply by the passage of time following Dr P's assessment. Indeed, it was clear from our own meeting with Dr P that he did not agree with the description of Dr S's depression as severe.

4.10 Having heard from Dr P and Dr C, we accept that both doctors assessed Dr S's mental state by asking relevant questions and by taking account of his demeanour. We note that he presented as calm and articulate when he was seen by Dr C on 23rd February, as he did also on 14th January when he was seen by Dr P. We are satisfied that if his demeanour had been that of someone who was severely depressed, this would have been apparent to Dr P and Dr C, both of whom had previous knowledge of Dr S. In coming to this conclusion, we have taken into account the findings of the three psychiatrists who prepared reports for the court, but who did so without discussing Dr S with either Dr P or Dr C, and we have also noted the observations of other people who saw Dr S at around this time. It is clear that during this difficult period Dr S's mental state was changeable. At times he was calm and rational, but there were also times when he was despairing and felt unable to cope. Throughout this period he was functioning reasonably well despite having to manage on his own while VS was in hospital. As far as we can ascertain, this changeable picture was as true on 23rd February as on 14th January.

4.11 Even if Dr S's depression in January and February 2000 was more severe than appeared at the time to Dr P and Dr C, the treatment they gave was in our opinion appropriate. Dr S's condition did not warrant hospital treatment at that time, whether as a voluntary patient or under compulsion. We incline towards Dr P's opinion that the best "treatment" for Dr S was to see an improvement in VS's condition such that he could be optimistic about their future together.

4.12 We commented to Dr P on the fact that he did not make contemporaneous notes of the 14th January consultation in Dr S's medical records. The only written record is the letter to Dr C. While this was perfectly sufficient for the purpose of communicating Dr P's clinical assessment and comments on treatment to Dr C, it provides very little information about the consultation itself. Had Dr P made a full entry in the medical records this would not only have assisted us but, more importantly, it would have informed any other clinician who might have had to assess or treat Dr S.

We recommend that consultant psychiatrists and other doctors should always make a full note in a patient's medical records of matters of clinical significance which arise in the course of a consultation. This should be in addition to any correspondence.

4.13 An important element of the 14th January consultation was to assess the risk presented by Dr S, arising out of the words he had spoken at the Meadows on 31st December when he expressed thoughts of killing VS and himself. It was what he had said on that occasion which led the duty psychiatrist to make the referral to Dr P. Dr P told us that he took seriously the risk to VS. He described it as significant:

"If you think about the kind of way risk assessments go you pick up some sort of perceived risk and you look up the tree to somebody who has got the experience and seniority, if you like, to take the responsibility for taking that further, which is what happened. So, yes, we did perceive that there was a significant risk. There was no immediate risk perceived, but there was a risk that was significant if she was sent home. The management of that risk was, of course, not to send her home".

4.14 As we have seen, Dr P pursued this strategy for managing the risk. He arranged that VS was not discharged directly home from Royal Haslar Hospital. She would instead have spent some time at the Meadows where Dr P would have been able to manage the timing of her return home and where her needs would have been further assessed and appropriate services organised. This was Dr P's risk management strategy. We conclude that on the information available to him, it was reasonable for Dr P to come to this view, and that he acted properly in putting the strategy into effect. We also note that in the period after 14th January no new information became available which could reasonably have led to a different view of the risk. On the contrary, when he spoke to the community psychiatric nurse on 21st February Dr S appeared to be generally happy with the way matters were being handled. We have seen that Dr S was someone who was well able to articulate his concerns to nurses and doctors when he felt the need to do so. There was no occasion prior to the homicide when he told anyone that he had thoughts of killing VS before she was discharged from Royal Haslar Hospital, although this is what he told the police was on his mind. In particular, on the morning of 23rd February Dr S did not volunteer any information to Dr C which would have indicated that there was an immediate risk to VS.

4.15 Dr P was in hindsight mistaken in his belief that Dr S would not harm VS while she remained in hospital, but we do not criticise him for this. However, it is in our opinion a weakness in Dr P's position that he did not formally record his assessment of the risk. As we have already noted, the only written record of the consultation was a short letter to Dr C. That letter does not mention the possible risk of harm to VS or the strategy for managing the risk. There is therefore no corroborating evidence that Dr P carried out an adequate clinical risk assessment. In our opinion this requires the clinician to consider all relevant available information, including that volunteered by the patient, and to formulate a risk assessment. The following guidance issued by the Royal College of Psychiatrists describes what we have in mind.

A formulation should be made based on … history and mental state. The formulation should, so far as possible, specify factors likely to increase the risk of dangerous behaviour and those likely to decrease it. The formulation should aim to answer the following questions.

- *How serious is the risk?*
- *Is the risk specific or general?*

- *How immediate is the risk?*
- *How volatile is the risk?*
- *What specific treatment, and which management plan, can best reduce the risk?*[1]

4.16 In his evidence to us, Dr P honestly admitted that he could no longer remember the details of his consultation with Dr S, and he was therefore not able to say what questions he had asked Dr S for the purpose of his risk assessment. We think Dr P should have asked Dr S specifically about his thoughts of harming VS and made a record of what he said. We do not, however, think it likely that Dr S would have provided any new or different information at the consultation on 14th January had he been asked such questions. We share Dr P's view that Dr S's primary motivation was to ensure that VS received appropriate treatment. On the occasion of his interview with Dr P on 14th January this purpose was furthered through the intervention of the consultant in accident and emergency medicine. Dr S's anxieties, which gave rise to the thoughts of harming VS, were thus temporarily calmed.

4.17 Another matter on which it would have been helpful for Dr P to have asked Dr S specific questions, and recorded the answers, was the letter from his brother which he brought with him to the consultation. Dr P told us that:

"what he indicated … was that his brother was actually being released from prison quite soon and was coming his way to be rehabilitated. This was another thing for him coping with. It was another stress for him really. I think it is fair to say that, in hindsight, you might interpret that as saying, 'This is a vague threat that I am going to do the same as him', but that is a very speculative comment".

4.18 We think it is understandable that Dr P did not make any connection between the letter and Dr S's thoughts of killing VS. Indeed, it is by no means certain that there was any such connection. But still it was a deliberate decision of Dr S to bring the letter with him to the consultation and we think Dr P could reasonably have been expected to ask questions about it and to have recorded Dr S's answers. As it happens, we think it unlikely that Dr S would have volunteered information of a kind which would have informed the assessment of risk. We repeat that Dr S was someone who knew how to make a point and if his intention in bringing the letter was to make the risk to VS more credible then we believe he would have made sure that his purpose was achieved. We think it more likely that his brother's letter, in which he wrote of his impending release from prison, served to remind Dr S of another stress factor in his life. The very fact that his brother was shortly to be leaving prison would place demands on Dr S to adjust to the changed situation. Although it subsequently appeared from the police interviews and from comments made by the psychiatrists who prepared reports for the court proceedings, that Dr S attached importance to the letter, it is unclear precisely in what way he saw the letter as being significant. It seems to us highly unlikely that, had he been asked about it in greater detail on 14th January, he would have said to Dr P that the

[1] Special Working Party on Clinical Assessment and Management of Risk (1996) Assessment and clinical management of risk of harm to other people. Royal College of Psychiatrists, London

knowledge that his brother had killed his wife and served only a short prison sentence made it easier for him to contemplate killing VS.

4.19 Finally, Dr P told us that he was not aware of Dr S's past history of domestic violence, to which we have referred above. That information was available in the medical records held by Dr C but had not been communicated to Dr P. From what Dr S said about this in the course of the police interviews, we conclude that had Dr P asked him about past domestic violence he would have denied it. Further, we do not consider it was a significant factor in the assessment of risk. The domestic violence had occurred many years previously and in circumstances which were clearly different from the situation in January and February 2000. We think it worth quoting at length what Dr P said to us about this because it shows the careful thought he has given to the case and also gives an insight into the practical reality of risk assessment in general psychiatry:

"I was not aware of the documented evidence in the GP notes that there had been some physical violence at home. That was not referred to in any GP referrals to me either. That is a point actually that I have given some thought to. It is something that … the internal inquiry raised as an issue. I think the first thing to say is that really it would be unusual in general psychiatric practice to be reviewing GP notes on every referral that was made to the service with the level of indication of risk that was available both from the GP referral and through my own assessment of him. Actually you would require, I think, a reasonable degree of suspicion to be triggered to be looking through notes quite so thoroughly as that. Whilst it would be absolutely brilliant if we could do that for everybody, it would actually be [impracticable]. The level of risk that he presented to me was low. The only way that I would perceive myself as having looked through his and her notes in that context would be if that's what my standard practice was for everybody. I would be surprised if other psychiatrists would practise to that level of thoroughness, although in an ideal world we'd all like to. The second thing about it is that my understanding since the events was that actually that referred to episodes of violence that had happened some ten or 15 years previously. Even if I did know about it, I think, because of the length of time between then and the present time, as it were, that would have not been an indicator to me of there being a high risk of further episodes of violence happening, although it would be a moderate indicator of the potential for it happening. Obviously the risks of a violent act happening again, if there already has been one, are significantly higher than they would be if it had never happened - I understand that."

4.20 In conclusion, while we consider it a weakness of the consultation on 14th January that Dr P did not adequately record and communicate his risk assessment, we do not believe that this indicates a failure adequately to assess risk. We think that it was reasonable for Dr P to make the link between the VS's discharge home and the risk of harm being done to her by Dr S. We do not believe that there was any evidence available to Dr P on 14th January, or which would have become available through reasonable enquiry, which could have led to the conclusion that she was at risk while still in hospital. We therefore conclude that Dr P's analysis, which proved to be wrong, that VS would only be at risk when she returned home, was justifiable on the basis of the available information. We consider below whether the assessment of risk and the risk management plan should have been recorded using the Trust's Care Programme Approach (CPA) documentation.

4.21 In trying to understand why Dr S killed VS, the fact that he was depressed, to whatever degree, does not provide the full picture. Indeed, the circumstances of the offence probably reveal more about Dr S's personality than about the mental illness from which he was then suffering. The question arises whether the Dr P should have been aware, or made himself aware through questioning, of the abnormal personality traits which were later described by Dr C. Sh and Dr J. O'G in their reports. It is clear from Dr S's psychiatric history that it was well understood that he reacted badly when he could not control events. Indeed, this aspect of his personality explains his proneness to depression. We believe that Dr P did understand this. However, prior to the homicide, Dr S's problems of personality did not appear to put other people at risk in any way. On the contrary, Dr S had sustained relationships, worked and lived his life without any criminal convictions. The information available would not have warranted a diagnosis of personality disorder. It would not have been possible in our view for Dr P to formulate his clinical risk assessment, with reference to the risk of violence arising from Dr S's personality, beyond what he in fact did on the basis of his clinical understanding of the interaction between Dr S's personality and his past history of mental illness. Dr P understood that Dr S's problems in relation to VS's illness arose from his inability to control matters and the loss of a relationship on which he was highly dependent. We do not believe that further analysis of Dr S's personality would have changed the picture significantly in any way. Further, we do not believe that there was anything Dr P could have done clinically to ameliorate those features of Dr S's personality which were relevant to the assessment and management of risk.

4.22 The final point we would make about risk is that the options open to Dr P were limited. It would not have been possible to detain Dr S under the Mental Health Act. His illness was not such as to warrant detention and inpatient treatment. Nor would it have been possible to limit his contact with VS. We have already noted that Dr S was visiting her every day and regularly taking her out for walks within the hospital grounds. There would have been no basis for placing restrictions on his contact with her at that time.

Follow-up after the 14th January consultation

4.23 Following the consultation on 14th January Dr P and Dr C were both aware that Dr S remained Dr P's patient and would be seen again before being discharged back to Dr C's care. However, Dr P did not make a further appointment for him and it was left to Dr S to initiate this by the request he made when he attended Dr P's outpatient clinic on 17th February. Given Dr P's concerns about risk and the possibility that Dr S's mental health would deteriorate further because treatment with antidepressant medication would not be fully effective, we think as a matter of good practice it would have been better had Dr P made a further appointment to see Dr S following the 14th January consultation. We do not think this is a situation where the initiative should have been left entirely with the patient himself. We do not suggest, however, that had such an appointment taken place before 23rd February there is any reason to believe that it would have prevented the death of VS. We point again to the consultation with Dr C on 23rd February when Dr S was characteristically unwilling to disclose his thoughts, at a time when he had been carrying the cord in his pocket for some days. We also point to the fact that the community psychiatric nurse, who assessed VS on 21st February, spoke to Dr S following her assessment when he expressed himself as being satisfied with the outcome and with the plan for VS to be transferred to the Meadows. We think it highly unlikely that anything different, whether about his mental state or the risk to VS, would have emerged in any consultation with Dr P at around that time. Nonetheless, we make the following recommendation which in our opinion reflects good practice.

We recommend that whenever a consultant psychiatrist has seen a patient, and following the consultation will be retaining clinical responsibility, a follow-up appointment should be made for the patient.

4.24 We think it important to bear in mind that Dr S could have asked at any time for an urgent consultation with Dr P, or with his consultant colleague, but he did not do so. It is our understanding that when he asked for the appointment on 17th February, Dr S was not seeking an urgent consultation about his own mental health. Had this been what he wanted he would surely have mentioned it to Dr C on 23rd February. We think it likely that what was in his mind on 17th February was VS's discharge. We note that the assessment by the community psychiatric nurse was originally to have taken place on 16th February but was cancelled at short notice without Dr S being informed. We think this is the likely explanation why Dr S attended Dr P's outpatient clinic the following day and requested an appointment. We make this point because when Dr S was sentenced there was a suggestion that he had sought help from services but it had not been forthcoming, possibly because resources were not available to treat him. In our opinion there is no basis for this suggestion. We note also that when interviewed extensively by the police, Dr S did not once say that he had been trying to see Dr P or that he had otherwise sought help which was not forthcoming. We therefore conclude that this was not a situation in which he was let down by the unavailability or inflexibility of services in responding to his needs.

Communication

4.25 We have already commented on the absence of any reference to the risk to VS in Dr P's letter to Dr C. We have considered whether Dr P should have communicated his concerns to anyone else in addition to Dr C. First, whether he should have mentioned the matter to clinicians at Royal Haslar Hospital. Given his view that the risk would arise in practice only at the point where VS was discharged from hospital, and given also that Dr S was visiting her on a daily basis without causing any concern, we think it reasonable that Dr P did not communicate his assessment of the risk as it would not have affected the management of VS's care. We have also considered whether he should have communicated his concerns directly to VS. He had not seen her since her transfer to Royal Haslar Hospital from the Meadows. He could have arranged to see her there but it is difficult to see how he could have talked to her about the risk without adding to her worries at a time when she was already under considerable strain. The nature of the assessed risk was not that Dr S would attack VS in hospital. This was not therefore a situation in which it would have been appropriate to warn her of the risk or to advise her what action to take to guard against it. In the context of their relationship the risk arose because of its *"enmeshed"* nature and their mutual dependence. This was clearly not a matter which could have been resolved to any degree by Dr P at this time. We conclude that there would have been no practical benefit in Dr P speaking to VS about what he understood to be the risks. We therefore think it was reasonable and acceptable for him not to have drawn his risk assessment to her attention. Finally, we have considered whether Dr P should have communicated his concerns to family members and in particular to VS's children. It is important to note that they were not at risk and neither were they in a position to prevent Dr S from harming VS. This would have been a matter of the utmost sensitivity for Dr P to discuss with VS's children and we do not believe he would have been justified in breaching medical confidentiality in this way.

4.26 So far as the communication between those caring for Dr S and those caring for VS at Royal Haslar Hospital is concerned, we look at this from the point of view of those caring for Dr S. We have seen that Dr P did not communicate his clinical findings about Dr S or his assessment of risk to those caring for VS. We consider that he was right not to do so. However, the plan he devised, which was that VS should be discharged via the Meadows, was communicated to those caring for VS, and she was visited by the community psychiatric nurse at Royal Haslar Hospital and assessed there while she was still a patient. We are satisfied that those caring for VS knew as much as they needed to know in order to plan her care in association with mental health services provided by the Trust.

Care programme approach

4.27 We turn now to the question whether the care and treatment provided to Dr S complied with relevant national guidance and local policies. This requires consideration of the Care Programme Approach (CPA), which was introduced in 1991 to provide a framework for the care of mentally ill people outside hospital (The Care Programme Approach for people with a mental illness referred to specialist psychiatric services HC(90)23/LASSL(90)11). In its original form CPA had four main elements: systematic arrangements for assessing the health and social needs of people accepted for specialist psychiatric services; the formulation

of care plans to address the identified health and social care needs; the appointment of a key worker (Care Co-ordinator) to keep in close touch with the patient and monitor care; regular review and, if necessary, changes to the care plan. Changes were made in 1999, in particular to reflect concerns about risk assessment within CPA (Department of Health: Modernising the Care Programme Approach (October 1999)).

4.28 In 2000, local implementation of CPA was by means of a Joint Operational Policy agreed between the Trust and Hampshire Social Services. We are satisfied that the Joint Operational Policy meets the requirements of the national guidance. It is our understanding of the Joint Operational Policy that Dr S came within CPA by virtue of the fact that he had been referred to, and been seen by, Dr P. This was certainly Dr P's view. This is what Dr P told us about CPA, with reference to Dr S's care:

"I interpret it as meaning it is an approach to how you deal with people's care. It is a care programme approach. That is what it means. It is supported by paperwork, and often the paperwork actually is very cumbersome and unhelpful, in my view. In any case, the CPA policy at that time would be that an out-patient is a care programme approach review, and an out-patient letter is the documentation to follow that up … The arrangements … were to have people either on standard or enhanced CPAs and a standard CPA could be a uni-disciplinary thing".

4.29 Dr P commented critically on the forms and other documentation to be found in the CPA policy document:

"It is supported by paperwork, and often the paperwork actually is very cumbersome and unhelpful, in my view".

Nonetheless, he told us that he believed that in the consultation of 14th January and its follow-up, he had complied with the Joint Operational Policy.

4.30 We have considered two issues in relation to CPA. First, the appropriateness of interpreting it so as not to require a multidisciplinary approach; and second, whether Dr P complied with the requirements of the local policy, notwithstanding that he did not complete the CPA paperwork.

4.31 The aim of the Joint Operational Policy is stated as being to:

"Provide every person who is accepted by the specialist mental health services with a systematic and comprehensive approach to their care and treatment.

The following key components are central to the process:

- *service user and carer involvement and agreement*
- *needs-led assessment of health and social care needs, including risk assessment*
- *individual care plan detailing all interventions and resources required, including those unavailable at the time of assessment*

- *regular review of planned care*
- *allocation of a Care Co-ordinator to co-ordinate, monitor and review planned care"*

4.32 We consider that there is no reason why in an appropriate case CPA cannot be implemented by a consultant psychiatrist without wider multidisciplinary involvement. In such a case the consultant psychiatrist is the Care Co-ordinator. This was Dr P's understanding of the position. We agree with him that this was an appropriate response to Dr S's needs in January and February 2000. Nothing would have been gained by involving other professionals or agencies at that time.

4.33 It could be argued that Dr P, in the consultation on 14th January and the follow-up letter to Dr C, covered all the above components and that, accordingly, the requirements of CPA were met. This is the view Dr P expressed when he gave evidence to us. However, it seems to us that this it to omit an important dimension of CPA. The policy is more than guidance to clinicians to assist them in carrying out assessments. Importantly, it seeks to impose a degree of standardisation and thereby to impose specific requirements on mental health professionals of all relevant disciplines. It also aims to ensure that there is an information base, whether in relation to clinical or social care issues, which is available to all practitioners who are, or may become, involved in a particular patient's care. These aims are achieved in practice by requiring practitioners to complete standardised documentation.

4.34 We have considerable sympathy for the view expressed to us by Dr P that the paperwork requirements of the CPA policy are cumbersome:

"what actually happens with large amounts of paperwork being repeatedly built in is that you very rapidly get unmanageable volumes of notes in which it is even more difficult to find important information because it is full of rubbish. The Specialist Mental Health Trust, which now provides mental health care in Fareham and Gosport, is, as we speak really, reviewing its CPA paperwork with a view to minimising it and making it as useful as possible."

4.35 The documentation in the Joint Operational Policy is extensive. As we understand it, a consultant psychiatrist, or other mental health professional, who saw a patient for an initial consultation would be expected to complete the following:

- A four page Community Mental Health Assessment, guided by a one page Interview Checklist.
- An initial risk screening and risk management plan, which forms part of the standard assessment.
- A Standard Care Plan containing "the identified need/differential diagnosis and the agreed plan of care/management". Although, where a consultant psychiatrist is the Care Co-ordinator, a letter to a general practitioner is an acceptable alternative to completing the Standard Care Plan.

- In every case where the initial risk screen identifies a medium or high risk, a five page Detailed Risk Assessment must be completed, though not necessarily by the person carrying out the initial interview.

4.36 There are a number of other forms within the Joint Operational Policy but these do not concern us as they are relevant only to patients entitled to enhanced, as opposed to standard, CPA or they relate to subsequent reviews of care plans and similar matters.

4.37 If our understanding of the Joint Operational Policy is correct then it is clear that Dr P's practice on this occasion did not conform to its requirements. We share Dr P's opinion that some of the standard forms are not suitable for use by consultant psychiatrists. They are designed to be used by a wide range of people. It would be unnecessary and inefficient for someone of Dr P's experience to have to go through a detailed checklist and complete a four page form every time he saw a new patient. In terms of Dr S's clinical care, there would have been no benefit in doing so.

4.38 As we have already stated, we take the view that Dr Ps risk assessment should have been recorded. We think there are advantages in initial risk assessments being recorded on standard forms which are used by all those within mental health services who carry out assessments. We consider that in most cases completion of the standard Risk Screen would provide a sufficient record. It identifies the nature of the risk(s) and provides a space for specifying each type of risk which has been identified and whether it is current. The form then requires the likelihood of risk (low, high or medium) and severity (low, high or medium) to be stated. The next section of the form provides space for details of the risk management plan. This is followed by the statement that if the risk has been identified as medium or high a Detailed Risk Assessment must be completed and the name of the person who will carry out the Detailed Risk Assessment must be entered on the Standard Risk screen form.

4.39 In the circumstances of Dr S's case, the totality of the risk assessment could have been adequately recorded using the standard form Risk Screen, without the need for completion of the five page Detailed Risk Assessment. No doubt there are other cases where completion of the longer form would be necessary, even at the initial consultation, but in our opinion this was not such a case. We think it would have been desirable for Dr P's risk assessment and risk management plan to have been recorded on the Risk Screen document. This would not have added significantly to the time he needed to spend on the case but it would have provided a sufficient record of his assessment and important information of potential use to other clinicians and mental health professionals.

4.40 In the light of this discussion we make the following recommendations.

We recommend that:

1. ***There is a need to clarify the application of the Joint Operational Policy to consultant psychiatrists.***

2. ***The CPA documentation should be revised to make clear where consultant psychiatrists are not expected to use forms and checklists which have been designed for use by other practitioners within multidisciplinary teams. The present position, whereby a letter to a general practitioner is an adequate substitute for the prescribed care plan documentation, should be retained in cases where the consultant psychiatrist is the Care Co-ordinator and there is no wider multidisciplinary involvement in the patient's care.***

3. ***Every patient who is referred to specialist mental health services should receive an initial risk assessment which should be recorded using the standard Risk Screen document, which incorporates the risk management plan.***

4. ***Where the initial risk assessment identifies a significant risk to self or others, the completed Risk Screen document should be copied to the patient's general practitioner with any letter sent by the psychiatrist.***

Conclusion

4.41 In our judgement those directly involved in Dr S's care and treatment acted conscientiously and with professional competence. To the extent that we have identified areas where practice could have been better, particularly in relation to recording information and adherence to the local CPA policy, we do not suggest that these shortcomings are causally relevant to VS's death. Indeed, we do not believe that there is anything Dr P, or anyone else, could reasonably have done to have prevented Dr S from killing VS.

Chapter 5: Summary of recommendations

5.1 We recommend that where a person is assessed by mental health services and information of clinical significance, including matters with a bearing on risk assessment, concerning a person who is not currently receiving treatment from the service is disclosed to clinical staff, a record should be made. This should be sent either to the person's general practitioner, where the person has a general practitioner, or where the person concerned is a patient of specialist mental health services, to the consultant psychiatrist in charge of the patient's care and should form part of the person's medical records.

5.2 We recommend that consultant psychiatrists and other doctors should always make a full note in a patient's medical records of matters of clinical significance which arise in the course of a consultation. This should be in addition to any correspondence.

5.3 We recommend that whenever a consultant psychiatrist has seen a patient, and following the consultation will be retaining clinical responsibility, a follow-up appointment should be made for the patient.

5.4 We recommend that:

1. ***There is a need to clarify the application of the Joint Operational Policy to consultant psychiatrists.***

2. ***The CPA documentation should be revised to make clear where consultant psychiatrists are not expected to use forms and checklists which have been designed for use by other practitioners within multidisciplinary teams. The present position, whereby a letter to a general practitioner is an adequate substitute for the prescribed care plan documentation, should be retained in cases where the consultant psychiatrist is the Care Co-ordinator and there is no wider multidisciplinary involvement in the patient's care.***

3. ***Every patient who is referred to specialist mental health services should receive an initial risk assessment which should be recorded using the standard Risk Screen document, which incorporates the risk management plan.***

4. ***Where the initial risk assessment identifies a significant risk to self or others, the completed Risk Screen document should be copied to the patient's general practitioner with any letter sent by the psychiatrist.***

Appendix 1: Documents received by the inquiry

1. Dr S's medical records.

2. VS's medical records.

3. Statements, expert reports and exhibits in the criminal proceedings.

4. Transcript of the hearing at Winchester Crown Court (14.7.00).

5. Report of the Internal Inquiry into the Events Leading up to the Death of VS (Portsmouth Healthcare NHS Trust - December 2000).

6. Policy documents, including the Joint Operational Policy on Care Programme Approach and Care Management (April 2000).

7. Documents submitted to the Inquiry by AS and MD.

8. Statement submitted to the Inquiry by Dr P.

Appendix 2: Witnesses seen by the inquiry

The following witnesses were interviewed on 15th July 2003

Dr P (Consultant Psychiatrist, West Hampshire NHS Trust)
Dr C (General Practitioner)
AS (VS's daughter)
MD (VS's son)

The following witness was interviewed on 22nd September 2003

GH (Staff Nurse, Portsmouth City Primary Care Trust)

Dr S was invited to give evidence but declined to do so

Annex A

HAMPSHIRE AND ISLE OF WIGHT STRATEGIC HEALTH AUTHORITY

ACTION PLAN - INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF Dr S

Two action plans have been prepared as a result of the Independent Inquiry into the Care and Treatment of Dr S: the Hampshire and Isle of Wight Strategic Health Authority action plan and the West Hampshire NHS Trust action plan.

West Hampshire NHS Trust Action Plan (attached at Annex B)

All of the recommendations within the Dr S Inquiry report will require implementation by West Hampshire NHS Trust (now called the Hampshire Partnership NHS Trust). The Trust has prepared an action plan (**set out at Annex B**) detailing how these recommendations have and will be implemented. The Hampshire and Isle of Wight Strategic Health Authority Clinical Governance lead, in conjunction with the Director of Nursing and Clinical Governance of the Fareham and Gosport Primary Care Trust will monitor the Trust's progress against the Trust action plan and ensure implementation. A report will be brought to the Strategic Health Authority's Audit and Governance Committee on a six monthly basis to ensure satisfactory progress is being made to implement the recommendations and ensure that the lessons learnt in this tragic incident are not repeated within Hampshire and the Isle of Wight.

Hampshire and Isle of Wight Strategic Health Authority Action Plan

The Strategic Health Authority action plan is set out below. The plan has been prepared to ensure that wider learning from the Inquiry is appropriately shared and acted upon. The recommendations set out in the second column have been drawn directly from the Inquiry Report.

Rec No.	Recommendation (Drawn from the Independent Inquiry Report)	Action	Lead	Timescale
N/A	General Actions	The Chief Executive of Hampshire and Isle of Wight Strategic Health Authority (SHA) will write to the Chief Executives of all Strategic Health Authorities in England and the National Patient Safety Agency, enclosing a copy of the RS report highlighting the conclusions and asking them to ensure that the lessons learnt from this case are disseminated and, where appropriate acted upon.	SHA Chief Executive	14.04.04

Rec No.	Recommendation (Drawn from the Independent Inquiry Report)	Action	Lead	Timescale
5.1	We recommend that where a person is assessed by mental health services and information of clinical significance, including matters with a bearing on risk assessment, concerning a person who is not currently receiving treatment from the service is disclosed to clinical staff, a record should be made. This should be sent either to the person's general practitioner or, where the person concerned is a patient of specialist mental health services, to the consultant psychiatrist in charge of the patient's care and should form part of the person's medical records.	SHA will share the learning from this Inquiry with the Department of Health in order to ensure that the new definition of an encounter takes account of the recommendation set out in para 5.1 SHA will undertake a review of the ethics and mechanics of the disclosure of such information within the current legal framework. Draft protocol on information to be developed for adoption by the NHS of Hampshire and Isle of Wight	Professor Martin Severs, SHA Non-Executive Director SHA Information Security and Governance Specialist	30.04.04 30.06.04
5.2	We recommend that consultant psychiatrists and other doctors should always make a full note in a patient's medical records of matters of clinical significance which arise in the course of a consultation. This should be in addition to any correspondence.	The SHA Director of Public Health will write to Medical Directors and Professional Executive Committee Chairs of Primary Care Trusts and NHS Trusts within Hampshire and the Isle of Wight reiterating the importance of making notes in medical records.	SHA Director of Public Health	14.04.04
5.3	We recommend that whenever a consultant psychiatrist has seen a patient, and following consultation will be retaining clinical responsibility, a follow-up appointment should be made for the patient.	The SHA Chief Executive will write to the other providers of mental health services for the population of Hampshire and the Isle of Wight (namely the Isle of Wight HealthCare NHS Trust, Portsmouth City Primary Care Trust and Surrey Hampshire Borders NHS Trust) highlighting this recommendation and seeking assurance that it will be implemented.	SHA Chief Executive	14.04.04

Rec No.	Recommendation (Drawn from the Independent Inquiry Report)	Action	Lead	Timescale
5..4	We recommend that: 1) There is a need to clarify the application of the Joint Operational Policy to consultant psychiatrists. 2) The CPA documentation should be revised to make clear where consultant psychiatrists are not expected to use forms and checklists which have been designed for use by other practitioners within multidisciplinary teams. The present position, whereby a letter to a general practitioner is an adequate substitute for the prescribed care plan documentation, should be retained in cases where the consultant psychiatrist is the Care Co-ordinator and there is no wider multidisciplinary involvement in the patients care. 3) Every patient who is referred to specialist mental health services should receive an initial risk assessment which should be recorded using standard Risk Screen document, which incorporates the risk management plan 4) Where the initial risk assessment identifies a significant risk to self or others, the completed Risk Screen document should be copied to the patient's general practitioner with any letter sent by the psychiatrist.	See Action relating to recommendation 5.3 (above)	As above	As above

ANNEX B

Hampshire Partnership NHS Trust (formerly West Hampshire NHS Trust) - Sexton Independent Enquiry Action Plan

RECOMMENDATION	Action	Implementation Process	Timescale and individual	Evidence
5.1 We recommend that where information of clinical significance, including matters with a bearing on risk assessment, concerning a person who is not currently receiving treatment from the service is disclosed to clinical staff, a record should be made. This should be sent either to the person's general practitioner or, where the person concerned is a patient of specialist mental health services, to the consultant psychiatrist in charge of the patient's care and should form part of the person's medical records.	West Hants NHS Trust will develop via its Clinical Governance forums a standard approach to implementing and interpreting this recommendation following due consideration of legal, professional and organisation resource constraints.	Trust and Directorate clinical governance groups to action Share agreed message via professional committees, local clinical governance and other communication methods (e.g. clinical governance newsletter) Recommendations to be amended to existing policies or separate protocol written following CG forum recommendation	Chair Trust Clinical Governance Chair AMH Clinical Governance April - May 04	**Minutes of meetings** **Agreed communication** **Newsletter or similar** **Protocols or amendments to policy**
5.2 We recommend that consultant psychiatrists and other doctors should always make a full note in a patient's medical records of matters of clinical significance which arise in the course of a consultation. This should be in addition to any correspondence.	West Hants NHS Trust agrees that as a minimum a note that a consultation took place should be held within the medical record. The degree of detail and extent of duplication will be a matter of clinical judgement.	Trust and Directorate clinical governance groups to action Share agreed message via professional committees, local clinical governance and other communication methods (e.g. clinical governance newsletter) Recommendations to be amended to existing policies (medical records) or separate protocol written following CG forum recommendation	Chair Trust Clinical Governance Chair AMH Clinical Governance April - May 04	**Minutes of meetings** **Agreed communication** **Newsletter or similar** **Protocols or amendments to policy**

5.3 We recommend that whenever a consultant psychiatrist has seen a patient, and following the consultation will be retaining clinical responsibility, a follow-up appointment should be made for the patient.	West Hants NHS Trust supports this finding as good practise for the majority. However it is acknowledged that in circumstances where it is clinically appropriate that deviation might take place. Given this, West Hants NHS Trust will develop via its Clinical Governance forums a standard approach to implementing and interpreting this recommendation. Significant work is being undertaken across the Trust with booking systems for patients and it will seek to incorporate this recommendation into this work to ensure it is robustly implemented.	Trust and Directorate clinical governance groups to action Share agreed message via professional committees, local clinical governance and other communication methods (e.g. clinical governance newsletter)	Chair Trust Clinical Governance Chair AMH Clinical Governance April - June 04	**Minutes of meetings** **Agreed communication** **Newsletter or similar** **Protocols or amendments to policy**
5.4 We recommend that: ***1) There is a need to clarify the application of the Joint Operational Policy to consultant psychiatrists.***	The Trust had implemented a new CPA joint operation policy, introduced on the 1st November 2003 in which all of these points have been addressed.	New policy already implemented	Complete	**Policy and Paperwork**
2) The CPA documentation should be revised to make clear where consultant psychiatrists are not expected to use forms and checklists which have been designed for use by other practitioners within	The Trust will review the operation of this policy after 6 months and will specifically ensure that within this review each of these recommendations are robustly re-tested to ensure absolute clarify.	Lead CPA officer	Lead Directorate CPA Officer Summer 04	**Policy and Paperwork** **Evidence of Review**

multidisciplinary teams. The present position, whereby a letter to a general practitioner is an adequate substitute for the prescribed care plan documentation, should be retained in cases where the consultant psychiatrist is the Care Co-ordinator and there is no wider multidisciplinary involvement in the patient's care. ***3) Every patient who is referred to specialist mental health services should receive an initial risk assessment which should be recorded using the standard Risk Screen document, which incorporates the risk management plan.*** ***4) Where the initial risk assessment identifies a significant risk to self or others, the completed Risk Screen document should be copied to the patient's general practitioner with any letter sent by the psychiatrist.***	see above	see above	see above	
FOR ALL RECOMMENDATIONS	Audit compliance to agreed positions	Trust and Directorate clinical governance groups to agree priorities for Auditing compliance.	Chair Trust Clinical Governance Chair AMH Clinical Governance April - June 04 (agree audits and timescales)	**Minutes of meetings** **Audit Brief** **Audit report and dissemination**