

# HUNDREDFAMILIES CASE REVIEWS AND RELATED NEWS ARTICLES: EAST ENGLAND

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## 1. Colin Obray

Summary: In November, 2001, university lecturer Colin Obray is first admitted to hospital due to physical ailments and a serious suicide attempt. He is given Haloperidol, citalopram, Lorazepam and Omeperazole. He experiences frightening delusions. On Dec 20 Dothiepin and Diazepam are substituted for the citalopram. About this, the review report notes: “Changing his medication was appropriate, but a phased withdrawal of the Citalopram would have been advisable”, hinting that they believe that subsequent events were influenced by citalopram withdrawal. By this time CO is “confused”, “irrational and aroused” and completely unable to function but his wife decides to care for him at home. The review report states that “Mr X undoubtedly had a mental disorder”. On Dec 21 CO tries to strangle his wife and when the police arrive they find him to be in a “trance”. His wife sends him to hospital for a medication review, and he is noted to be suffering bizarre ideas and delusions. He seems to be recovering and on Feb 13, 2002, he returns home, still on medication. On Feb 17 CO calls the police and calmly explains that he has murdered his wife. The news article contains no reference to the citalopram or other medication.

### WIFE KILLING 'A TRAGEDY' — (Somerset County Gazette)

[http://www.somersetcountygazette.co.uk/news/7201369.WIFE\\_KILLING\\_A\\_TRAGEDY/](http://www.somersetcountygazette.co.uk/news/7201369.WIFE_KILLING_A_TRAGEDY/)

15 Aug 2002

A SENIOR university lecturer was ordered to be detained under the mental health act after admitting stabbing his wife to death at their home on the Lizard Peninsula in February.

Colin Obray, 63, inflicted multiple stab wounds on his wife Anne, 60, at their bungalow in Ledra Close, Cadgwith. They had previously lived in Porthleven in a new housing development. Mentally-ill Obray pleaded guilty to manslaughter on the grounds of diminished responsibility when he appeared before Exeter Crown Court.

He was made the subject of a hospital order under section 37 of the Mental Health Act by Judge Graham Cottle.

Det Sgt Malcolm Read, who investigated the case, said it was a very tragic incident.

"He stabbed his wife and then rang the police to say what he had done," he said. "She suffered multiple wounds. He is suffering from mental health problems."

Mr Obray was a retired senior lecturer who taught statistics at Warwick University. Mrs Obray was also a teacher. Det Sgt Read said: "They had three daughters who are all professional people. One works in the City of London and another is a pharmacist. They are a very intelligent family. The daughters are coming to terms with effectively losing both their parents." The Obrays had moved to Cornwall but had not settled very well, moving house several times before finally settling in Cadgwith a few months before Mrs Obray's death.

"The hospital was treating him. Mrs Obray wanted him back home and in the community. This attack was a one-off. What happened was tragic."

Obray's plea of manslaughter was accepted by the Crown Prosecution Service.

Psychiatrists will determine when Obray should be released. He is being detained at the Butler Clinic in Dawlish, Devon.

Residents in Cadgwith were shocked by the death of Mrs Obray. The normally tranquil peace of the village was shattered when police arrived and cordoned off the hillside bungalow in Ledra Close.

## **THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF A PATIENT KNOWN AS X**

[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/COLIN\\_OBRAY\\_FEB02.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/COLIN_OBRAY_FEB02.pdf)

### **SUMMARY OF EVENTS**

Mr X was a retired university lecturer who moved to Cornwall on his retirement, where he and his family had spent many happy holidays. He and his wife moved house several times and eventually settling in the Helston area, west Cornwall.

In October 2001 Mr X developed some physical health problems leading to hospital admission for investigations of gastric bleeding, caused by inflammation to the lower end of the oesophagus. He apparently feared that he might have a malignant illness, which was eventually ruled out. Following a

serious disagreement, in which they discussed previous marital disharmony, he made a serious suicide attempt and was admitted to Treliske Hospital, Truro, with multiple cuts to his wrists, neck and abdomen, requiring emergency surgery. During his stay in this hospital he tried to jump out of the window. Following his recovery from his injuries and an assessment by the liaison psychiatry team, on 7 November 2001 he was transferred to Trengweath Hospital, the mental health inpatient unit at Redruth, to the care of Dr Jeremy Scott, Consultant Psychiatrist.

This admission was for about 13 days, following which he was looked after in the community by his wife and supported by a Community Psychiatric Nurse (CPN) and his General Practitioner (GP).

Unable to settle at home and becoming more unwell, he was readmitted on 1 December for a further 10 days and then discharged. Sometime during the early hours of 21 December he attempted to strangle his wife and was readmitted to Trengweath Hospital.

During this third admission Dr Scott referred Mr X to a Consultant Psychiatrist for older people, requesting a second opinion as he gave the impression of developing early onset of an organic dementia, possibly of a vascular or Alzheimer's in origin. However Dr Steven Naylor, Consultant Psychiatrist for older people, was of the view that Mr X's clinical presentation was not due to pre-senile dementia but more likely to be as a result of his anxiety.

He was discharged on 12 February 2002, again with support from Ms Helena Harper (CPN). She visited him at home on 15 February 2002. Although he was quiet, it was apparent that he became more anxious the longer the meeting went on.

On 17 February 2002 Mr X made a 999 telephone call to the police. He was described as speaking "calmly and in normal conversation level". He said, "I have murdered my wife" and asked that a police officer be sent to their address. Mrs X had suffered 14 stab wounds to the chest and abdomen. Some of the wounds were inflicted after death.

A police surgeon and a psychiatrist assessed Mr X and concluded he was fit to be detained, and so he was remanded in custody. On 25 March 2002, under Section 48 MHA 1983, he was transferred to the Butler Clinic, where he is still a patient.

Mr X pleaded guilty to manslaughter and on 2 August 2002 was sentenced to be detained on a hospital order under section 37 Mental Health Act 1983. It was not seen to be necessary to make an order under section 41 Mental Health Act 1983 restricting his discharge from hospital.

#### MR X'S FIRST ADMISSION TO TRENGWEATH HOSPITAL AND DISCHARGE [excerpts]

9 November 2001 Mr X was described as feeling low (2/10), finding the ward intimidating and noisy, and unable to concentrate on reading the newspaper. The next day he was bright, cheerful and very conversational, allowing staff to help with his personal hygiene. He was quoted as saying he would need a lot of help at home. He continued to improve.

Dr Birch saw Mr X. He told her that during the night he found the level of observation intrusive and hindered his sleep, but appreciated the opportunity to talk to staff. He also found the ward intimidating but was 'getting used' to it. He told her that he felt 'shame' at being so low as he had such a wonderful life and felt that he would not attempt to harm himself again. He did not understand why the previous attempt happened and had he had someone to talk to, he wouldn't have gone through with it. Mr X was undecided about wanting to talk to his wife about his feelings.

His Care Plan was as follows

- the level of observation was reduced to every 20 minutes
- give regular night analgesia and lactulose
- review sutures on Monday
- start antidepressants - Citalopram

20 November 2001 Mr and Mrs X attended Dr Scott's ward round. Mr X still appeared anxious and withdrawn and Mrs X stated that her husband found the ward rounds very stressful. Mrs X agreed to see the CPN. Mr X was given a week's supply of Haloperidol, Citalopram, Lorazepam and Omeperazole, to be used as instructed.

#### MR X'S THIRD ADMISSION TO TRENWETH HOSPITAL AND DISCHARGE

20 December 2001 Mr X was seen in the outpatient clinic and was both agitated and distressed. He was pre-occupied with morbid delusional ideas such as being tortured or burned to death. Mrs X was very insistent that she could look after him at home, knowing that she could keep in touch with ward. Dothiepin 50mgs was prescribed instead of Citalopram, and Diazepam 2mgs to be taken as necessary, up to four times a day. Dr Scott wrote to Dr Dorrell: "...he is again very depressed and anxious but his wife is very insistent that she is able to look after him at home. He is expressing irrational fears and at times he appeared rather confused so we may, in the end, have to readmit him to hospital. However I do hope he may yet be able to settle and recover at home..."

Comment - Ms Harper told us that Mr X refused to leave the room, or was not able to leave the room. He stood in the corridor motionless and mute. He was given some diazepam or lorazepam and after much coaxing he was transferred to Mrs X's car who then took him home. Ms Harper had not seen him like that before. Mrs X appeared to make matters worse by telephoning family members and friends requesting them to speak to him. He was so confused and did not appear to know what was going on. Dr Scott has informed us that Mr X "believed he was to be forcibly taken to Trengweath Hospital to be tortured and executed." Dr Scott had not seen evidence of such psychosis during the previous inpatient stays.

We doubt that Mr X was able to give informed consent to the change in his treatment at this point. The case notes do not record an explanation for his psychosis nor do they record a plan of investigation for the psychosis. He was not prescribed any anti-psychotic medication. We also have reservations about the extent to which a clinician could successfully make a risk assessment at this point, given how irrational and aroused Mr X was.

Mr X was undoubtedly far worse than at the time of discharge. In our view Mr X should have been admitted to hospital at this stage. It is quite possible that either Mr or Mrs X would have objected to this plan, in which case an assessment under the Mental Health Act (1983) could have been initiated. The nearest relative cannot block admission under Section 2 of the Act, which would have been the appropriate Section to use in the circumstances, allowing as it does for admission for assessment for up to 28 days. Mr X undoubtedly had a mental disorder and there was a potential for serious risk, as evidenced by his very serious suicide attempt. Clinical staff would understandably have reservations about the consequences of such an action on the therapeutic relationship with Mr and Mrs X, but paradoxically such a move might have brought into sharp relief the need to establish clear boundaries with Mrs X.

It has been suggested to the Inquiry panel that the threat of admission might have provoked serious medical problems such as a stroke or heart attack because Mr X had “ serious cardio-vascular disease.” In fact the medical notes explicitly exclude such disease. In addition Dr Scott, in his medical report dated March 2002, refers to Mr X as having no health problems apart from his abdominal complaint and his mental health difficulties.

Clearly Mr X could not have been held against his will at the clinic. If he refused admission he could have been allowed home without the threat of detention, so as not to scare him into any rash action. In these circumstances the risks would justify a lack of frankness to the patient and carer. An Approved Social Worker and the GP could then have performed a Mental Health Act assessment later at the patient’s home, following on from Dr Scott’s completed recommendation. Assuming they were in agreement with the need for compulsory admission, Mr X could then have been taken to Trengweath.

Had Mr X been admitted at this stage, we cannot say with any certainty what might have transpired with regard to improvements in the accuracy of diagnosis, a more effective treatment plan, and the ultimate outcomes in this case. As it was, Mr X was sent home, apparently on his wife's insistence, and his medication was altered. Changing his medication was appropriate, but a phased withdrawal of the Citalopram would have been advisable.

21 December 2001 The Police and an ambulance crew attended Mr and Mrs X’s home at 06.39hours as Mr X had attacked his wife earlier, trying to strangle her. She hid in the toilet as instructed by the police. When they entered the house they found Mr X holding onto the toilet door handle, staring at his hands. Further police assistance arrived at 06.54hours; Mr X was restrained and wrapped in a blanket as he had no clothes on. He appeared passive and in a trance unable to respond to anything. Mrs X was released from the toilet and examined for any injuries. None were visible. Mrs X told the police officers that the previous night she and her husband had had heated discussions, about their previous marital difficulties, which were continued that morning. She stated that she did not believe that her husband would hurt her, and only locked the door when the police instructed her to do so.

Mrs X wanted her husband to go to Trengweath Hospital to have his medication reviewed and so the ambulance crew took him there. During the examination Mr X was worried about being tortured by his wife and daughter. He also worried about being burnt, and that his other daughter wanted to harm

him. During the duty SHO's assessment he made contradictory statements about being in Trengweath Hospital, saying –“not safe here - why should I be risk anywhere. I'm mad – I'm not mad”. Mr X admitted that he was feeling anxious “ because my wife and daughter are coming to kill me”. His speech was quiet and repetitive. He scored 16/30 on the mini mental state examination (MMSE) – unable to do tasks which should have been easy for him. During the physical examination Mr X made no verbal responses, and could not be persuaded to leave the clinical room without physical help.

A history was taken from Mrs X. She stated that Mr X was “terrified he would be put back in hospital again”. She would not leave him and agreed that his depression was increased after his discharge. Mrs X also told the doctor that, in her opinion, when in Trengweath Hospital Mr X had said the Citalopram was working so that he could go home. She went on to say that he now had delusions, thinking he was “ESN and that he was a psychopath” without knowing what it meant. He thought that their youngest daughter was dead and that other family members were going to torture him. The SHO concluded that the diagnosis was, “?severe anxiety with depression”. Dr Scott had previously prescribed Prothiaden, which was to be continued, and 10 minute observational checks were started. The following day Mr X took his medication and settled, although he remained very disorientated and confused. At this time Dr Maggie Hand, Medical Director, was conducting a survey of patients who were re-admitted as an emergency within 90 days or less having previously discharged. This was in response to a National Performance Indicator to evaluate performance. The Trust had a high emergency re-admission rate and the survey was seen as a way of identifying which service developments were required to decrease the number of re-admissions. The completed form was returned to the Clinical Audit office and no copy was kept in the patient's notes because of individual confidentiality and the need for anonymity. The form was divided into five sections as follows: 1. what care did you receive at home since your last admission? 2. how helpful did you find your last admission? 3. why do you think you needed to come into hospital on this occasion? 4. what other services or care, if it had been available, would have been preferable to hospital admission or might have prevented admission? 5. is there anything else you think it would be useful for us to know about?

Mr and Mrs X completed such a form and they kept two copies as part of their own note keeping. One copy had Mr X's comments only and the other had his original comments with annotated notes we presume by Mrs X. In the completed section on care at home, the CPN, outpatients, out of hours service and GP contact had been ticked.

On the form Mr X described the previous admission (following the attempted suicide), as “ my absolute nightmare” and annotated against it was “the manner of (name)'s last admission so terrified him he was unable to speak to me at all. The next morning, he became more and more depressed, losing weight and started compulsive teeth grinding. Unknown to me he persuaded the nursing staff he was getting better and told Dr Scott the drugs had started working. (name) was suffering from the delusion that I was trying to kill him. He then tried to strangle me” Mr X described his reason for admission on this occasion as “ I wanted to speak to a doctor about my medication as my wife had done the previous week. I did feel very depressed but not in any imminent danger. I would have been happy to see a doctor next week”. He went on to write against question 4 “ a doctor to consult to speak to over the phone to discuss medication and change it if necessary. Too long between consultations” and against

question 5 “on my notes I had asked to be seen with my wife present. I was having difficulty with social interactions. The on-call doctor terrified me and ordered my wife to leave the room. I was worried about what I would say to the doctor and we had been told she could stay with me previously. When I was asked if I would be seen alone, and I was too frightened to speak, Richard said that if I said nothing, that would mean yes. After my wife had left I felt coerced into agreeing to a witness statement with David and Heidi. I felt it was against my will. I was then under the impression that I would be there for life. Later David told me I would be in Tregweath Hospital for a very long time and at the very least months”

Comment As this was a confidential questionnaire this information was never shared with the staff in this format.

23 December 2001 The SHO spoke to Mrs X and her daughter, telling them that Mr X was settling although he had been observed in his bed area trembling, feeling unsafe and at risk of being attacked by his wife. These symptoms were explained as part of the depression and anxiety rather than as the result of any physical problem. The SHO thought it would be useful to have an EEG and to bring forward the CT scan.

24 December 2001 Mr X was seen by Dr Birch and appeared unable to talk and only able to follow simple commands. She ordered blood tests and for his fluids and food intake to be increased. He didn't know that it was Christmas Eve and that the following day was Christmas Day. However he did recognise a staff nurse who had not been on duty for 10 days.

25 December 2001. Mr X was visited by his family and ate the sandwiches they had brought in for him as he was still reluctant to eat the hospital food. He brightened up as the evening wore on, ate his supper and enjoyed watching television.

26 December 2001 Mr X was found wandering around the sleeping area, saying he had lost his clothes. He was in fact looking in the wrong space.

1 January 2002 Mr X was still having periods of confusion but these had become less in the last few days.

2 January 2002 Mr X kept an appointment at Treliske Hospital accompanied by his wife. When Mr X returned to the ward he was agitated, finding it hard to concentrate, and was confused about his washing and clothes. Because of his confusion the staff found it necessary to help him have a bath that evening.

3 January 2002 Mr X attended Dr Scott's ward round. He expressed no feeling of paranoia although still felt 'panicky'. He gave a good account of what he had done the day before and his memory seemed good. His wife said he was suffering from the same stomach cramps that he had experienced before, in the two years since she had had breast illness.

Later that night he was seen by Dr Birch, as he collapsed whilst retching in the toilet. His pulse was 100 and regular, blood pressure 150/60 and there were no neurological deficits. He was very distressed

saying “ I haven’t been telling the truth. I’ll never get out of this”, expressing guilt about the past and secrets he had never told anyone. She concluded that he had a gastro-intestinal infection and nausea following anxiety. Haloperidol 5mgs was given and he was encouraged to rest in bed.

Comment The family were of the belief that Dr Birch thought these symptoms were the same stomach cramps he was experiencing due to his anxiety, but this was clearly not the case from her records.

4 January 2002 Mrs X telephoned to express her concerns about her husband’s presentation. She felt that he presented as “quite well” at the ward round but to her he was confused at times and “obsessed” about his clothing, believing he didn’t have any. He had cried before the ward round, and she felt he was not getting better. Mrs X queried whether the medication was making him confused and asked that she should be present at the ward rounds, so that she could provide her perceptions of her husband’s well being and presentation. The ward was notified that the EEG was arranged for the 16/1/01.

5 January 2002 The duty SHO was called as Mr X apparently collapsed in his chair shortly after his wife had left. He had not been feeling well for a couple of days with abdominal aches. He said he was a coward, had not been totally honest with his family as he had wanted to die because his wife might leave him. She had threatened to do so before. His speech was slow, rational and coherent. His mood was depressed and anxious with suicidal thoughts. The diagnosis was severe depression with anxiety. The doctor spoke to Mrs X who told him that she thought the Diazepam and Lorazepam made him worse and confused.

6 January 2001 Mr X remained unwell and more anxious and confused, and was advised to rest on his bed away from his wife. He slept, and on waking felt better, but when he returned to the day area and his wife he became confused and anxious again. Later that evening he was reluctant to take his medication, saying that his wife had told him not to take it as it made him worse.

8 January 2002. Dr Birch saw Mr X. He was no longer vomiting but had some diarrhoea. He knew which day it was but didn’t manage to count beyond 51 before becoming anxious. Mrs X was interviewed and she again said she thought the diazepam was making him confused. She talked at great length about Mr X’s childhood. She was unable to give an exact history and spoke in a long monologue presenting as distressed and anxious.

The Care Plan was reviewed as follows 1. continue the medication 2. refer .....for opinion re. Cognition 3. no leave at current time. 4. The CT scan was normal

9 January 2002 Dr Birch saw Mr X alone. He had had his breakfast and had had no further abdominal pain or vomiting. He made good eye contact with good speech, if a little slow. At times he found it difficult to answer questions, and was anxious about saying the right things when asked how he was feeling. He feared being incarcerated and split up from his family. He didn’t feel his memory and cognition was improving and on occasions he complained he couldn’t remember what day it was, or what the correct route was when his wife was driving.

10 January 2002 Mr X went out with his wife in the afternoon. Dr Scott referred Mr X to Dr Steven Naylor, Consultant Psychiatrist for older people, requesting a second opinion. He outlined Mr X's medical history to date, including the attempted suicide, which seemed to be linked to "a depressive illness and marital problems". He went on to say ".....fortunately no sinister pathology was found and his symptoms were attributed to some benign inflammation in the lower oesophagus. He seemed much relieved when he learned of the results of his investigations and he went home in good heart and with apparently much improved marital harmony although the psychodynamics of family relationships seem extremely complicated. Both Mr and Mrs X are very anxious and their interactions are difficult to understand and probably much influenced by a wide range of fears some of which seem to be illogical or unfounded..... For a short time Mr X did quite well at home with a CPN and antidepressant medication (Citalopram).

However before Christmas he re-presented at the outpatient clinic in a very disturbed state in which he appeared to be deluded and to have lost his grasp on reality. He behaved in an agitated state, pacing up and down and fluctuating from being almost mute to shouting loudly.... He calmed down with some Diazepam but later at home attacked his wife and had to re-admitted to Trengweath. He had since then shown varying degrees of disorientation and cognitive impairment. Initially he was grossly disorientated and on Christmas Eve he did not have any awareness of the date or the season. Quite rapidly he regained much of his orientation and the subsequent fluctuations have been less marked. At his best he is fully orientated and his short-term memory is reasonably good though still impaired. However he appears to function well below the sort of level that would be expected in view of his background as a university lecturer in mathematics..... He also shows emotionally lability and incongruity and his mental state is generally unstable. The whole picture is strongly suggestive of an underlying organic disorder possibly of vascular aetiology leading to a presentation of early dementia with relatively lucid intervals. His depressed mood and his severe anxiety clearly played some part in his impaired functional capacity but I am not so sure that we can attribute the symptomatology purely to a depressive pseudo-dementia".

11 January 2002 Dr Birch saw Mr X. He was still anxious at times and still experiencing poor memory, misremembering a previous conversation the day before with Dr Birch. He scored 26/30 on the MMSE. He enjoyed going out for lunch with his wife and they both requested to have home leave over the next weekend. He was sleeping well and so diazepam was reduced to 1mgs.

14 January 2002 Mr X telephoned his daughter and was heard crying, presenting as anxious, indecisive and confused. In discussion with Mr David Taylor, (S/N), he stated he did not want to be separated from his family. Mr Taylor told him that as an informal patient he could go home the following day. He stated he was physically unwell and needed to be in hospital.

15 January 2002 Mr X attended the ward round. Dr Scott spent considerable time with Mr and Mrs X. Mrs X felt that her husband should have a sigmoidoscopy and or a colonoscopy as she was concerned that he might have bowel cancer with brain metastases. She also thought he had a testicular lump.

Comment Mrs X had already been given the results of the CT scan by Dr Birch, which revealed no abnormality.

Mr X was seen later on the ward when he expressed concerns that he might be sectioned and therefore never leave the ward. He was reassured that this was not the case.

16 January 2002 Mr X had an EEG at Treliske Hospital.

17 January 2002 Mr Robin Gordon, occupational therapist, saw Mr X. He was also seen and examined by Dr Winters, SHO, prior to referral to Dr Levine, Consultant Physician, because of Mrs X's concerns about the possibility of her husband having a testicular lump. Mr X was very anxious that he might be physically ill. The EEG results showed nothing of any significance. Later in the day he went out with his wife.

18 January 2002 Dr Steven Naylor interviewed Mr X to provide a second opinion of his confusion and poor memory. Dr Steven Naylor interviewed him. Dr Naylor concluded that his symptoms were consistent with severe anxiety disorder/panic disorder, exacerbated by antidepressant introduction, with episodes of dissociative cognitive impairment. He wrote the following treatment plan 1. that his current antidepressant (Dothiepin) be reduced and withdrawn, and later if needed Imipramine (a different antidepressant) could gradually be introduced. 2. Use Lorazepam or Clorazepam for trial period to control panic as clinical test of extant anxiety is causing symptoms. 3. Dothiepin reduced to 50 mgs.

20 January 2002 Mr X still very anxious, quite inarticulate and concerned that he had not made sufficient progress since admission. He needed much persuasion to take his medication.

22 January 2002 Mr X attended Dr Scott's ward round and presented as anxious and distressed at times. He had spent time out of the hospital with his wife. Mr X's antidepressant medication was reduced. The EEG showed signs suggestive of early stages of dementia. His wife told Dr Scott that prior to his admission her husband had taken St John's Wort, which made him worse. On this occasion, Mrs X presented as 'very dramatically distressed'

23 January 2002 Dr Scott wrote to Dr Naylor: "..... I would certainly agree there is a large functional overlay arising from his severe anxiety. His wife describes his pre-morbid personality as confident, self-assured and gregarious and it would appear that there was probably an absence of dissociative phenomena until very recently. I wonder, there fore, if there is a co-existing organic component contribution to the psychopathology even though the recent improvement in his orientation and short term memory is sufficient to enable him to perform well during testing. Our suspicions are supported to some extent by the EEG report which indicates diffuse changes consistent with possible mild dementia...."

24 January 2002 Mr X spent time painting in the activity room and according to Mr Gordon was more relaxed.

25 January 2002 Dr Birch telephoned Dr Levine's secretary to ascertain when Mr X's appointment would be. Dr Levine was on holiday and would see the referral on his return. Mr X was very confused and unable to string together a sentence which made any sense.

28 January 2002 Mrs X anticipated seeing Dr Naylor, but had not shared this information with the staff and, as Dr Naylor was not due on the ward that day, she was unsuccessful.

29 January 2002. Mr X did not attend Dr Scott's ward round and so Mrs X was seen. She told Dr Scott that Mr X was improving in his cognition since the Dothiepin had been stopped but that he was still anxious. Mr X had a strong belief that the police would arrest him when he went home. She inquired about the appointment with Dr Levine.

30 January 2002 Mr Bernard Kearney, Team Leader, had a long conversation with Mrs X about all her concerns since Mr X had been admitted. During the conversation it seemed that her concerns appeared to have been resolved. Mr X remained anxious.

31 January 2002 Mr X spent time in the activity room revisiting his computer skills with the occupational therapist.

1 February 2002 Mr X commenced two days leave from the ward.

3 February 2002 Mr X returned from leave and both he and his wife reported that it had gone well. Mr X had cleaned the car and cooked meals.

5 February 2002 Mr X attended Dr Scott's ward round and he requested to have more home leave as well as extra doses of Lorazepam. Mrs X was pleased with his progress, though asked whether it was possible that Mr X had encephalitis.

8 February 2002 Mr X returned from leave to be interviewed by Dr Birch, who had a long discussion with him about his admissions. He was given six days medication and told to return in four days time for the ward round.

12 February 2002 Mr X returned from leave to attend the ward round. He was fully orientated and reasonably cheerful. He was sleeping well and had a good appetite. He was active at home, gardening and visiting friends. He was discharged from the ward to be followed up by the CPN. His medication was prescribed as Lorazepam 0.5mgs twice daily and could be omitted on the days that he felt relaxed. Mr X agreed to see a therapist for massage and relaxation classes.

Dr Scott referred Mr X, as a private patient, to Dr McClean, Consultant Neurologist, for a further opinion of his physical health as Mr and Mrs X had requested an appointment. He informed Dr McClean about the EEG and CT head scan. He went on to say "the EEG results lent some weight to the possibility of an organic dementia but subsequent clinical progress has been encouraging and Mr X now shows good recall for recent events and he is once again fully orientated. I wondered if perhaps the EEG abnormalities might have been due to some reversible inflammatory process and I had in mind repeating the EEG in about six months to see if any significant differences had occurred in that period.

Mr X and his wife would be most interested to hear from you on your thoughts on his EEG and I am sure they will be most appreciative if an opportunity to talk to you about this matter on a private patient basis could be offered”.

13 February 2002 Dr Sarah Ashley, SHO to Dr David Levine, saw Mr X, as Dr Levine had seen him previously and diagnosed ‘irritable bowel syndrome’. She recommended a CT scan and paracetamol tablets for the pain. There was no plan to see Mr X in the clinic again. Dr Birch completed the discharge prescription form, which was faxed to the GP. Mr X’s medication was 1. Lorazepam 0.5mgs twice daily to be reviewed in 2-3 weeks 2. Omeprazole 20mgs daily 3. Aspirin 75mgs daily Dr Birch also noted that he had had a poor/adverse response to Citalopram/Dothiepin. He was given an outpatient appointment for three weeks and was to be visited by Ms Harper CPN.

15 February 2002 Mrs Harper, CPN visited Mr X at home. He was quiet during the meeting and Mrs X did most of the talking, mainly complaining about his treatment and in particular, not receiving the EEG results and not knowing why Dr Naylor was asked to give a second opinion. Mrs X had stopped Mr X’s medication two nights previously and so was advised to recommence as prescribed, 0.5mgs Lorazepam in the morning and again in the evening. Mr X was referred to an anxiety management group when there was a vacancy.

17 February 2002 The Police received a 999 call from Mr X at 08.47 hours. He stated that he had murdered his wife. She had multiple stabs wounds. When the police arrived, the front door had been smashed with a mallet, which was in the kitchen. Mr X was arrested on suspicion of murder and taken to the police station. Mr Rob Waring acted as the Appropriate Adult, and later that evening Dr F Lehmann-Waldau, Consultant Psychiatrist, conducted a mental health examination. As a result Mr X was considered unfit for interview but fit to be detained with 24 hour one to one observations.

## 2. Jayne Helen Coulter

Summary: Teenager Jayne Coulter, 19, under NHS mental health care for at least 6 years, is taking citalopram. In the past she has attempted suicide by drinking alcohol and overdosing on citalopram. Four months before the tragedy a doctor added a neuroleptic drug for a reason that is unclear, since JC was not psychotic. April 1 2002 she stabbed her younger boyfriend to death. Mixing booze with her psych drugs was an obvious factor in the tragedy, and yet the independent case review is completely silent on the connection. The review report notes that: “The key conclusion of the inquiry is that the homicide was not a preventable event.” Yet it probably would not have happened had the NHS refrained from prescribing an SSRI to a person under 18 years old, as the MHRA recommends. The SSRI is not mentioned in any news articles.

### Boyfriend killer jailed for life — (Halifax Courier)

<http://www.halifaxcourier.co.uk/news/calderdale/boyfriend-killer-jailed-for-life-1-1987019>

Published 11:57 Tuesday 18 February 2003

A YOUNG woman who brutally stabbed her boyfriend to death after a drinking binge could walk free from prison in less than three years.

Jayne Helen Coulter (20), of Clough Lane, Mixenden, Halifax, was jailed for life yesterday but was told she would only have to serve two years and eight months in prison before she could apply for parole. She denied murdering 18-year-old Nathaniel Lees on Easter Monday last year but admitted manslaughter on the grounds of diminished responsibility.

Mr Paul Worsley QC, prosecuting, told Leeds Crown Court that on the day of Nathaniel's death, the couple, who moved in together in October 2001, had both been drinking cider.

At 4 pm neighbours heard the pair arguing, doors slamming and Coulter shout, "Nathan, don't leave me", followed by a long loud scream.

She had stabbed her boyfriend several times and became hysterical as he stumbled outside in bloodstained clothes and collapsed on a grass verge.

Nathaniel was cradled in the arms of neighbours until paramedics arrived but he died in the ambulance on the way to Calderdale Royal Hospital.

Police officers attended but Coulter was abusive and threatened to kill herself.

She and Nathaniel both had a history of self harm and on this occasion her arms were covered in cuts - some of which were new.

She remained volatile at Halifax police station and assaulted officers while trying to injure herself by hitting her head against a cell wall.

Five hours later a test revealed she had 175mg of alcohol in 100ml of blood. It was estimated she would have had 270mg of alcohol in her bloodstream at the time of the attack - about three and a half times over the legal limit for a driver.

A 20cm long brown handled kitchen knife was recovered from the scene.

A post-mortem examination revealed Nathaniel had received a fatal stab wound to the front of the chest which penetrated the heart and the liver. He had a second stab wound and a number of cuts and scratches.

When Coulter was interviewed she could not remember the attack but claimed she would not want to hurt Nathaniel.

In mitigation, Mr David Fish QC, for Coulter, drew attention to the sad facts of her adolescence.

Psychiatric reports revealed that Coulter is suffering from an untreatable personality disorder.

When passing sentence, the recorder of Leeds, Judge Norman Jones QC, said: "You, of course, have to live the rest of your life in the knowledge that you killed someone you had genuine affection for and probably still do.

"Having read the medical reports, I am satisfied that all three psychiatrists are satisfied that you pose at least some risk for the foreseeable future. I have come to the conclusion that the only sentence I can pass upon you is one of life imprisonment."

He said she would be assessed by the Parole Board in two years and eight months but warned her not to raise her hopes.

Coulter will begin her sentence in a young offender's institution but will be transferred to an adult prison when she reaches 21.

### **Independent Inquiry Report, West Yorkshire Strategic Health Authority — (Dr Simon Baugh)**

[http://www.hundredfamilies.org/wp/wp-content/uploads/2014/10/JAYNE\\_COULTER\\_APR02.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2014/10/JAYNE_COULTER_APR02.pdf)

February 2005

Brief Case Summary

Independent Inquiry Report, West Yorkshire Strategic Health Authority — (Dr Simon Baugh)

Brief Case Summary

Ms A was a 19-year old out-patient of the South West Yorkshire Mental Health NHS Trust, resident of Halifax. On the 1st April 2002 she was arrested and charged with the murder of her partner and assault of two police officers. She was subsequently found guilty of manslaughter by reason of diminished responsibility.

Ms A had been an out-patient of the Child and Adolescent Psychiatry Services at age 13-14 years, related to stress around her father's serious ill health and her own physical health problems.

She first presented to the adult psychiatric services following an overdose of the antidepressant citalopram, prescribed by her general practitioner.

She was initially managed by the Deliberate Self-Harm Team, but was also referred to Dr B a Locum consultant Psychiatrist in Halifax, and was subsequently seen by his Staff Grade Doctor in the out-patient clinic...

5. Child Psychiatric Contact

Ms A was referred to a child psychiatrist in 1995 by her GP, she was stressed by the death of her grandfather, her father's serious ill health and the fact she was overweight.

She had regular weekly therapy and her care was active, dealing with her problems including involving her school and arranging home tuition.

Comment

Records indicate this seems to have been a success...

#### 6. Contact with Adult Services

a) Ms A first presented to the Halifax A & E Dept in Nov 2001 following an overdose of the antidepressant citalopram plus alcohol. She was assessed by a community psychiatric nurse who was part of a Primary Care team. She was assessed as no longer being suicidal, with no sign of depression or psychosis.

In December 2001 she became more upset and felt "out of control", feeling she may self-harm again, a referral was made to psychology for a second opinion and also for cognitive therapy. She was seen in the clinic by Dr C, who made changes to her medication, adding a neuroleptic (Chlorpromazine) to her antidepressant treatment...

### 3. Mark Corner

Summary: MC, a socially withdrawn adolescent, without family support for school attendance, is referred to NHS Mental Health Services. Before he turns 17 he is prescribed Prozac. He becomes withdrawn, angry, suffers hallucinations, is paranoid, develops agoraphobia and has thoughts of self-harm and suicide. Nobody connects the onset of these symptoms with Prozac. Until he is 24, he is prescribed various psychoactive medications, mostly "anti-psychotics", to deal with the Prozac side effects, and he often fails to take them as directed. He uses cannabis and drinks heavily. The mental health team blames his paranoia, lack of motivation and other problems on schizoaffective disorder, the cannabis, and drinking. When he complains that he feels worse and becomes aggressive, he is told to keep taking his meds. At 26 he attempts suicide in April by overdosing on a cocktail of illegal and prescription meds, including paroxetine, which has been added somewhere along the way. In July the same year he is arrested on suspicion of murder. A forensic psychiatrist decides that because his symptoms persist when he is not drinking and taking illegal drugs, he has schizophrenia. MC has never been observed while not under the influence of psychoactive medication. The forensic psychiatrist, who first meets MC after the murder, decides that while he is schizophrenic he is not insane in a legal sense.

**'Bin bag' killer detained in hospital — (BBC News)**

[http://news.bbc.co.uk/2/hi/uk\\_news/england/merseyside/3306841.stm](http://news.bbc.co.uk/2/hi/uk_news/england/merseyside/3306841.stm)

Last Updated: Wednesday, 10 December, 2003, 15:46 GMT

A man who killed and dismembered the bodies of two prostitutes in Liverpool has been detained indefinitely at Ashworth Hospital under the Mental Health Act.

Mark Corner, 26, pleaded guilty to the manslaughter of Hanane Parry and Pauline Stephen on the grounds of diminished responsibility at Liverpool Crown Court in October. He denied murder.

Body parts of Miss Parry, from Chester, and Miss Stephen, of Skelmersdale, Lancashire, were found dumped in bin bags in an alleyway in the Everton area of the city earlier this year.

At the hearing, the prosecution accepted psychiatrists' reports he was suffering from paranoid schizophrenia at the time.

Care review

Corner had been known to psychiatric authorities since he was 17-years-old, and was a community patient of Merseycare NHS Trust.

The trust says it is reviewing the way it cared for him.

In a statement it said: "Providing care in the community for patients with mental health problems is not an exact science, and ensuring service users take medication regularly and attend for appointments can be problematic."

The dismembered bodies of Miss Parry, 19, and Miss Stephen, 25, were found in the red light district of St Domingo Vale on 20 July.

Body parts were later discovered in bin bags at the back entrance to Corner's flat in Everton, in his freezer, and dumped at Stanley Park, in the shadow of Liverpool FC's ground.

Police were alerted to Corner's crimes after he confessed what he had done to his brother Ian.

After he was arrested, psychiatrists concluded he was suffering from "hallucinations, delusions and violent and sadistic thoughts".

### **[Independent Review into the care and treatment of Mark Corner Commissioned by Cheshire and Merseyside Strategic Health Authority](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/MARK_CORNER_JULY03.pdf)**

[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/MARK\\_CORNER\\_JULY03.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/MARK_CORNER_JULY03.pdf)

Excerpts from report:

This section of the report provides a chronological review of the significant events entered within the clinical documentation reviewed in relation to the care and treatment of MC...

4.3 November 1990. Aged 13 years, MC was referred to Mental Health Services due to a possible depression. He was seen on four occasions and also interviewed by an Education Welfare Officer due to his failure to attend school.

[In 4.8, we learn that at some point MC has been prescribed Prozac, but the initial prescription is obviously not deemed a significant event by the investigators. It would explain certain things, however, like the self-harm and the suicidal thoughts – SSRI Ed]

4.5 June 1993. MC was referred for counselling by a community paediatrician. He had difficulties attending school and was deemed to be suffering from low esteem and an inability to mix in addition to a tendency towards violence. Since his admission to special school staff felt there was a pent up anger and this was causing some concern.

4.6 October 1994. Aged 17. MC was seen by his GP and complained of depression, hearing whispers and of thoughts of self-harm. He was referred for further assessment in a week's time. During the second assessment it was noted the symptoms remained and he was referred for a mental health assessment.

4.7 November 1994. MC was seen by a Consultant Psychiatrist at home following a referral by his General Practitioner. He was assessed as being fairly inactive and had not left the house for the previous two months due to the fact that he felt that people were looking at him. On examination he was assessed as depressed. He expressed thoughts of suicide and there was no evidence of thought disorders or hallucinations. The psychiatrist opinion was that MC was suffering from agoraphobia consequence upon long standing depression and social difficulties. The long term plan considered for him was attendance at the Oakdale Unit for help with his agoraphobia.

4.8 February 1995. MC as admitted under the care of the mental health team at Fazakerley Hospital, via the accident and emergency department. He presented as feeling low with a disturbed sleep, aggression and irritability. He reported paranoid thoughts regarding people being in the house at night and claimed to hear voices of people talking in the house. He indicated that he had not been taking his prescribed Prozac medication. A care plan was completed. MC was reported be suffering from regular mood swings and suicidal ideation. The short term goal established was to stabilise his mood in order to reduce the onset of aggression and thoughts of self harm with the long term goal to establish a network of support to improve MCs coping skills.

4.9 March 1995. MC was discharged from Fazakerley Hospital with a working diagnosis of a depressive illness. He had made some improvement on the ward but remained very low. He was given an appointment to attend the Oakdale Unit and prescribed Dothiepin 75mg nocte. MC attended the Oakdale Unit later that month and his medication was changed to Thioridazine 50mg nocte and Dothiepin 75mg nocte. No evidence of harm to himself or others was observed or of neglect and there no risk was identified.

4.11 July 1995. MC was admitted to the observation ward in accident and emergency following an overdose of Dothiepin. He admitted this was due to strange thoughts and reported homicidal ideas

during this time. He appeared withdrawn with no auditory hallucinations and no clear defined symptoms of depression. A psychiatric review whilst on the ward elicited hatred towards other people and a sense of frustration. MC indicated his hatred was great enough to harm others. The clinical impression was one of possible incipient schizophrenia or schizoid personality disorder.

4.13 September 1995. Following a GP attendance it was noted MC still felt depressed and indicated a non-compliance with prescribed medication. No thoughts of self harm were noted but motivation appeared poor with limited eye contact during this attendance. MC indicated he was willing to try a different antidepressant and was prescribed Lofepamine 70mg.

4.16 April 1996. Aged 19 years, he was re-referred to mental health services by his general practice.

A further visit that month to his GP indicated he was drinking heavily but refused a referral to the Windsor Clinic for assessment for this problem. He was prescribed Chlordiazepoxide 10mg for one month.

4.21 January 1999. Aged 21 years: GP review visit. MC is currently prescribed Paroxetine. He indicates that this drug helps his anxiety but not his depression and complains of erratic sleep patterns.

4.22 February 2002. MC is seen by his GP and observed to be in employment as a security worker. He reports it's a stressful job due to the need to interact with people. He reports a disturbed sleep and appetite with subsequent weight loss. Increasing levels of aggression are reported since ceasing Paroxetine which he had stopped taking. It was suggested that he recommenced this and was given a further prescription.

4.23 May 2002. MC reported to his general practitioner on a follow up visit that he had stopped taking Paroxetine as he felt it was not helping. He reported his symptoms to be worsening with increasing aggression. He was asked to re-attend at a later date.

August 2002 It was noted during a GP visit on 6th August that MC had been smoking cannabis and had increasing paranoid thoughts and hearing voices through the walls.

On 18th August 2002 MC was admitted to the Ferndale Unit, MerseyCare NHS Trust via the accident and emergency department. MC had indicated he could hear the neighbours talking about him through the walls of his property and he was taken into police custody after an apparent attempt to remove a kitchen knife and move towards the neighbours' house. On admission with a Police escort he was not able to speak and could not be assessed for purgative function. He was prescribed Lorazepam 4mg.

Subsequent clinical consultations revealed a long standing history of cannabis misuse and concurrent cocaine and heavy alcohol consumption. He reported the fact that he was a body builder and was on regular steroids but self admitted to administration of more than the recommended doses. He further reported auditory hallucinations and discussed the ideas that his neighbours were talking about him and thought that cameras were spying on him. He had been suffering from poor sleep, had lost significant weight and further had been terminated from his employment.

He was detained under Section 2 of the Mental Health Act (1983) under the care of a Consultant Psychiatrist.

During this admission a risk assessment was conducted which indicated the following:

Suicide = 48 (moderate/severe) • Violent aggression = 53 (moderate/severe) • Neglect = 1 (low)

4.25 19th August 2002. It was noted that during this admission MC had been hostile towards members of staff and reported the fact that neighbours had been speaking about him. He had admitted that he may have used the knife. He reported that his family couldn't hear the voices but he clearly can. MC was given a diagnosis of schizophrenia and started on an antipsychotic medication: Olanzapine.

4.26 23rd August 2002. It is reported that MC was much more settled on the ward although quiet and subdued. No thoughts of harm to himself or others were expressed. During this time it was noted, from a previous set of clinical notes, that MC had had thoughts of harm towards others and a morbid fascination with people who had died after they were mutilated. However, it was recorded that during this assessment MC had not indicated thoughts of this nature. MC was reported not to engage with a new risk assessment although there were no obvious signs of hostility or threats of violence since his admission. He was re-graded to level 2 (intermittent) observations with a long term goal of discharge from the unit with relevant community after care.

4.27 27th August 2002. MC's Consultant Psychiatrist presented a report to the Mental Health Review Tribunal. He was of the opinion that MC was suffering from a psychotic illness which required further assessment and treatment. He acknowledged that the incident leading to MC's admission was a very serious one and that there will be a risk to himself and other people if he were to be discharged prematurely.

4.28 28th August 2002. The Mental Health Review Tribunal's decision was that MC was not to be discharged. This decision records no discharge "in the interests of his own mental health and the protection of others". It was deemed MC was suffering from schizophrenia with a continuing evidence of psychosis and a lack of insight into his condition. He was thought not stable enough for discharge.

Following the decision MC was subdued but settled with no obvious abnormal perceptions. He agreed that he should stop cannabis as this clearly added to his paranoia but continued to believe that his neighbours were talking about him but admitted that this feature had become to bother him less. He was allowed to have Section 17 leave for the weekend and one hour of unsupervised leave on the grounds.

4.29 2nd September 2002. His weekend leave was uneventful with no problems reported. He did not experience any problems with his neighbours and began to question whether or not he had actually heard any voices at all. He was granted more weekend leave and six hours leave per day.

4.30 3rd September 2002. A detailed past medical history was taken by a Senior House Officer in Psychiatry. He described a difficult childhood with frequent absences from school with infrequent

alcohol consumption, cannabis, with LSD and “downers” taken infrequently. He disclosed that he had been once remanded into custody for a few hours for having a modified powerful airgun.

4.31 10th September 2002. MC returned from leave with no reported problems. He appeared compliant with his medication and denied using cannabis. He indicated he was keen to be discharged.

4.32 11th September 2002. MC was re-graded from Section 2 Mental Health Act (1983) to informal status. He was discharged from hospital with no psychotic phenomena and a good insight into his illness.

In a discharge letter to his General Practitioner, the Senior House Officer reported that his progress on the ward was rapid and that it was thought that his psychotic phenomena could have been induced by cannabis. He had been discharged and prescribed Olanzapine 10mg with a working diagnosis of paranoid schizophrenia. The Senior House Officer assessed his risk as low to himself and others and of neglect low. He indicated that MC's prognosis was good if he remained cannabis free and remained compliant with his medication. He was to be reviewed again in outpatients in three weeks time.

4.33 11th September 2002. A note is made in the Care Programme Approach documentation that indicates a diagnosis of ‘depression’ (of note to the investigative team: CPA documentation including risk assessment and required level of CPA not completed). Relapse markers noted included increased use of cannabis and cocaine abuse and increased levels of paranoia.

Nobody is listed under the persons present at the care meeting review.

Medication prescribed Olanzapine 10 mg nocte.

No date for CPA review was set and an outpatient appointment was fixed for 7th October 2002.

4.34 12th September 2002. MC was referred for a Community Psychiatric Nurse visit by his Consultant Psychiatrist.

Later that month, although the date is not clearly identified, MC was visited by the Community Psychiatric Nurses (CPN's) following this request. No risk assessment was conducted. The CPN's reported to be not aware that MC had previously been the subject of detention under Section 2 of the Mental Health Act (1983).

4.35 21st September 2002. MC was seen in the accident and emergency department by a duty psychiatric Senior House Officer. He had taken an overdose of Paracetamol, the aim of which he indicated was to aid his sleep. It is noted that he had been diagnosed the week before with paranoid schizophrenia. He self reported a non-compliance with his prescribed Olanzapine medication and reported heavy alcohol consumption in the previous few days.

He also reported to be feeling isolated and lonely. He was given a four day course of Zopiclone and discharged. A member of his own family phoned shortly afterwards to express concerns that he was not

fit to be discharged. He was referred to the Crisis Management Team of Mental Health Services and for review in outpatients.

4.36 23rd September 2002. MC was contacted by the Crisis Management team. He reported feeling much the same and denied any suicidal thoughts and indicated that a prescription was waiting for his anti-psychotic medication at his GP's surgery.

4.37 24th September 2002. The Crisis Management Team contacted MC's Consultant Psychiatrist. They discussed recent events and MC's family's concerns regarding the need for Community Psychiatric Nurse visits and an urgent outpatient appointment. It was noted that his consultant would liaise with the CPNs and arrange for an outpatient appointment.

4.38 7th October 2002. MC was assessed by a Senior House Officer in Psychiatry in outpatients. Since his discharge from the Ferndale Unit it was noted he had stopped taking his prescribed Olanzapine and resumed significant consumption of alcohol and cannabis. The paranoid thoughts and auditory hallucinations had returned. It was noted that he had started hearing voices again indicating that the neighbours were talking about him, despite the fact he had moved into a new flat. He mentioned he had threatened a neighbour with a knife who had called the police who gave him a verbal warning. He had moved back home because he was feeling lonely and had restarted his Olanzapine. However, he thought his paranoid thoughts had remained.

He was prescribed Venlafaxine 75mg. His General Practitioner was requested to prescribe these as required. It was planned to review him in four weeks time. A risk assessment conducted indicated a categorised risk to himself and others as 'low' with a 'moderate' risk of neglect.

4.39 25th October 2002. MC failed to attend his outpatient appointment.

4.40 7th December 2002. MC was admitted to the accident and emergency department, Aintree Hospital with injuries sustained during an assault. It was noted that he was intoxicated and admitted he was drinking considerably. He was observed for a while on the short stay ward and discharged to the care of his parents.

4.41 13th January 2003. MC failed to attend his scheduled outpatients appointment. The Senior House Officer had noted that the matter should be discussed with the Community Psychiatric Nurses before making a further appointment.

4.42 21st January 2003. MC was seen by his General Practitioner and he was noted to be drinking significantly. He reported he had stopped his prescribed medication three months ago.

4.43 31st March 2003. MC failed to attend a scheduled outpatient appointment. His case was to be discussed.

4.44 18th April 2003. Aged 26 years, MC was admitted to the observation ward via accident and emergency department at Aintree Hospital following an overdose of a mixture of drugs: Largactil, Ecstasy, Paroxetine and Dihydrocodeine. He indicated he had been using 60 to 70 Ecstasy tablets per

week for the previous six months. Following some time on the observation ward, he was discharged on the 19th April 2003 to the care of his General Practitioner.

4.45 21st July 2003. MC was arrested by police on suspicion of murder.

4.46 23rd July 2003. MC was arrested again on suspicion of a second murder.

4.47 13th October 2003. MC was assessed by a Consultant Forensic Psychiatrist. He expressed the following opinions:

MC was not under disability with respect to court proceedings.

MC did not satisfy the criteria for “insanity” as he clearly recognised that his actions were wrong.

MC described symptoms suggesting an underlying psychotic illness. Such symptoms were consistent with the diagnosis of schizophrenia.

There was also evidence of early conduct disorder. He had met the criteria for both paranoid and schizoid personality disorders.

MC gave a history of alcohol and illicit substance abuse. The symptoms of his mental illness persisted in the absence of drugs and alcohol thus indicating that his psychotic symptoms were a product of an underlying mental illness rather than as a result of intoxication.

MC suffered from an abnormality of mind caused by the presence of both mental illness and psychopathic disorder.

## 4. Paul Khan

Summary: PK has been under mental health services since 1983. Reference is made to a “conduct disorder” when he was a boy so he has probably been medicated since that time. At the age of 26 he is diagnosed with paranoid schizophrenia by the NHS. On January 25, 1996 PK’s GP assesses him as paranoid without delusions, and with “moderate depression and retardation” and prescribes Cipramil (citalopram). Feb 10: Inpatient psychiatric notes indicate that he has been readmitted to hospital having been referred by his GP for reporting violent urges to attack people. GP continues the citalopram but adds Zuclopethixol and Diazepam. Two days later PK makes statements that indicate he is delusional. On Feb 13, in a library, PK grabs a stranger by the throat and slashes his face with a cut-throat razor. PK is incarcerated.

From 2000 to 2002 he is maintained on Olanzapine and is reported to be doing well. He moves to outpatient status. However, he has “poor concentration, broken sleep pattern, lack of energy, a reduction in motivation and negative thoughts”. So, PK is started on Sertraline 50mg daily increased to 100mg after 1 week. On March 14, 2003 PK’s girlfriend reports that he is “not himself” and “something is not right with him”. On Mar 24 his father reports that he is withdrawn and seems unwell. The next

day, March 25, 2003, PK stabs to death an older man who is walking his dog. In news articles there is no mention of the SSRIs. In both the independent review and the news, mental illness is blamed and the potential contribution of the SSRIs is not explored.

### **Schizophrenic gets life for stranger killing — (The Telegraph)**

<http://www.telegraph.co.uk/news/1445473/Schizophrenic-gets-life-for-stranger-killing.html>

1:48PM GMT 30 Oct 2003

A schizophrenic who killed a stranger after being released from a secure mental hospital has been jailed for life.

Paul Khan, 34, stabbed retired accountant Brian Dodd more than 30 times in the head and neck as he walked his dog, leaving him unrecognisable to his widow Enid.

He pleaded guilty to Mr Dodd's manslaughter on the grounds of diminished responsibility earlier this month and was sentenced at Mold Crown Court this afternoon.

Mr Justice Gibbs told him: "This was the ultimate horror, a savage and sustained killing completely at random on an unsuspecting and innocent member of the public."

He ordered that Khan serve a minimum of six years before being considered for parole but stressed that he believed Khan should be in prison for much longer.

He said: "In my view the defendant presents an extreme danger to the public. It is also my view that he will continue to present such a danger for a very long time."

The attack on Mr Dodd, which took place in Prestatyn, north Wales, in March, happened six years after Khan slashed a man's throat in a Cardiff public library.

Following that incident he was ordered to remain in a secure mental hospital indefinitely but was released in August 2000 after doctors recommended he could be cared for in the community.

However, by the time Mr Dodd's killing, Khan had stopped taking his medicine and was seriously mentally ill, believing his psychiatrist was controlled by aliens and stockpiling weapons to protect himself.

Khan was seen by his psychiatrist two weeks before the murder and no problem was detected. He was also seen at home by a psychiatric nurse on the day before the killing but no alarm was raised.

Later that day, Khan stole his father's car and drove to Frith Beach in Prestatyn where he attacked Mr Dodd, possibly because their dogs fought each other.

Khan was arrested three days later. The Welsh Assembly has launched an inquiry into why his condition was allowed to deteriorate while he was being cared for in the community.

## Independent External Review into a Homicide at Prestatyn, Wales on 25th March 2003

Commissioned by Cardiff Local Health Board

[http://hundredfamilies.org/wp/wp-content/uploads/2014/07/PAUL\\_KHAN\\_MAR03.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2014/07/PAUL_KHAN_MAR03.pdf)

### Background

On 25th March 2003, PK, a Cardiff resident, killed BD, a retired accountant, by inflicting multiple fatal knife injuries on him at Frith Beach Festival Gardens, Prestatyn. He was initially readmitted on 30 March 2003 under Section 2 of the Mental Health Act, formally recalled by the Home Office on 31 March 2003 under Section 42(3) and redetained as a Section 37/41 patient. At his criminal trial in Chester Crown Court PK pleaded guilty to manslaughter on the grounds of diminished responsibility and was subsequently transferred to Ashworth Hospital, Liverpool.

At the time of the offence PK was under the care of the Community Forensic Psychiatric Team at Whitchurch Hospital, Cardiff and was living in independent accommodation. PK has a history of contact with mental health services since 1983. At the age of 26 he was diagnosed with paranoid schizophrenia.

### *[First Incident 1996: Bad reaction to citalopram, withdrawal leads to delirium-psychosis-triggered assault]*

5 January 1996 - A discharge report indicated that PK's first psychiatric admission to Whitchurch Hospital was voluntary following referral from his GP. The impression was "a 26 year old man with poor impulse control leading to a forensic record, who presented with a history of auditory hallucinations but in whom there was no objective evidence of serious mental illness. There may be evidence of a post-traumatic stress reaction but this would be better managed as an outpatient." He was discharged on 8 Jan 96. (Discharge summary 10 Jan 1996 by SHO to CP1)

25 Jan 1996 - CP2's letter indicated that on assessment, PK reported a 4-month history of depression following his release from Dartmoor prison. He was seen with a friend of 16 years standing who confirmed she had never seen him like this. Mental State examination revealed moderate depression and retardation. He was not hearing voices at this time and his previous auditory hallucinations were considered typical of depression. He admitted to paranoid feelings but there was no evidence of delusions. He was prescribed Cipramil [citalopram] 20mg daily. (Letter to GP1 from CP2 25 Jan 1996)

10 Feb 1996 - Inpatient psychiatric notes indicated that following referral from his GP for violent urges, PK was readmitted to hospital. He experienced urges to attack people and described auditory hallucinations. The GP had started him on Zuclopethixol 10mg bd, Cipramil 20mg od and Diazepam 5mg tds. (Inpatient psychiatric notes - 10 Feb 1996)

11 Feb 1996 - Inpatient psychiatric notes indicated that PK was refusing medication and denied any psychotic phenomenon. Later that day self-discharged against medical advice. (Inpatient psychiatric notes - 11 Feb 1996)

12 Feb 1996 - Inpatient psychiatric notes indicated that the GP phoned the ward saying PK requested readmission. PK was expressing intrusive thoughts telling him to harm people. He was spoken to on the phone when he said "satellite TV owes me money" and "I want to kill my mother and father, my mother puts things in my food". Following discussion with the Specialist Registrar on call it was felt that the picture was more of personality disorder with no mental illness. He was to be followed up in Outpatients. (Inpatient psychiatric notes - 12 Feb 1996)

13 Feb 1996 - A psychiatric report indicated that whilst in a public library PK grabbed a stranger by the throat and slashed the victims face with a cut-throat razor, leading to a 12cm laceration. He was remanded to HMP Cardiff where he spoke of believing he was being followed by MI5, voices telling him to stab people, Martians following him, thoughts being put into his mind via satellite, and headaches due to the microwave. He also said that Martians had given him the razor and that he felt it had been a cry for help because people were ignoring his complaints

### *[Second incident: Sertraline leads to murder]*

3 April 2000 - The Home Office emailed a statement opposing discharge – "The Home Secretary is pleased to note the progress PK has made. However discharge at the present time would be premature. PK has only just started a limited amount of unescorted leave to the local area and the Home Secretary would like to see testing on increasing periods of unescorted and overnight leave successfully completed before agreeing a discharge plan."

9 July 2002- The outpatient notes stated that PK was reasonably well. No evidence of psychosis. However reported being disturbed by noise, especially at night by children and cars in the street. Olanzapine changed to 10mg nocte.

1 Aug 2003 - The Home Office requested, via email, the Social Supervisor's progress report addressed to SW3.

6 Aug 2002 - A letter from CP1 regarding outpatient review stated PK was going through a depressive spell with low mood, diurnal variation in mood, poor concentration, broken sleep pattern, lack of energy, a reduction in motivation and negative thoughts. No psychotic features evident. Diagnosed with post psychotic depression and started on Sertraline 50mg daily increasing to 100mg after 1 week. He remained on Olanzapine 10mg daily and depot depixol 80mg fortnightly. (Letter to GP from CP1- 7 Aug 2002)

14 March 2003 - A psychiatric report indicated that the last date that PK's girlfriend reported seeing him. She stated that she felt he wasn't himself and that something was not right with him. (Psychiatric report dated – 1 Oct 2003)

24 March 2003 - A psychiatric report indicated that PK's father reported that he had visited PK on 24th March and had noticed that he had lost his appetite and that he was quiet and distant. These were familiar indications that PK was not well. His father told him to contact his nurse. (Psychiatric report dated – 1 Oct 2003)

24 March 2003 - Hand written CPN notes stated CPN2 received a telephone call from PK at approximately 10.30-11.00am. PK informed him that his father had told him off and that he should be visited at home. As CPN2 was in the area he was able to see PK within the hour.

PK was alone in his flat and he informed CPN2 that his father had told him off for not eating enough food and that his father and mother thought he was becoming unwell. PK was noted to be a bit quiet, but otherwise there was no cause for concern. PK asked for his medication to be reduced. [It wasn't] PK phoned his father and at the request of CPN2 attended the flat.

The issues that had raised concerns over PK's health were discussed, in particular PK's father's belief that he wasn't eating enough. CPN2 noted that PK was a big man who would often eat normally in his presence.

It was decided that the best course of action would be for PK to attend at Whitchurch Hospital the following day for an appointment with CP1. CPN2 had no concerns relating to PK's mental health. He did not notice any change in his behaviour to what he was like normally on his visits.

25 March 2003 - A psychiatric report indicated : HOMICIDE OFFENCE: On the morning of 25 March 2003 (actual time not specified) an elderly gentleman received at least 28 stab wounds to the head, neck and chest whilst walking his dog in Festival Gardens, Prestatyn. The victim died of his injuries. Several eyewitnesses reported seeing a man fitting PK's description walking his Rottweiler dog in Festival Gardens at that time. The Ford Mondeo was also seen in the car park. There was considerable forensic evidence linking PK to the offence.

## 5. Keith McDonald

Summary: An ordinary young man, Keith McDonald, goes to his GP for pain from a car accident, and is prescribed psychoactive medications, starting with Dothiopin. After 5 months Zolpidem is added. A little over two months after starting Zolpidem, he becomes uncharacteristically aggressive and slaps a woman in line at a bank, and puts chewing gum in her daughter's hair. After this, his GP prescribes citalopram for anxiety and insomnia. When KM reports his anxiety and insomnia are not improving, Paxil is tried. KM reports that he cannot tolerate Paxil, so the GP puts him back on citalopram. Seventeen days after this medication adjustment KM complains to the GP about "abnormal extreme thoughts" which worry him. The GP does not suspect the SSRI, so the medication is continued and KM is referred to a psychiatrist. After several visits, the psychiatrist discharges KM Aug 21, 2002. The discharge notes appear to indicate that the psychiatrist does not think that KM is mentally ill, or in need of medication. It is not clear if KM continues taking citalopram or stops taking it at that point. On Sept 9

he attends a job centre (he has recently lost his job), is verbally abusive and assaults a man. Two days later he murders a shopkeeper with a machete. When that happens, he is diagnosed with schizophrenia, and the potential role of the medications in his problems is never considered.

### **Police 'warned' before machete attack — (BBC News)**

[http://news.bbc.co.uk/2/hi/uk\\_news/england/west\\_midlands/2976687.stm](http://news.bbc.co.uk/2/hi/uk_news/england/west_midlands/2976687.stm)

Last Updated: Friday, 25 April, 2003, 15:48 GMT 16:48 UK

A schizophrenic has been detained indefinitely under the Mental Health Act after he admitted killing a woman in a revenge attack.

Balbir Kaur's husband had knocked Keith McDonald off his bike less than a month before she was killed with a machete at her Costcutter shop in Aston, Birmingham.

Birmingham Crown Court heard that police had been warned before the attacks that McDonald had threatened another shopkeeper with a machete.

The 26-year-old, of Hartington Road, in the Lozells area of the city, pleaded guilty in February to Mrs Kaur's manslaughter on the grounds of diminished responsibility.

#### Public threat

The court heard Mrs Kaur's death was the culmination of a number of visits to the shop by McDonald, who was suffering auditory hallucinations.

He had demanded £300 compensation from the Mrs Kaur after her husband, Harkanwal Singh Poonia, collided with his bicycle in Clifford Street, Lozells

Mrs Kaur and another shopkeeper, Mohammed Jahinger, were attacked within minutes of each other at their premises in Aston and Lozells on 16 September last year.

Mrs Kaur, from Perry Barr, suffered massive head injuries and died in hospital while Mr Jahinger was slashed across the hand and neck as he dialled 999.

"Obviously there is concern that these matters had been reported to the police and the defendant had not been arrested," he added. Mr Parker said an internal police investigation is now under way into the circumstances of the case.

Sentencing McDonald, Judge Richard Wakerley, QC, the Recorder of Birmingham, said treatment at a secure psychiatric unit was in the public interest and would also prevent any deterioration in the defendant's condition.

The chairman of Birmingham's Council of Sikh Gurdwaras, Sewa Singh Mandla, said: "We feel very much let down by the authorities.

"If they had acted upon the complaints made, then this incident would have been avoided."

## **Hundredfamilies.org — Birmingham and the Black Country NHS Report of the Independent Inquiry into the Care and Treatment of KM**

[http://www.hundredfamilies.org/wp/wp-content/uploads/2014/10/KEITH\\_MCDONALD\\_SEPT02.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2014/10/KEITH_MCDONALD_SEPT02.pdf)

Sept 02, 2005

### **SUMMARY OF EVENTS**

KM attended his General Practitioner in November 2001 complaining of feeling depressed and anxious as well as having difficulty in sleeping. His symptoms did not improve and he was referred to Consultant Psychiatrist A, Northern Birmingham Mental Health NHS Trust.

On 28 May 2002, KM was assessed by a CPN, accompanied by a student nurse, who recorded in the CPA Assessment Summary 'history of significant and unstable risk in relation to significant violence/harm to others'.

On 21 June 2002, the Senior House Officer, (SHO) assessed KM and following a discussion with the Associate Specialist, another appointment was made for 16 August 2002 when he saw the Associate Specialist. His mother accompanied him as suggested by the SHO. An appointment was also made for KM to attend the Early Detection and Intervention Team (ED:IT) on 12 August which he failed to keep.

KM's mother told the Associate Specialist about the arguments which had taken place between KM and some of the local shop keepers. She was not unduly concerned about her son's mental state and so he was discharged from the mental health services back to the care of his General Practitioner.

Some few weeks before the tragic incident KM and the victim's husband, Mr. H, were involved in a collision. Mr. H agreed to pay for the damage to KM's bicycle but, according to KM, the money was not forthcoming.

On 9 September 2002, KM attended the Job Centre. Whilst waiting, he felt he was being 'looked at' which he did not like, resulting in him hitting another man who was also 'signing on'. He was charged with assault and given bail.

On 16 September 2002, KM went to one of his local shops with a machete and fatally injured the shop owner, Mrs H. She was taken to a local hospital and then later transferred to the Queen Elizabeth Hospital where she died the following morning.

After he left that shop KM went to another shop, nearer his home, where he attacked and seriously injured another man, Mr. M. Later that day KM attended a local police station, and was arrested. He was charged with murder and 'wounding with intent to do grievous bodily harm'. Consultant Psychiatrist B

assessed KM, and found him 'fit to be interviewed'. He was transferred to HMP Birmingham and then to HMP Woodhill. Having been further assessed by Consultant Psychiatrist B and the Consultant Forensic Psychiatrist, he was admitted on 17 April 2003 to the Raeside Clinic under section 48/49 MHA 1983. The following day he appeared in Court pleading guilty to manslaughter and grievous bodily harm. When sentencing KM on 25 April 2003, the Judge, QC said, 'treatment at a secure unit was in the public interest' and he has been detained since under Section 37/41 of the Mental Health Act 1983.

#### KM'S LIFE UNTIL 2002

[A rather ordinary life is described. Not an academic achiever, KM nonetheless took a catering course and got a job which he enjoyed, and had a girlfriend].

At the beginning of 2000 KM had a road traffic accident sustaining minor injuries causing pain in his back and shoulders. On 28 January 2000 he saw his General Practitioner A, who prescribed Ibuprofen, an anti-inflammatory drug.

3 FEBRUARY 2000 KM went back to see his GP as he was still in pain...

MAY 2000 KM returned to see his GP complaining of insomnia and broken sleep. He denied having nightmares but was restless and unable to relax.

The GP recorded:

"Panic attacks occasionally. Happy at work. Single no girlfriend, had relationship for 3 years – broken up.... Family – mv-No psychotic illness. ME (medical examination) anxiety state with sleep disturbance"

He was prescribed Dothiopin 25mgs, to be taken four times a day.

He returned again 20 October 2000 and this time was prescribed Zolpidem 10 mgs. To be taken at night. The notes recorded

" .... not sleeping – no domestic problems or at work. Not stressed at work addition explained treatment Zolpidem 10 mgs. Nocte....."

12 JANUARY 2001 KM was convicted with two accounts of 'Battery'. He assaulted two female customers, a mother and daughter whilst they were queuing at the bank. KM slapped the mother and put chewing gum in the daughter's hair.

8 November 2001 KM attended his GP as he was still not sleeping. The GP recorded:

"single. On examination no relationship problems. Smoke—no. drinks about 4 units per week. Goes to bed at 3-4am, watching TV, playing video games. Advised about sleep hygiene"

On this occasion KM told his GP he had given up smoking. He was prescribed Citalopram, an anti-depressant.

20 November 2001 KM returned to see GP B as he was still having problems with sleeping and was irritable. The computer records states that they had a long chat resulting in GP B recording,

“anxiety and depression. Try Paroxetine”

6 FEBRUARY 2002 The police were called to the National Exhibition Centre by a Security Officer, who told them “a male was going berserk with a knife”. A member of staff was working in the kitchen laughing and joking with another staff member when KM grabbed her by the chest and held a knife to her throat for two minutes causing a red scratch to her skin.

11 February 2002 KM went back to see GP B as his symptoms were still present. He could not tolerate the Paroxetine and so his treatment was changed to Citalopram (an anti-depressant) 20mgs.

28 February 2002 KM returned to his GP. He was doing ‘ok’ on Citalopram but was now complaining of “abnormal extreme thoughts that he doesn’t like and tries to suppress. Willing to attend CMHT –refer”

4 March 2002 GP B wrote a referral letter to Consultant Psychiatrist A, based at HW House.

“I would be most grateful if you could see this 25-year-old gentleman who is complaining of symptoms which is suggestive of anxiety / depression.

He presented a few months ago requesting sleeping tablets for insomnia, which I declined. Since then he has continued to see me and is currently on Citalopram 30mg daily he seems to think that these are helping. However, he has problems with intrusive thoughts of an aggressive nature, which he recognizes as irrational and anti-social. But is concerned that he is having to battle with this.

He has a normal premorbid personality, and no past medical history of note. Thank you very much for seeing him”

18 MARCH 2002 GP B wrote a further referral letter to Consultant Psychiatrist A, based at HW House. He said:

“I would be most grateful if you could see this 25-year-old man with symptoms of anxiety and depression. He presented with this problem around November of last year, complaining of insomnia. Later it became apparent that he was having intrusive thoughts for which he recognized as abnormal and extreme. These are causing him some distress and I have started him on Citalopram 20mg daily. He has a past medical history of asthma. I would be grateful if you would kindly see him and advise”.

23 MARCH 2002 KM went to Mr. M’s shop, brandishing a knife and threatened the staff.

18 APRIL 2002 KM failed to surrender to custody – appeared at Solihull Magistrates Court and was fined £20 plus £20 costs. The Court requested a Pre-sentence Report for the next hearing on 21 May 2002.

8 May 2002 Following a visit to the Perry Barr Probation Office a Pre-sentence Report was completed for the Court. It contained details of the offence in February 2002 and stated that KM intended to plead guilty.

KM'S CONTACT WITH MENTAL HEALTH SERVICES IN 2002 In the section headed ASSESSMENT OF RISK OF HARM TO THE PUBLIC AND THE LIKELIHOOD OF REOFFENDING, the report states: "although it would appear KM does not have much of a criminal history, it is a little concerning that this is the second time he has been convicted of an offence of Common Assault. Although KM considers himself to be a fairly tolerant person, he does admit that when he suffers persistent taunts of unacceptable behaviour or language, this does make him angry and he would like the opportunity of work being undertaken with him to teach him alternatives other than to break the law. Without such work, I do believe there could be a risk of KM re-offending if he is placed in a similar situation again which could also, of course, pose a risk of harm to the public Although KM is currently receiving medication for depression, he is adamant there is no risk of self harm"...

29 May 2002 KM kept the appointment for a preliminary assessment at HW House. A Community Psychiatric Nurse (CPN) conducted the assessment accompanied by a nursing student, who wrote the notes:

"...The plan of action which has been made known to KM and to which he is agreeable is that he should undergo a further assessment and in the meantime continue the medication prescribed by his GP. He will also have to keep off the cannabis which usually make the paranoia worse".

18 JUNE 2002 Whilst he was waiting to 'clock off' KM had a verbal altercation with a fellow worker and pushed him over some pallets causing injuries to his head and wrist. KM was not arrested on this occasion as the victim did not press charges...

Sometime in June KM went to Mr. M's shop, reportedly 'spoiling for a fight' which again Mr. M said he reported to the police.

21 August 2002, the Associate Specialist wrote: ".....As you are aware, at our last assessment we had difficulty to draw a conclusion as to whether [KM] was suffering from mental illness or not. When I enquired of his mother she believed he is keeping fine apart from him loosing his temper [sic] quite easily. She hasn't noticed any abnormal behaviours or gestures in him... When I saw him today he was casually dressed, pleasant, quite relaxed and stable in mood. His speech and mood were normal. There were no overt psychopathological symptoms. In today's assessment along with his mother, I couldn't find any clear psychotic symptoms in him. It appears to me that he is a person who has a paranoid personality. I don't think he needs pharmacological intervention at this stage. Therefore, following discussion with his mother, I have discharged him from our clinic but please do not hesitate to contact us again if you think we can help him".

[note: the discharge note appears to indicate that KM did not need to continue taking citalopram (Celexa) although because this had been prescribed by his GP it is impossible to be sure. We know, however, that on Sept 11, he was either on Celexa or in withdrawal. – SSRI Ed]

9 SEPTEMBER 2002 KM was no longer employed because of his poor time-keeping. KM attended the Job Centre. Whilst he was there he was verbally abusive to another man and assaulted him. Another man

went to apprehend KM and was also assaulted by him. The police were called, he was arrested and later charged with 'battery'...

11 September 2002. 16 SEPTEMBER 2002 KM went back to Mr. H's shop at about 11.52 hours. KM was seen to be holding a machete and swing it [sic] hitting Mrs H several times. In all he hit her about six times before she fell to the floor.... she died the following day at 11.45 hours. KM was seen still carrying the machete when he entered Mr. M's shop. He was shouting and was heard to say "I hate you." He struck Mr. M on the back of his neck and his left hand for which he required hospital treatment. At the same time two Police Officers were patrolling the area and were flagged down by a passer-by and went to the aid of Mr. M. At 19.50 hours that evening KM, accompanied by his father and uncle went to a local police station after having been persuaded by his sister and father to give himself up. When KM was arrested and read his rights, the Police Officers asked him if he understood, to which he replied "yes".

## 6. Thomas Gallagher

Summary: After several years of a deteriorating relationship, TG's wife Elizabeth leaves him in August 2002. During the marriage breakdown, TG has started to take antidepressants and has become a heavy drinker. The independent review report is confusing in places and contains inconsistencies. However, it appears that TG has been prescribed fluoxetine and Diazepam. Shortly after Elizabeth moves out, TG attempts suicide by overdose but he calls her and is rescued. On Sept 3, 2002, his antidepressant is changed to paroxetine (Paxil, Seroxat). Some time between Sept 3 and 19 he smashes up the house, because on Sept 19th 2002, he expresses regret for having done this. He also makes threats to stab his wife, repeated several times over the next few days. On Sept 22 he makes good on his threat, stabbing Elizabeth over 30 times and killing her. While news articles make reference to the overdose, they do not mention the SSRIs. The independent review mentions the SSRIs but does not explore any potential link between the meds, the suicide attempt and the killing.

### Wife killer's care probe — (The Chronicle)

<http://www.chroniclive.co.uk/news/north-east-news/wife-killers-care-probe-1666522>

00:00, 24 Oct 2003

Health chiefs have ordered an inquiry into the care for a former psychiatric patient who butchered his estranged wife

Thomas Gallagher was jailed for life in April for murdering wife Elizabeth in Shiremoor, North Tyneside.

But today Elizabeth's mother Sylvia Shortt said she only blamed Gallagher not the system.

She said: "He took an overdose about a month before he murdered my daughter. He had 10 days in North Tyneside Hospital and received the best possible care."

Northumberland, Tyne and Wear Strategic Health Authority has commissioned an independent inquiry into the care and treatment he received before he committed the murder.

Gallagher picked up a knife and stabbed 34-year-old mum-of-two Elizabeth 30 times in the chest and back at their former home in Park Grove because he thought she was taunting him about a new relationship.

Elizabeth's parents, Brian and Sylvia Shortt, from Shiremoor, are now looking after the their daughter's two children - Lucy, eight, and five-year-old Lauren.

Mrs Shortt added: "He took the overdose and phoned my daughter so she would come rushing round. We don't think he meant to kill himself but that it was a way to get sympathy and get her back.

"It is ironic she saved his life and he ended up murdering her.

"We have no sympathy for him. He's left two little girls without a mum. He has destroyed everyone's life but we are determined to cope."

Painter and decorator Gallagher, 45, a heavy drinker, had struggled to cope since the couple's marriage broke down.

He had taken an overdose shortly before last September's killing. Once he was released from hospital he went on a wrecking spree at the matrimonial home. He had threatened to stab Mrs Gallagher only weeks before carrying out his warning.

A Health Authority statement read: "We have commissioned an independent inquiry into the care and treatment of Thomas Gallagher.

"This is taking place under national guidelines relating to crimes committed by people who have been in receipt of mental health services."

### **Report to Northumberland, Tyne and Wear Strategic Health Authority of the Independent Inquiry Panel into the Health Care and Treatment of Thomas Gallagher**

[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/THOMAS\\_GALLAGHER\\_Sep02.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/THOMAS_GALLAGHER_Sep02.pdf)

SUMMARY OF EVENTS

TG was born on 17 June 1957 and was aged 45 at the time of these events. He was married to Elizabeth Gallagher (EG) and the couple had two children who were aged seven and four at the time of these events. EG worked as a pharmacist's assistant at a local pharmacy and TG worked irregularly as a self-employed decorator. Other than one isolated episode in which he took an overdose in 1979 (aged 22) he had not had any contact with mental health services.

The relationship between the couple deteriorated in the late 1990's, at which time TG developed a pattern of regular heavy drinking. In about mid-August 2002 EG left the family home taking the children with her and returned to her parent's house. TG continued to have regular contact with the children.

On 17 August TG presented to his general practitioner (GO) who noted that he was very upset about the sudden split with his wife. He was prescribed Diazepam (a tranquilliser).

On 19 August TG took an overdose of 20 Diazepam tablets, 10 Fluoxetine tablets (an antidepressant – apparently obtained from a family member), and approximately eight pints of beer. He had written a suicide note, but after taking the overdose he had telephoned his wife at his parents-in-law's house, and told her that he had taken the overdose...

The following day, 20 August 2002,, he was seen by the deliberate self-harm team at North Tyneside General Hospital who assessed him as being at high risk of further self-harm, and he was therefore admitted to ward 21...

On the night of 8/9 September 2002 TG was arrested following an incident in which he caused damage to the family home when drunk. He was detained by the police and put before the North Tyneside Magistrates' Court later on the 9 September 2002, when he was bound over to keep the peace. Later that day, he presented himself to the accident and emergency department at North Tyneside General Hospital expressing threats of further self-harm and threats of serious harm to his wife.

On 10 September 2002 he was allowed to go on home leave. A clinical review carried out in his absence assessed him as displaying no evidence of any mental illness, and on 11 September 2002 he was discharged, with medical follow up one week later at the community mental health team's community clinic.

On 22 September 2002, at the family home, RG killed his wife by stabbing her. Subsequently he was charged with and pleaded guilty to murder. He was convicted on the 2 April 2003 receiving a mandatory life sentence.

FIRST ADMISSION 20 AUGUST TO 3 SEPTEMBER 2002 (Page 18)

19 August 2002

TG was brought by ambulance to the accident and emergency department of North Tyndale General Hospital with a history of having taken an overdose of Diazepam, Fluoxetine and alcohol. He was admitted overnight to a medical ward for observation and assessment.

FIRST ADMISSION 20 AUGUST TO 3 SEPTEMBER 2002 (Page 25)

1.1 TG was admitted for observation and assessment on the night of 19 August 2002 and was assessed by the deliberate self-harm team the following day. They found that he had taken a serious overdose of 10 Paroxetine [*fluoxetine??*] and 20 Diazepam combined with 8 - 9 pints of beer. TG had written a suicide note and said during the assessment that he thought that the medication would be enough to kill him. He was not pleased to have survived and still felt suicidal. After taking the overdose he had called his wife and now regretted doing that. He was clearly in despair about the break-up of his marriage and appeared to have few sources of support. The team carried out the Beck suicide score and found him to be at high risk of suicide. They discussed TG's situation with the medical staff on Ward 21 following which an informed decision to admit TG to the ward as an informal patient was made.

3 September 2002 (Page 23)

The plan included that TG remain on his present medication (Fluoxetine) for a period of six months and that he self-refer to Turning Point (a drug and alcohol service) if necessary.

The senior house officer made a contemporaneous medical note of the meeting. He noted that TG said that he was feeling well although lonely; that he was not sure about the accommodation position; that he wanted to stop/decrease alcohol but did not want to be referred to the drug and alcohol service.

#### NARRATIVE OF TREATMENT

4 September 2002

On the day after his discharge TG attended his GP who recorded that TG felt very agitated. The GP changed his anti-depressant medication [to paroxetine (Seroxat, Paxil) - see Sept 19] and arranged to see him a further week ahead.

19 September 2002 (Page 39)

According to the prosecution witness statement of RO, TG telephoned him at approximately 1.15 am, clearly drunk and repeated several times his threat to stab his wife.

Later that morning TG attended the Whitley Bay community mental health team for medical follow up with the senior house officer (SHO). He was said to be having no problems with his mood but still to be drinking significant amounts. He expressed regret about drinking and smashing up his house. He was noted to be prescribed Paroxetine and Diazepam by his GP.

21 September 2002

According to the prosecution witness statement of RH, TG became drunk during the evening and told him "I've got a knife. I'll do it".

22 September 2002

TG went to the family home at approximately 11:30 am following which TG killed his wife by stabbing her. The pathologist subsequently identified more than thirty stab wounds to the body of which ten were deeply penetrating.

## 7. Sherzad Muhamed

Summary: A homeless Iraqi man with language and employment challenges goes to his GP complaining of physical problems. The GP prescribes citalopram. The GP does not ask about SM's experience with the medication when he was on it for one month in the past. Nor does he explain what the drug is for, or the side effects. Seven months later Muhamed stabs a pensioner to death in a motiveless crime at the flats where he had previously lived. The press reports the murder but makes no mention of the SSRI. The Independent investigation report notes the medication but ignores it completely as a potential contributor to the tragedy.

### Man convicted of frenzied knife murder — (Kent Online)

<http://www.kentonline.co.uk/maidstone/news/man-convicted-of-frenzied-knife--a15120/>

01 October 2004

A 29-year-old Iraqi Kurd has been found guilty of murdering a pensioner in a frenzied knife attack in Maidstone.

Sherzad Muhamed had denied being responsible for the death of 67-year-old Richard Cromarty in July last year.

Mr Cromarty died from more than 20 knife wounds that had been inflicted on him at flats at 67 Kingsley Road. The attack was so ferocious that ribs were fractured. The fatal wound was 10-12cm deep and penetrated Mr Cromarty's heart.

Muhamed, who denied murder, was discovered asleep on the step of a nearby post office after the street was cordoned off by police.

He later claimed during his trial at Maidstone Crown Court that he was sleeping rough at the time and that another Iraqi had once brandished a knife at the flats.

He said he had lived at the flats for a year but left shortly before Mr Cromarty was murdered and had never returned.

But Muhamed, of no fixed address, was found guilty by the jury after hearing evidence that a mixture of Muhamed's blood and Mr Cromarty's was found on cars parked nearby.

The court heard during the trial that there was no apparent motive for the killing. Mr Cromerty had lived at the flats for several years and, said Alan Kent, prosecuting, had led a "solitary and lonely life".

Mr Cromerty's dying words were captured on a security film. Indicating a large carving knife he said: "Help me, help me. Been stabbed. Help. It's that Iraqi - just stabbed me with this."

The court heard that as well as the blood on parked cars, Mr Cromerty's blood was also found on Muhamed's trouser pocket. When arrested and interviewed by the police Muhamed was told of the DNA evidence. He claimed he was being set up.

He added that he was walking about in the area on the night of the murder but did not go to the flats.

After the verdict, Judge Warwick McKinnon told Muhamed he faced a mandatory life sentence but was adjourning for psychiatric reports on the basis that they may affect the minimum term he will have to serve before being considered for parole.

### **Report of the independent review of the care and treatment of Sherzad Muhamed – Verita**

[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/SHERZAD\\_MUHAMED\\_JULY03.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/SHERZAD_MUHAMED_JULY03.pdf)

#### Summary:

In July 2003, Sherzad Muhamed, a Maidstone resident who was receiving NHS outpatient treatment for anxiety and depression, committed a murder for which he was convicted in September 2004.

#### 3. Findings

Prior to his move to Maidstone and registration with the Holland Road Surgery (Dr. Patel) on 27th June 2002, SM had been registered successfully with GP practices in Birmingham (from 19th July 2001) and Gravesend (from 27th October 2001).

The computer record at the Birmingham practice (Victoria Road Surgery) indicates that SM attended twice for essentially routine purposes and then on a final occasion, on 11th Sept 2001, consulted the GP with concerns about his weight, which the GP recorded was normal.

During the eight months with the practice in Gravesend (Gravesend Medical Centre) SM consulted twice. On 30th October 2001 he was treated for symptoms of conjunctivitis, but the notes also record some stress-related symptoms (palpitations and sleeplessness), and SM mentioned his father having died 3 weeks previously. SM returned to the GP on 22nd January 2002m with the same stress-related symptoms (again mention was made of his father's death). He was prescribed a 28-day course of citalopram and asked to return if he did not feel any better after the treatment. According to the practice records he did not return.

After registering in June 2002, SM consulted his GP feeling himself to be physically ill on several occasions. He ceased work for reasons of ill health and Dr Patel ratified his claim for sickness benefit. On 23rd August 2002, Dr Patel referred SM to the Maidstone Hospital for cardiology investigations and then after a further consultation in November 2002 Dr Patel referred SM for a mental health assessment. Feeling that language difficulties were obstructing communication, Dr Patel arranged an interpreter to be present for the consultation with SM on two occasions.

Dr Patel told the team that he was not convinced that SM had genuine physical symptoms warranting specialist cardiology investigation nor was his mental ill-health at the time such that it could not be managed within primary care. During this period Dr Patel initiated medication for depression. This was citalopram, the same drug prescribed earlier by the Gravesend practice which by implication had helped SM previously (since he did not return with symptoms after the initial course of treatment). This medication was continued while SM was being seen as an outpatient.

No reason was found why the non-medical aspects of SM's situation that might have had a bearing on his mental health - housing, employment, social contacts, family and personal relationships, use of alcohol or drugs - should have suggested to the GP the need for other agencies to be brought into the picture at this time...

In Maidstone...SM expressed dissatisfaction with his relationship with Dr Patel; he had begun to feel that his treatment was not effective (he believed that the medication was simply to help him sleep) and he felt that Dr Patel did not show him and his problems sufficient consideration...

### 3.1.2. Secondary Care

The Trust received SM's referral on 28th November 2002. Dr Patel referred SM to a named consultant, Dr. Sigakumar, which the review team understands was usual practice at the time. Dr Patel referred in his letter to SM's "symptoms of severe anxiety and underlying depression..."

...on 29th January...It was decided to continue current medication.

At the third consultation, on 9th April...SM [reported] feeling fearful, depressed, tearful ...somewhat hopeless." The notes record that "the interpreter feels that it may have something to do with his father's death". At this consultation SM had no thoughts of self-harm or suicide...

## 8. John Peters/ "P"

Summary: John Peters has a history of abusing amphetamines. He comes to the NHS in 1993 at the age of 25, complaining of suicidal thoughts and depression. Instead of helping him get off the speed, the NHS loads him up with neuroleptic medication. By May, 2001 he is also taking 100 mg sertraline

(Zoloft/Straline), an SSRI. He continues with the SSRI and Olanzapine but stops showing up for his depot shots of other medication. He continues to use amphetamines. On May 1, 2002 the NHS receives reports from neighbours that Mr Peters is behaving strangely, flashing, setting fires and ranting. It seems he is becoming delirious/psychotic. On May 12 Peter murders a neighbour for no reason. He is convicted of manslaughter, pleading diminished responsibility and confined in two psychiatric facilities. He is released back into the community in 2005. In 2010 he is charged and convicted of trafficking amphetamines.

The stated NHS position is this: "Although we monitor and maintain our service users in the community, we cannot be responsible for criminal behaviour that is not linked to an individual's mental health." Had the amphetamine addiction been addressed instead of giving Mr Peters additional psychoactive drugs, the murder of Mr Warnes might never have happened.

### **Death could have been prevented — (BBC NEWS)**

[http://news.bbc.co.uk/2/hi/uk\\_news/england/devon/3897239.stm](http://news.bbc.co.uk/2/hi/uk_news/england/devon/3897239.stm)

BBC NEWS | UK | England | Devon

Thursday, 15 July, 2004, 13:26 GMT 14:26 UK

The killing of a Plymouth postal worker by a psychiatric patient may have been prevented if health workers had done more to help him, an inquiry has found.

The independent inquiry was looking into how John Peters killed 60-year-old Roy Warnes in May 2002.

John Peters has since been convicted of manslaughter on the grounds of diminished responsibility.

Mr Warnes' daughter, Susan Bellamy, told the BBC lessons must be learned to prevent such incidents happening again.

John Peters, who was 33 at the time, was under the care of the mental health services in Plymouth, but living in the community when he attacked and killed Roy Warnes who was living in a flat in the same building in Lipson Road.

Mrs Bellamy said Peters had prompted a number of complaints from neighbours.

She said: "He was ranting and raving at people going past, banging on doors and lighting fires in the flat.

"Nothing was done. No one went out to see him and no one called him in."

An internal investigation by the Plymouth Primary Care Trust concluded his care had not been adequate or appropriate and that he had, in fact, had no care, treatment or supervision from the mental health services for a year before he killed Mr Warnes.

It said there were systems, communication and individual failures.

The independent inquiry commissioned by the South West Peninsula Strategic Health Authority to investigate the incident said in a report published on Thursday the killing could not have been predicted.

But it said it could have been prevented if the professionals responsible for his care had taken more assertive action.

The panel identified a number of shortcomings in John Peters' care and made 23 recommendations, most of them directed to Plymouth Primary Care Trust.

The Trust said it had already put into place recommendations from the internal inquiry and would continue to learn lessons.

Ann James of the Trust said: "A number of individuals are no longer working in that team. We've change the management arrangements for that team.

"We now have much clearer policies and guidelines about how to work with individuals who are quite difficult to engage in some of our mental health services."

### **Independent Inquiry into the Care and Treatment of the Patient Known as P**

[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/JOHN\\_PETERS\\_May02.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/JOHN_PETERS_May02.pdf)

#### **SUMMARY OF EVENTS**

P was born 24 June 1968 in Plymouth and brought up by his mother. She married when P was about one year old and thereafter he took his stepfather's surname.

P attended several primary and secondary schools where he said he was bullied. When he left school he held a variety of manual jobs in the building trade and on the fishing boats but in latter years was unemployed. He moved to live in the Saltash and Torpoint area of Cornwall, returning to live in Plymouth when he was about 28 years old. His family had little contact with him. His mother and stepfather were divorced when he was in his late teens and she later married his stepfather's uncle.

He used drugs for some years and latterly regularly used amphetamine which, he told us, he injected intravenously.

P's General Practitioner (GP) first treated him for a mental illness in 1993 when he complained of suicidal thoughts and depression. In 1994, aged 26 years, he was referred to a Community Psychiatric Nurse (CPN).

In 1996 Dr Peter Urwin, Consultant Psychiatrist Cornwall Healthcare NHS Trust, saw him and described him as "this rather strange young man with primarily panic attacks". He was seen again following a normal EEG (electro-encephalogram) and a psychometric assessment, which demonstrated he was of low intelligence, although some of the tests he undertook were dependent on a certain level of social understanding and education which he lacked. P did not keep his next appointment in July 1997 and no further follow up was arranged.

In April 1998 P was admitted to the Glenbourne Unit, Derriford Hospital, in the care of Dr Howard James, Consultant Psychiatrist, using section 2 Mental Health Act 1983 (MHA) from Charles Cross Police Station. Dr Christine Dean and Dr Stephen Robinson completed the papers requesting admission for assessment. He stated that he had recently 'broken up' with his girlfriend, with whom he had daughter, after almost ten years. He was discharged on 1 May 1998, to be followed up by Ms Jeannette Callus, ASW.

From March 1999 until June 1999 P was on remand at HMP Exeter, charged with a serious driving offence and not complying with his bail conditions. Dr Howard James saw him and arranged for his transfer to the Glenbourne Unit under section 38 MHA 1983 later converted to section 37 MHA 1983. In September P went on section 17 leave and it was alleged that whilst in the community he administered a noxious substance and raped a fellow patient.

27 September 1999 - P was again remanded to HMP Exeter. The victim was admitted to the Glenbourne Unit and was unable to give evidence, which delayed the court proceedings.

February 2000 - Dr James saw P in prison as the section 37/17 MHA 1983 had lapsed. On this occasion he was fit and well and did not fulfil the criteria for further detention under the Mental Health Act 1983.

March 2000 - P was acquitted of the charges and as such became a 'free agent'. He failed to attend numerous appointments with either Ms Callus or Dr James.

November 2000 - P was charged with driving whilst disqualified and remanded on conditional bail at Plymouth Magistrates' Court.

January 2001 - Dr James completed a further court report in which he stated that Ms Callus was the key worker and that a CPN would administer the depot injections (a long acting injection of an anti-psychotic drug). He went on to recommend that a Probation Order with a condition of treatment would provide the means of ensuring that P continued to receive treatment.

February 2001 - P was made subject of a Probation Order with a Condition of Treatment. Ms Valerie Stewart, Probation Officer, wrote to Dr James informing him of the Order and requesting a meeting. Mr Edward Read, CPN, became the allocated community nurse.

April 2001 - Ms Giulia Pridmore, Probation Officer, wrote to Dr James informing him that she was P's Probation Officer and asked for an update on his mental health status and whether he had an allocated CPN. Ms Callus and Mr Read undertook a joint visit to P to inform him that Mr Read would continue to give his injection and that there was no further need for social work input.

May 14 2001 - Mr Read administered a test dose of Zuclopenthixol depot injection when P attended the Nuffield Clinic without an appointment.

June 2001 - Dr James saw P at the Nuffield clinic on which occasion he requested his injection. A further test dose was given.

August 2001 - Ms Jill Narin, Probation Support Officer (PSO) wrote to Dr James introducing herself as P's new Case Manager, requesting an update on his mental state and enquiring if he had an allocated CPN.

27 September 2001 - Ms Narin saw P and wrote to Dr James informing him of this and that P was 'low in mood'.

23 November 2001 - Mr Read wrote to Dr James informing him that he had not seen P since 17 August 2001.

7 January 2002 - P was sent a final warning letter because he was 'in breach' of his Probation Order.

22 February 2002 - P was arrested and appeared in court, charged with breaching his Probation Order. The Order was revoked and he received a 12 month Conditional Discharge for the original offence of driving whilst disqualified.

25 April 2002 - Mr Paul McGarry (Housing Manager) telephoned Ms Callus about concerns regarding P's antisocial behaviour. A referral was made to the Gateway Service (the service which carried out assessments). Dr Brian Pollard (GP) visited but was unable to see P.

3 May 2002 - Ms Callus informed Dr James about P's antisocial behaviour and he also received a letter from the GP who had tried to see P at home. P's ex girlfriend telephoned Gateway Service for advice because P wanted contact with their daughter. On 7 May 2002 Dr James took the

GP letter to the team meeting with the intention of discussing its contents with Mr Read.

12 May 2002 - Another tenant, who lived at the same house as P, went downstairs at about 07.30hrs and saw that the panes of glass in the inner hall doors were broken. He found Mr Warnes dead in the

vestibule. He telephoned the police who attended the scene. P was charged with murder and pleaded guilty to manslaughter with diminished responsibility. He was made subject to a Hospital Order with an accompanying Restrictions Order (section 37/41)

## CHAPTER 5

### P'S CONTACT WITH MENTAL HEALTH SERVICES IN 2001 [excerpts]

3 January 2001

P kept his appointment with Dr James at the Nuffield Clinic. P was unkempt with poor concentration and appeared distracted at times. He was still hearing voices, although they were not as bad as they had been 18 months previously. He had not seen Ms Callus, as he did not feel he needed any help. At the same time Dr James confirmed with her that she was prepared to continue as his key worker. P told Dr James that he was taking his oral medication and self-administering his depot neuroleptic injection, sometimes every other day...

19 June 2001 - Dr Julia Beresford, GP in the same practice as Dr Pollard, replied to Dr James' letter. **She confirmed his oral medication as being Sertraline 100mgs and Olanzapine 15mgs nightly.** P told her he was having regular depot injections and she assumed they were being given by one of the CPN team.

## CHAPTER 6

### P'S CONTACT WITH ANY OF THE STATUTORY SERVICES IN 2002

2 January 2002 - A 'breach' letter was sent to P as he failed to keep his Probation Service appointment on 22 November, however this letter was withdrawn and Ms Nichols wrote again asking him to attend the office on the 7 January 2002. He did not attend and was sent a 'breach' letter with another appointment for 11 January 2002, but he failed to keep this one as well.

1 May 2002 - Dr Pollard wrote to Dr James "Just to update you on this patient. I was contacted by Jeannette Callus ASW, yesterday because of concerns that had been expressed by neighbours of P's. Apparently he was 'flashing' in the courtyard and also setting fires. I see from the notes that in fact there has been no contact with P since August last year and he has not collected any medication since October 1st 2001..."

Dr Pollard told us that he unable to understand why his letter was not 'perceived' as urgent, and he was sure that there was an implicit sense of urgency in his letter. This was borne out by the fact that he stated that P had had no contact with anyone since August 2001 despite the treatment order, that things were beginning to fall apart, that P was setting fires, and that he had not collected any medication since October 2001.

7 May 2002 - Dr James told us he discussed the GP letter at the team meeting held that day, as the day before had been a Bank Holiday, and therefore the regular allocation meeting did not take place. Mr Read was present, as was Ms Murphy, but he had no recollection of any discussion about P.

12 May 2002 - Another tenant who lived at the same house as P went downstairs at about 07.30hrs and saw that the panes of glass from the inner hall doors were broken, and found Mr Warnes dead in the vestibule. He telephoned the police who attended the scene. P was charged with murder. P pleaded guilty to manslaughter with diminished responsibility. He was made subject to a Hospital Order with an accompanying Restrictions Order (section 37/41).

### **Victim's daughter furious as killer reoffends — (BBC News)**

<http://www.bbc.com/news/uk-england-devon-11202960>

6 September 2010

Peters (pictured) was using amphetamines before he killed Roy Warnes

The daughter of a postman who was killed by a psychiatric patient eight years ago has said she is horrified the killer has committed further offences.

John Peters killed 60-year-old Roy Warnes, of Plymouth, in May 2002.

On Monday, Peters, 42, from Southway in Plymouth, pleaded guilty at the city's crown court to possessing amphetamine with intent to supply.

NHS Plymouth, which runs mental health services in the city, said it was not responsible for his criminal actions.

Peters had been using amphetamines before he killed Mr Warnes, who lived in a neighbouring flat.

I was absolutely shocked and horrified when I heard he had been arrested  
Susan Bellamy

The 42-year-old, who had been diagnosed with mental health issues and prescribed medication, admitted manslaughter on the grounds of diminished responsibility.

An investigation two years later found Mr Warnes' death could have been prevented if Peters had had more help from the mental health services.

After his conviction, Peters spent two years at a medium security psychiatric unit in Dawlish before moving to a low security hospital near Plymouth.

He was released into the community in 2005 but kept under NHS supervision.

Plymouth Crown Court heard on Monday that he was under the ongoing care of the psychiatric services. His case was adjourned for four weeks for a pre-sentence report and he was granted bail.

'Hands on drugs'

Mr Warnes' daughter said if Peters had been adequately supervised by mental health services it would not have been possible for him to offend again.

Ms Bellamy said: "I was absolutely shocked and horrified when I heard he had been arrested.

"I just feel they have not looked after him again.

"He's got his hands on some drugs and it's all leading back to what happened eight years ago."

She added: "I really think they are not doing their jobs properly. They have let my family down and my dad would be turning in his grave."

Dr Simon Payne, medical director for NHS Plymouth, said Peters had been subject to "regular and close monitoring" since 2005.

He said: "There is no suggestion that recent events are in any way linked to the care and treatment he has received from the mental health service.

"Although we monitor and maintain our service users in the community, we cannot be responsible for criminal behaviour that is not linked to an individual's mental health."

He added: "Mr Warnes' death was a terrible loss for his family and friends and we are committed to doing all we can to make our mental health services as safe as possible."

## 9. Dennis Foskett

Summary: DF is given psychoactive drugs at the age of 15, and ever since experiences episodes of low mood. For many years, he takes lithium and amitriptyline. When in 1985 his GP adds mianserin, a tetracyclic antidepressant "known on occasion to aggravate psychotic symptoms, such as feelings of persecution", "Mr Foskett report(s) feeling worse, reckless and agitated". Less than a week later, he calls his GP urgently requesting a home visit. The GP complies but DF batters both her, and his beloved wife, to death with a hammer. He remembers nothing about these killings. He is diagnosed with psychotic depression.

There appears to be a connection between the introduction of mianserin, the akathisia it immediately produced (about which DF complained to his GP), and the killings. However the independent review, which purports to consider the role of medication, dismisses this important issue, noting: “the level of any contribution, if any, of mianserin is impossible to determine”. They quote Dr David Healy in support of their contention that there is no established connection between violence and antidepressants: “the more severe the mood disorder, the greater the likelihood that the disorder rather than its treatment led to the violence”. However, Dr Healy would probably not automatically assume that a disorder that appeared after starting a medication was independent of its introduction. Also, they did not notice that Dr Healy has often said the risk of adverse medication reactions increases following medication introduction or dosage increase.

In 1995 Mr Foskett is absolutely discharged. He remarries. In 2003, a couple of weeks after his amitriptyline dosage is increased, he reports insomnia and increased anxiety. Within another week, he murders his 2nd wife. The review dismisses the role of medication in this instance, also, noting that: “Mr Foskett had been treated with amitriptyline [and lithium] for many years without any recorded problems. This allows for a fairly conclusive opinion that it is highly unlikely that medication contributed to Mr Foskett’s actions in July 2003.”

#### **Wife-killer stabs 'soulmate' to death — (Bucks Free Press)**

<http://www.bucksfreepress.co.uk/news/493588.print/>

4:02pm Wednesday 26th May 2004

By Times Group

A New Barnet man stabbed his soulmate' to death after he was released from hospital for killing his wife and doctor, the Old Bailey heard on Monday.

Dennis Foskett, 61, a former mental patient, bludgeoned Pauline Cole, 50, with a towel rail and slashed her throat with a kitchen knife on July 28 last year.

He then took an overdose of pills before dialling 999 to tell police and paramedics: "Oh, it's terrible here. I just can't believe it."

Foskett, of Spar House, Lytton Road, was found with Miss Cole's body in her one-bedroom flat in Manor Park, east London.

A psychiatrist told the court that Foskett suffers from a depressive psychosis with an underlying personality disorder.

Miss Cole met Foscett when she was being treated for depression at the Goodmayes Hospital in Essex. Foscett had been detained there for killing his wife of 20 years, Margaret Foscett, and Dr Eva Glickman with a hammer at his home on May 17, 1985.

He had admitted two counts of manslaughter on the grounds of diminished responsibility but was released from the facility in 1993.

It was then he developed a relationship with Miss Cole.

Foscett denied murdering Miss Cole, but admitted manslaughter on the grounds of diminished responsibility.

The Common Serjeant of London, Judge Peter Beaumont, told Foscett he would be detained in a mental hospital indefinitely under the Mental Health Act.

## **REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF DENNIS FOSKETT**

[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/DENNIS\\_FOSKETT\\_LON\\_07.03.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/DENNIS_FOSKETT_LON_07.03.pdf)

### Issues and relevant services

Sometime during 27 July 2003 Dennis Foscett, aged sixty, killed PC his longterm partner, whom he had met at Goodmayes Hospital, Goodmayes, Essex, in about November 1987. Mr Foscett called the emergency services at 1.02 a.m. on 28 July saying that he had killed his 'wife' and taken an overdose. The police found PC with multiple lacerations to her head and neck; she had bled to death and had been dead for some time. Mr Foscett remains amnesic of the details of this event which is the trigger for this Inquiry. He was suffering from severe depression.

At the time that Mr Foscett and PC met, he was an inpatient at Goodmayes hospital under sections 37 and 41 of the Mental Health Act 1983 ('MHA'), having killed his wife Margaret and their general practitioner, Dr Eva Glickman, on 17 May 1985. He was then aged forty two. He was diagnosed as suffering from severe depression at the time. Chapter Two summarises Mr Foscett's early history and the events leading to these killings of which he is similarly amnesic. PC also suffered severe mental health problems and was an inpatient at Goodmayes Hospital when they met. These details are relevant to Mr Foscett's care and are set out in Chapter Five.

Following the double homicide in 1985 and having spent a period on remand at HMP Brixton, he pleaded guilty to two counts of manslaughter on the grounds of diminished responsibility at the Central Criminal Court, London. On the advice of two consultant psychiatrists he was made the subject of a MHA disposal. In a controversial decision, the judge accepted the evidence of the two psychiatrists that Mr Foscett was no danger to the public unless the depression recurred and directed that he be treated at a local hospital rather than under conditions of high security. The depression had receded and was well controlled by medication with which Mr Foscett was completely compliant. Mr Foscett's early history and offences in 1985 are set out in more detail in Chapter Three.

On 11 April 1995 Mr Foskett was absolutely discharged by a Mental Health Review Tribunal...Mr Foskett gained his own independent accommodation in October 1996, from which time he and PC were effectively co-habiting, dividing their time between their two homes. This period and the events leading to PC's death are described in Chapter Nine.

#### Psychiatric history

Dennis Foskett... has a long history of mental illness and first developed problems during his adolescence, aged about fifteen. This was his first diagnosis of depression following a bout of 'flu. Thereafter he developed a significant illness which manifested itself on at least another three occasions prior to 1985. In March 1970 he was admitted to hospital for ten days following another round of bad 'flu about two months previously. It is noted that Mr Foskett thought that he was going to die and became very depressed with suicidal thoughts. As a result, he lost his job. He had been married for six years by this time. It was recorded that during the course of his depression he had often felt 'extremely aggressive towards other people, but realises that this feeling is irrational'. He was treated with amitryptiline. This appears to have been his second episode of depression.

There was another hospital referral to Goodmayes Hospital in 1979 and again to the East Ham Memorial Hospital in 1981. The records of these admissions are not now available but they are referred to in a Home Office document of 1990. Subsequent to the 1985 homicides, Dr D.K Hirst, consultant psychiatrist, in his recommendation to the sentencing court commented that he had 'no doubt from reading case notes of his treatment at Goodmayes Hospital, that he is a man of considerable vulnerability in respect of his personality, prone to anxiety, and responding less robustly to stress than is normal.' He responded to anti-depressant medication and remained well for the three years leading to 1985.

Later accounts of this episode of illness indicate that he was experiencing very severe depersonalisation i.e. a change in self awareness such that the person feels unreal, and was having increasing difficulty coping with his job. He had feelings that he was being watched, was frequently crying and stressed by the feeling that he had to cope with his wife Margaret who suffered from epilepsy, see below. There is no evidence whatsoever that he was ever in fact aggressive or violent in any way prior to the offences in 1985.

#### 1985 OFFENCES

On 17 May 1985 Dennis Foskett killed his wife Margaret and their general practitioner of many years, Dr Eva Glickman. He was forty two years old and suffering from severe depression at the time. He pleaded guilty to two counts of manslaughter on the grounds of diminished responsibility and on 22 November 1985 was made the subject of a hospital order with restrictions unlimited in time, under sections 37 and 41 of the Mental Health Act 1983. Controversially, the judge directed that Mr Foskett be treated in a local psychiatric hospital, Goodmayes, situated in the London Borough of Redbridge in North East London, rather than a high secure hospital. The serious untoward incident report of 7 October 2003 concluded that Mr Foskett should have been placed in high security. The Inquiry Panel considered the following issues:

The role of any adverse reaction to medication in the homicides in 1985, and the appropriateness of the court disposal to a local hospital.

#### Depression and homicides

Mr Foskett's depression in April/May 1985 was precipitated by a bout of 'flu a month or so earlier. Mr Foskett says that he and his wife recognised that he was ill. He lost weight and interest in life and developed a belief that he was being watched, including by his work colleagues. He became more anxious and nervous than normal and became concerned about his performance at work. Mr Foskett recalls experiencing auditory hallucinations. He went to see Dr Eva Glickman, his general practitioner, at her surgery. She prescribed mianserin (Bolvidon), a tricyclic antidepressant known on occasion to aggravate psychotic symptoms, such as feelings of persecution. Mr Foskett reported feeling worse, reckless and agitated. His feelings of paranoia did not improve. His work colleagues had in fact encouraged him to go to the casualty department of Hackney Hospital, where he worked and he says that he did so.

Mr Foskett has never been able to provide a coherent account of what happened on 17 May. He was, and remains, almost totally amnesic of the killings. What is known is that Mrs Foskett called Dr Glickman and requested a home visit. This may have been up to a week after Mr Foskett started on mianserin. Dr Glickman left her surgery at around 6.45 p.m. and at 7.10 p.m. Mr Foskett was seen by a neighbour outside his house holding a hammer and shouting for help saying that he had killed his wife. He was very distressed and attempting to swallow a large number of pills. The bodies of the two women were discovered in the house.

He has since expressed strong feelings of remorse for both killings. He was unable to understand why he had killed two people for whom he had the highest regard and affection.

#### Adverse reaction to medication

Professor David Healy of the North Wales Department of Psychological Medicine, is one of the few experts in the UK researching the links between anti-depressant medication and violence. His evidence indicated the inconclusive nature of this research currently. As far as depression and homicide is concerned, his evidence was that while in general there are 'grounds to believe that antidepressants can precipitate acts of violence up to and including homicide', there have been only a very few reports making the link in relation to a variety of anti-depressants over the past 40 years. Links between anti-depressant medication and violence are not universally accepted by the medical and scientific communities. Again in general, he said that the more severe the mood disorder, the greater the likelihood that the disorder rather than its treatment led to the violence. It is not doubted that Mr Foskett exhibited a severe degree of disorder at the time of these two homicides and when he killed PC in 2003, but there is no reliable evidence that his illness was caused by improper drug prescription.

In relation to the killing in 2003, Mr Foskett had been treated with Amitryptiline [and lithium] for many years without any recorded problems. This allows for a fairly conclusive opinion that it is highly unlikely that medication contributed to Mr Foskett's actions in July 2003. This would be so even if there were

some grounds to implicate mianserin in the 1985 killings. These grounds might include the fact that he had started treatment relatively recently and had reported adverse effects to this treatment. However, the level of any contribution, if any, of mianserin is impossible to determine.

Prof Coid's final meeting with Mr Foskett was on 21 July 2003, about one week before he killed PC. At this interview, Prof Coid recalls that he was looking less well than usual and reported experiencing some anxiety since his benefits problem earlier in the year. He had remained anxious, especially in the previous two weeks. He was experiencing anxiety for periods of three to four hours at a time, but there was no change in the level of anxiety. He specifically denied palpitations, tremors, panics and the like. He was sleeping only four hours a night and waking more anxious. He reported being a little irritable, but not more than usual. He denied any changes in concentration, subjective depression and reported feeling better having increased his amitryptiline medication by 25 mg. Prof Coid expressly noted that he had no suicidal or homicidal ideation.

## 10. Richard Loudwell

Summary: In July, 1994, a GP prescribes antidepressants to a man, RL, worried when his job disappears as the result of a dockyard closing. They make him impotent and he is consequently unhappy. His GP refers him to mental health services because he is having "relationship problems associated with impotence". From 1997 to 2002, RL goes off and on antidepressants, and continues to complain of depression and impotence throughout. In April 2001, the NHS doctor prescribes Viagra for RL to help with his continuing sexual dysfunction.

In 2002, there is an incident of drinking followed by mania and strange behaviour. His family complains that he is not taking his medication. Now, he is a man in possible antidepressant withdrawal, on Viagra, and drinking. Now diagnosed with manic depression, there are a number of incidents of inappropriate sexual behaviour, including raping a man. He becomes suicidal. In December he rapes and murders Joan Smythe, an elderly neighbour.

The Independent review is critical of RL's "non-compliance" with his prescribed antidepressant, despite the fact that it never helped, and addresses the decision to add Viagra rather than help RL get off the antidepressant, as follows: "Viagra would not 'cause' sexual disinhibition and whilst it was prescribed, there was no clear evidence to suggest that in RL's case it was used either to facilitate offending or contributed to inappropriate behaviour."

### Broadmoor patient admits killing — (KentOnline)

<http://www.kentonline.co.uk/kent/news/broadmoor-patient-admits-killing-a12695/>

22 April 2004

KILLER Richard Loudwell is facing sentence after admitting he was responsible for the death of an elderly woman.

He was due to stand trial on a murder charge but his guilty plea to manslaughter by reason of diminished responsibility was accepted by the Crown.

His victim, 82-year-old Joan Smyth, was found strangled at her flat in Wakely Road, Rainham, on December 2 2002. She had bite and burn marks to her body.

John Hillen, prosecuting, told Maidstone Crown Court that acceptance of the manslaughter plea had been a possibility from the outset.

There had been many psychiatric investigations, he said, and Loudwell, 58, of York Farm, Lower Twydall Lane, Gillingham, had undergone a three-month assessment at Broadmoor Hospital.

“It was not contested by the Crown that the defendant was suffering from an abnormality of the mind,” said Mr Hillen.

“The issue was whether, given his denial of any criminal act at all against Mrs Smyth, there was substantial impairment at the time of the killing.”

The prosecution, he said, would not be able to contest evidence that there was impairment.

Judge Warwick McKinnon said he had to have in mind either an indeterminate sentence or a hospital order without restriction.

Loudwell, who spoke only to enter his plea, was remanded in custody until sentence next Tuesday.

### **Medway Primary Care Trust & Medway Council Independent Inquiry into the Care and Treatment of Richard Loudwell**

[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/RICHARD\\_LOUDWELL\\_DEC02.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/RICHARD_LOUDWELL_DEC02.pdf)

March 2006

On 2 December 2002 Richard Loudwell (RL) killed Joan Smythe. On 22 April 2004 at the Crown Court at Maidstone he pleaded guilty to manslaughter on the grounds of diminished responsibility. The court ordered that he be made subject to an interim hospital order under section 38 Mental Health Act 1983. RL was then detained in Broadmoor Hospital where he was assaulted on 25 April 2004 by Peter Bryan, another patient. This inquiry considers only events to the date of the death of Joan Smythe.

#### **SUMMARY OF EVENTS**

3.1 RL was born on the 10 August 1944. He lived in the same farmhouse in Kent all his life, as a child with his parents and two sisters and, after the death of his father in May 1999, solely with his mother. On leaving school, he undertook an apprenticeship and continued to work in Chatham Dockyard until he was made redundant when it closed in 1986. He subsequently found work at GEC Avionics in Rochester, but was again made redundant a few years later. Thereafter he tried several times to find work, including with a kitchen-fitting company, but with no real consistency.

3.2 In July 1994, the GP records indicate that RL was depressed and anxious and he was consequently prescribed an anti-depressant. In August his GP made the first of several referrals to the mental health services, when he was (according to the GP records) seen by a CPN, although no notes of the meeting(s) have been found. Later that year, in November, RL was referred to the psychology department at All Saints Hospital, Chatham for treatment of erectile dysfunction. He was again referred to mental health services in January 1995, when he was once more treated with anti-depressants and during that year continued to see a psychologist regarding relationship problems associated with impotence.

By January 1997, after a minor car accident, RL was again treated for depression. He took to his bed for at least four weeks. At this time he was experiencing extreme financial difficulties because he had unwisely loaned a lot of money to a 'friend'. Following a further emergency assessment, RL was informally admitted, for the first time, to the Medway Hospital, from 712 March, where he was treated for a 'brief depressive episode'. During a ward round, his sister reported that he had a tendency whilst at home to stand naked at the door. She also highlighted the possible deepening of his financial difficulties. He was discharged to outpatients with anti-depressant medication.

During April, RL's sister drew to the attention of the mental health services his inappropriate sexual advances towards women. Throughout the rest of 1997, he continued to be seen at outpatients, complained of continuing depression and impotence and spent an undue amount of time in bed. By December he had ceased taking his antidepressant medication.

In April [2001] RL was reported as responding well to the Viagra which had been prescribed for his erectile dysfunction. Police received information at this time, from a child care social worker, that RL was planning to move in with his girlfriend, a woman with young children. In a joint police/social services visit to the woman, she disclosed that they had met through a lonely hearts column and that she had no intention of allowing him to move in, or indeed of seeing him again. Police subsequently had reports that RL was frequently at another woman's home, having been reported by members of the public for parking his car dangerously on the pavement.

3.18 In June [2002]... RL's mother and sister expressed concerns about RL's strange behaviour, stating that he had exposed himself to an electrician working at the family home. They also drew attention to his extremely arrogant and argumentative demeanour, and the fact that he was dressing strangely. Subsequently, the police and probation officer decided that they should raise RL's risk assessment from medium to high, as he had admitted exposing himself and there were further complaints from members of the public about his behaviour while working as a kitchen sales adviser. Although at RL's outpatient appointment in July Dr Shobha could find no clinical evidence of depression, by October, Dr Bhasme once more referred him to mental health services, requesting an urgent assessment and community support, as his condition had apparently deteriorated.

3.20 By January 2002... RL was considered at 'high risk' until after his supervision ended in February, because of his behaviour and attitude. At this point, Dr Shobha considered that his depression was in remission and at around that time the GP noted that RL appeared euphoric. In late February there are numerous records of police involvement; at one point he was found wandering in Folkestone claiming

he had lost his car or that it had been stolen, was apparently mistaken for an illegal immigrant and kept in the cells overnight. On another occasion RL had asked directions of a stranger, with his trousers around his ankles and pornographic magazines were seen in his car. Three days later he was involved in a road accident and the other party considered that RL was drunk; police found him to be vague and confused and took him to hospital, but he was discharged the same night. The GP, being informed of concerns by the family, requested a further urgent psychiatric review.

3.21 Dr Shobha saw RL on 27 February [2002], accompanied by his sister, who reiterated her concerns that he had been acting strangely for about six weeks, had been aggressive and wandering around naked. He was admitted informally to hospital on 6 March, from the outpatient clinic. He was reported as acting inappropriately to female patients and persisted with this behaviour, despite being requested to stop and being threatened with assault by other patients. RL was discharged on 12 March, apparently because of his sexually inappropriate behaviour, which he had been unable or unwilling to control.

3.22 On 13 May, in a letter to Dr Shobha, the GP requested an early out-patient appointment and CPN visit, after the family raised concerns about RL neglecting himself, ceasing to take his medication and hoarding it. He was consequently admitted informally to hospital once more on 24 May. He was discharged after three days.

3.24 In early October 2002 police received a report that RL was sitting in a petrol station with a pornographic magazine, with his trousers open and his penis exposed. Dr Ratnaik (locum associate specialist) reported that RL had presenile dementia and a referral was made to a psychologist, and his diagnosis changed accordingly.

In late November police received worrying reports about RL; a pharmacy sales assistant reported RL had called into the shop, naked from the waist up, discussing intimate sexual details and requesting to take her photograph; RL was found with an 11-year-old girl, who was returned to her home in Margate. On 30 November, RL was arrested for the assault and rape of a man in Canterbury and was taken to Canterbury Police Station, where he was seen by the custody nurse. RL described himself as 'manic depressive and bi-sexual', indicated that he had been in hospital for depression and stated that he had 'no control over his sexual urges'.

3.26 At 8.00am on 2 December, Mrs D, RL's sister, tried to phone her mother as she was concerned about the impact on Mrs Loudwell of RL's increasingly bizarre and troubled behaviour. She then telephoned Colin Croft to register her concerns and to seek assistance. Mrs D received no reply and left a message on his mobile phone. She then visited the farm and found her brother to be emotional and suicidal. An argument developed, culminating in RL threatening to take his own life. At 9.45 the same morning, Mr D, RL's brother-in-law, telephoned and spoke to RL and asked him to remain at home. Mr D described RL's behaviour as almost childlike, manic and threatening.

3.27 Evidently RL decided not to remain at home and instead drove to Rainham. Here he met an elderly woman, who coincidentally lived in the same property as an aunt of his (although in a separate flat). He apparently assisted her home with her shopping and was invited indoors. RL sexually assaulted and killed Joan Smythe in her home later that day. He was subsequently convicted of her homicide and was

undergoing assessment in Broadmoor when he was assaulted by another patient and later died from his injuries.

Throughout RL's contact with psychiatric services there are frequent references noting his concerns about potency. There is recognition that this may have affected his mood and compromised compliance with antidepressant medication, on which he occasionally blamed his impotence. Given that his diagnosis was, until his March 2002 admission, one of a recurrent depressive disorder, the need to ensure compliance with antidepressant drugs and the lack of historical evidence of association between his erectile competence and his known offending at that stage, it seems reasonable to have prescribed Viagra.

#### Psycho-sexual counselling

8.10 RL was first seen by Dr Raleraskar, on 20 May 1998 after a telephone referral from the Christina Rosetti Day Hospital and one failed appointment. He reported erectile difficulties of three months duration that he blamed on the anti-depressant medication. He also expressed concern that his penis and testes were small. Dr Raleraskar suggested the GP refer him to a urologist for a physical examination. The second appointment took place on 22 July 1998 when RL reported being off medication and felt his mood had lifted recently. Dr Raleraskar had no further involvement with RL in her psycho-sexual clinic.

8.11 Hypertension, diabetes, anti-depressant medication, anti-psychotic drugs, depression and dementia can all cause loss of libido or impotence. Viagra is purely a treatment for erectile impotence. It is unlikely that there was a clinically significant interaction between Viagra and any anti-depressants or anti-psychotics RL was receiving.

The interest in treating RL's impotence, which was a significant concern to him and something he complained about frequently, may have contributed to his non compliance with anti-depressant medication.

Viagra would not 'cause' sexual disinhibition and whilst it was prescribed, there was no clear evidence to suggest that in RL's case it was used either to facilitate offending or contributed to inappropriate behaviour.

8.13 A formal risk assessment in March 2002 would have involved a comprehensive review of RL's sexual problems, the circumstances in which the problems occurred and details of RL's sexual activities. A decision to prescribe would then have been premised on the fact that the need to ensure compliance with anti-depressants outweighed the (at this stage theoretical) risk to others. With hindsight, if all the facts had been known, we think it unlikely he would have been prescribed Viagra.

8.14 Similarly, if the unfolding events in December 2002 had been known, then Viagra should no longer have been prescribed. It was only after the alleged rape of AB that the evidence suggested the possibility of penetrative sexual offending. This information, however, was not available either to mental health services or to Dr Bhasme at the time. It should also be stressed that Viagra does not cause sex

offending, nor does the prescription of the drug. We also note that there are ways to obtain Viagra without prescription.

## 11. **Abdur Choudhury**

Summary: Abdur Choudhury, in common with most people forced to take neuroleptic medication long-term, most recently Abilify, suffers side effects such as cognitive impairment, social withdrawal, loss of motivation, and probably many other side effects. He attacks his mother twice, once with a knife in 2009, and in a fatal beating June 26, 2010. Sudden outbursts of anger, and periodic assaults, are not uncommon for people who have been on these drugs a long time, and have nothing to do with inherent mental illness. Yet the independent review and the news articles refer only to AC's diagnosis and make no mention of the drug or its possible contributory role.

### **Man who killed mother sent to secure unit - Luton — (CPS Thames and Chiltern News)**

[http://www.cps.gov.uk/thames\\_chiltern/cps\\_thames\\_and\\_chiltern\\_news/man\\_who\\_killed\\_mother\\_sent\\_to\\_secure\\_unit\\_luton/](http://www.cps.gov.uk/thames_chiltern/cps_thames_and_chiltern_news/man_who_killed_mother_sent_to_secure_unit_luton/)

02/11/2012

A paranoid schizophrenic who battered his own mother to death in her living room was today, Friday, 02 November 2012, sent to a secure mental health unit.

Abdur Choudhury, now 34, punched and kicked his mother Ramatunnessa Choudhury shouting: "How much more? How much more?"

He rained punches and kicks on the 70-year-old in front of small children at her home in Bishopscote Road, Luton on Friday 26 June 2010, Luton Crown Court was told.

Beverly Cripps for the Crown Prosecution Service (CPS) said at one point Choudhury lifted up his mother's head as she lay on the floor and hit her with a clenched fist. "He continued to hit her in the face and the force of the blows caused her false teeth to fall out," she said.

The children's mother tried to phone for help, but Choudhury stopped her. He did allow her to take the children upstairs from where she was able to call for an ambulance.

Mrs Choudhury was taken to the Luton and Dunstable hospital where she died the following Monday, at 2pm, having suffered three cardiac arrests. She had injuries to her temple, forehead, had suffered broken ribs, injuries to her kidneys, broken bones and had acute blood loss.

Ms Cripps said the cause of death was multiple organ failure as a result of trauma.

Choudhury, previously of Napier Road, Luton pleaded guilty to manslaughter on the grounds of diminished responsibility. His case had been delayed until psychiatrists were able to say he was able to appear in court and make a plea.

He had previous convictions in 2009 when he had attacked his mother with a knife and had assaulted a doctor who was treating him.

The court was told he was the youngest of Mrs Choudhury's seven children.

Defence barrister Andrew Jefferies QC, defending, said: "The family have not just lost a mother; they have lost a son."

Judge Richard Foster passed a Hospital Order under the Mental Health Act with a Restriction Order, which means Mr Choudhury will be detained at Brockfield House Medium Secure Unit in Wickford, Essex indefinitely.

The judge: "This is a tragic case for everyone, particularly the defendant's family. I hope the end of proceedings can bring some solace to them."

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### **[An independent investigation into the care and treatment of a person using the services of South Essex Partnership University NHS Foundation Trust](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/CHOUDHURY_A_EEng_6.101.pdf)**

[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/CHOUDHURY\\_A\\_EEng\\_6.101.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/CHOUDHURY_A_EEng_6.101.pdf)

Undertaken by Con[http://hundredfamilies.org/wp/wp-content/uploads/2013/12/CHOUDHURY\\_A\\_EEng\\_6.101.pdf](http://hundredfamilies.org/wp/wp-content/uploads/2013/12/CHOUDHURY_A_EEng_6.101.pdf)sequence UK Ltd

June 2013

#### 1.2 Incident Overview

On 26 June 2010, Mr H was arrested following a serious assault on his mother, who was admitted to hospital for treatment of her injuries, but subsequently died. At the time of the incident, Mr H was visiting his mother at the home of his brother. He was also a patient of The Trust.

Initially, Mr H was unfit to plead and was sentenced to a Hospital Order by reason of insanity<sup>3</sup>. Subsequently, in November 2012, Mr H was considered fit to plead and at a sentencing hearing his plea of manslaughter on the grounds of diminished responsibility was accepted by the Crown. The patient was sentenced to an Indefinite S37/41 Hospital/Restriction Order.

1.2.1 Relevant Contextual Information Mr H first came to the attention of specialist mental health services in December 2006, after assaulting his mother, unprovoked. Soon after admission, Mr H assaulted a trainee doctor and was transferred from the open adult ward to a low secure unit on 22 December 2006.

In the three years prior to his admission, it is recorded in Mr H's mental health records that his friends and family had noticed a change in his behaviours. He had, it is reported, been working as a youth worker and left this post without any clear reasons for doing so. It is also reported that he began to dissociate from his friends and that he believed that his friends knew about conversations he had in his home.

Mr H's family reported that he also began to display aggressive behaviour towards his mother. His mother confirmed to Mr H's clinical team a range of unacceptable behaviours by her son towards her. Because of his behaviours, she left her home to live with another of her sons.

1.2.2 Relevant Clinical Information 2007 to 2009...

In January 2008 there was a multi-disciplinary meeting, including Mr H's relatives, prior to the forensic community team taking over responsibility for Mr H. The clinical records report that:

Mr H continued not to take responsibility for the events which occurred in 2006. • Mr H was more interactive with his brothers.

Mr H was venturing outside of his brother's home, which he had not done prior to the incident in 2006. Mr H was maintaining the boundary of not being in contact with his mother and only seeing her in the presence of other family members. • Mr H's relatives remained concerned about possible future risks. Mr H's then forensic consultant psychiatrist highlighted Mr H's persistent denial about what happened in 2006.

Mr H was to remain on depot medication.

Mr H's brother was content to provide accommodation for Mr H when he was discharged from the low secure facility.

Discharge from the low secure in-patient facility occurred on 19 February 2008.

19 February 2008 to 2 November 2009

Following Mr H's discharge from the In-patient Services to the community forensic service, he was monitored on a weekly basis by his care co-ordinator. He also attended outpatient appointments with his sector consultant.<sup>4</sup> At the time of his discharge he was on depot medication, which he continued to

take until May 2008, when Mr H changed to oral medication. This medication was Aripiprazole 10mg daily, which was increased after three weeks to 15mg a day.

In August 2008, at a CPA meeting, the clinical records reported:

Mr H showed no signs of psychosis and was medication-compliant.

Mr H advised that he was now responsible for his medication, and had been since 14 July 2008, and his brother no longer watched him taking his medication. He also reported some side-effects, including a dry mouth and agitation in his legs.

Mr H had visited his mother in the presence of another adult and that he had also been looking for work...

The next CPA meeting was scheduled for 17 November 2008. In the event, it occurred on 6 December 2008. The December CPA meeting focused on Mr H's discharge from the community forensic team to general adult mental health services...

On 17 April 2009 Mr H's community forensic care co-ordinator wrote to the team leader of the CMHT with the purpose of referring Mr H to that team. In this letter, the forensic care co-ordinator informed his colleague that "[Mr H] no longer presents a risk to himself or others".

On 1 June 2009 Mr H attended his first outpatient appointment with his new community consultant psychiatrist. The outpatient letter generated as a consequence of this and sent to Mr H's previous 'sector consultant' indicated that Mr H was very low risk and that it was appropriate for him to be discharged from forensic services to general adult services.

The letter also noted Mr H to be symptom-free, and that he accepted his diagnosis of paranoid schizophrenia. Mr H was noted as requesting to stay under the medical care of his pre-existing 'sector consultant', and the CMHT consultant advised that he would discuss this with his team and also the allocation of a care co-ordinator for Mr H.

Between 2 December 2009 and 14 January 2010 the community support worker met with Mr H on two occasions: once in a local department store (December) and the second at the house of Mr H's brother (13 January 2010). Text and telephone contact had also occurred during this period, as Mr H requested the re-arrangement of planned meetings owing to unfavourable weather conditions.

14 January 2010: The community support worker set out a closing summary on Mr H's file as he was leaving the community mental health team. The record the community support worker made communicated clearly that Mr H required meetings every other week at the department store and that monitoring of Mr H was required.

18 February 2010: Mr H attended an outpatient appointment with his CMHT consultant psychiatrist. No concerns were identified and a review was planned for three to four months' time.

7 June 2010: Mr H attended an outpatient appointment with his CMHT consultant psychiatrist. The record made suggested that Mr H presented as well. However, it was also noted that he could no longer work at his brother's restaurant.

25 June 2010: Mr H assaulted his mother who subsequently died of her injuries.

## 12. Mark Robinson

Summary: Mark Robinson takes citalopram. He reports to his GP that the drug is not helping and he feels anxious, conflicted, and has insomnia and panic attacks. So on October 15, 2010, his GP doubles his dose. In mid-Dec he tells a CMHT psychiatrist he needs help, explaining that he bought a baseball bat and a knife and went to the home of Albert Wright with the intention of killing him. The psychiatrist duly informs the police and for weeks officials talk about doing something. The psychiatrist reacts by changing his diagnosis and on Feb 17 increases MR's dose of citalopram again. On Feb 25 MR murders Albert Wright. MR is sentenced and jailed for life with no chance of parole for 21 years. The news article blames a grudge but no mention is made of medication. The independent review provides details of the prescription but does not consider it a potential contributing factor.

### Hainault pensioner's killer jailed for 21 years minimum — (The Ilford Recorder)

[http://www.ilfordrecorder.co.uk/news/crime-court/hainault\\_pensioner\\_s\\_killer\\_jailed\\_for\\_21\\_years\\_minimum\\_1\\_1183466](http://www.ilfordrecorder.co.uk/news/crime-court/hainault_pensioner_s_killer_jailed_for_21_years_minimum_1_1183466)

20 January 2012

A delivery driver who stabbed his stepdad's 80-year-old father to death with a steak knife in a row over his inheritance has today been jailed for at least 21 years. Mark Robinson, 35, knifed widower Albert Wright, of Trelawney Road, Hainault, 31 times "in order to inflict suffering" on his victim's son David. David Wright had married Robinson's mother Susan just three months before her death from liver disease and her son held him "at least partly responsible", the Old Bailey heard.

Robinson was angry he inherited the bulk of her estate, including a house in Borehamwood, Hertfordshire, and lucrative pension funds.

But the court heard David had paid Robinson £22,500 from the money he had inherited, on the understanding it would be paid to Robinson's 15-year-old daughter.

After the February 25 murder Robinson told police: 'I wanna stick it to him and if he has to live the rest of his life without his dad then so be it.'

Robinson, of Green Court, Green Close, Luton, admitted murder at a hearing on Monday.

Judge Andrew Bright said: “It’s clear that the murder of Albert Wright has had a profound and lasting impact, not just on David Wright but on the family friends and neighbours of Albert Wright.

“They have all had to come to terms in particular with the manner of Albert Wright’s death at your hands, which was shocking and deeply distressing for all those who knew him.”

Prosecuting, Roger Smart said: “The defendant attacked the deceased almost immediately after he answered the door and did not exchange words with him.”

In a statement read to the court, David Wright said: “My father was my only living family member with whom I had a relationship.

“Dad and I were very close. I was living with him at the time he was killed and his death has left me devastated.”

### **An independent investigation into the care and treatment of a mental health service user (X) in Bedfordshire by South Essex Partnership University NHS Foundation Trust**

[http://www.hundredfamilies.org/wp/wp-content/uploads/2016/06/MARK\\_ROBINSON\\_Feb11.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2016/06/MARK_ROBINSON_Feb11.pdf)

October, 2014

#### The Incident

1.6 During the day of 25 February 2011 X went to the house of Mr Y in Hainault, London. At around 18.00, when Mr Y opened the door, X attacked Mr Y with a knife, causing fatal injuries. Mr Y was discovered by his son Z, at around midnight on 25 February 2011. X was arrested on suspicion of the murder of Mr Y on 28 February 2011.

1.7 X had a period of care provided by secondary mental health services between October 2010 and February 2011.

1.8 He was initially referred to primary care ‘Talking Therapies’ in August 2010, and to mental health services by his GP in September 2010, after a period of time off work with anxiety, panic attacks and depression. He was seen for assessment on 15 October 2010 by a psychiatrist from the Luton Assessment and Single Point of Access (ASPA) team.

1.9 He was assessed as having intermittent thoughts of suicide but no active plans. There is no record of an assessment of risk to others at the time. His antidepressant medication, citalopram,<sup>1</sup> was increased, and he was given a further out patient appointment in 4 weeks’ time, when a referral to psychology would be considered.

1.10 He was seen again on 22 November 2010 and referred to psychology for assessment following disclosing psychological conflicts and anxiety.

1.11 X was next seen by a psychiatrist on 13 December 2010 and disclosed that over the weekend he had left his delivery lorry and taken the train to the house in Borehamwood where his mother used to live with his 'stepfather' Z. He stated he disclosed this because he wanted help.

1.12 He reported that he had bought a baseball bat (and later disclosed he had a knife) and waited outside the house from 14.00 to 23.30, with the intention of killing Z. He went again to the address on the following day but did not find Z.

1.13 The psychiatrist informed the police, and referred X to the Luton and South Beds Crisis Resolution and Home Treatment Team (CRHTT) on 13 December 2010, for more intensive input. ..

1.17 Although there were a series of daily phone calls made, some of which he answered, the CRHTT did not actually see him again until a cold call was made on 18 January 2011.

1.18 On this occasion his flat was observed through the letterbox to be in disarray and although X was present, he would not respond to staff.

1.19 Following a team discussion, a Mental Health Act assessment (MHA) was requested; but because of operational issues was not carried out, though police were asked to do a welfare check. The Mental Health Act 2007 made several key changes to the 1983 Mental Health Act, which laid down provision for the compulsory detention and treatment of people with mental health problems in England and Wales.<http://www.legislation.gov.uk/ukpga/2007/12/contents>

1.20 It was reported back to the CRHTT by the approved mental health professional (AMHP) that the police had visited and X was reported to be fine. After team discussion the CRHTT consultant asked for a formal MHA assessment, which was carried out on 21 January 2011 under Section 135 MHA.

1.21 X was assessed as not detainable under the MHA, and a plan of follow up action was proposed, including an appointment with his previous consultant at the ASPA/Community Mental Health Team (CMHT). X did not attend this follow up appointment on 27 January 2011, and it was agreed the CMHT would follow up. He was then discharged from the CRHTT with a diagnosis of Panic Disorder with Depression on 27 January 2011.

1.22 X attended an appointment with the CMHT psychiatrist on 17 February 2011, and was noted to have no evidence of psychosis or affective features, and he denied any thoughts of harm to himself or others. He was given a further appointment for four weeks later.

1.23 The homicide of Mr Y (Z's elderly father), was carried out at Mr Y's home address on 25 February 2011. X had travelled there with the intention of killing Z.

1.24 He had waited outside the house for Z to return, and when Mr Y returned instead, he decided to kill him, knocked on the door and fatally stabbed him.

1.25 X pleaded guilty to the murder of Mr Y and on 20 January 2012 was sentenced to life imprisonment, with a recommendation that he serve 21 years.

## Psychiatric History

4.7.3 X attended his GP after the accident at work in June 2010. He reported taking time off work because of anxiety and depression, and not sleeping well... He was prescribed citalopram 20 mg daily.

4.7.4 He was reviewed in July 2010 by his GP and was still getting panic attacks and insomnia, and finding the citalopram was not helping. He was referred to a primary care counselling service 'Talking Therapies'. X saw this counsellor for six sessions for management of anxiety symptoms, which was initially successful in getting him back to work in October 2010. However he returned to his GP after feeling ill and unsafe to drive at work.

4.7.5 The GP increased his citalopram to 40 mg daily in September 2010, and referred him to the community mental health team (CMHT) in Luton for psychiatric assessment...

4.7.10 At his next appointment on 13 December 2010, X disclosed to doctor K1 that when at work on 10 December he had parked his lorry and taken the train to Borehamwood (to the house his mother used to live in). He bought a baseball bat (and later disclosed having a knife) and planned to kill D (the man his mother had married before her death). He disclosed that he believed D had been encouraging her abuse of alcohol, and because of this she died. He reported waiting in bushes in front of the house between 14.00 and 23.30. D did not appear at all, and by 23.30 he reported being cold, and had many texts from his partner, who came to pick him up. 4.7.11 X told doctor K1 he returned to the house the following day but did not find Z. He disclosed that thoughts of killing Z had been present for a while, but deep inside he didn't want to do it. X said he had discussed this with his partner, and he had decided to disclose his thoughts so he could get help. No thoughts of harm to himself or anyone else apart from Z were elicited.

4.7.12 Doctor K1 told X he would need to inform the police, and proceeded to report the disclosure and X's actions over the weekend. This was logged by Bedfordshire police and Dr K1 was given a 'URN' (reference) number.

4.7.14 Dr K1 then referred X to the crisis resolution home treatment team (CRHTT) on the same day, because he believed X required more intensive input than the CMHT or ASPA could provide. The referral by Dr K1 describes X as "extremely volatile at the moment, and cannot control his thoughts and emotions...he appears very cold and there is high risk of him harming the person in question".

4.7.29 X did not attend the appointment on 27 January 2011. On 14 February 2011 Dr K1 wrote to him informing him that his diagnosis had been changed to 'Associated' (sic) Personality Disorder ICD10 F60.2'; that the team did not think he needed a care coordinator, and he had been referred to a psychologist. He was offered a further appointment on 3 March 2011. This letter was copied to X's GP.

4.7.30 Dr K1 wrote to X's GP on 25 February 2011, after a review on 17 February 2011. Dr K1 reported that X attended on 17 February 2011, and that he had no thoughts of harm to himself or anyone else, was "compliant and insightful", to continue on citalopram 60mg, and review in 3 months. It was noted by Dr K1 that the "psychology referral was already done".

### 13. Stephen Jacobs

Summary: In 1999, Stephen Jacobs' GP prescribes him citalopram for Irritable Bowel Syndrome and complaints of back pain. SJ has left his job to become full time carer for his wife who has various diagnoses and is on psych meds. He takes the citalopram erratically and over time becomes mentally ill and suicidal. Feb 18, 2011, the couple have numerous problems and SJ is feeling suicidal. His GP renews his citalopram prescription. Two days later, SJ drowns his wife and takes an overdose of her Stelazine (a neuroleptic). SJ is found guilty of manslaughter, not murder, by reason of diminished responsibility. The mental illness, not the citalopram, is blamed. The medication is not mentioned in news articles. The independent review notes the prescriptions but does not consider their possible role in events.

#### **Ipswich/Needham Market: Man detained indefinitely after pushing wife to her death in lake — (Ipswich Star)**

[http://www.ipswichstar.co.uk/news/ipswich\\_needham\\_market\\_man\\_detained\\_indefinitely\\_after\\_pushing\\_wife\\_to\\_her\\_death\\_in\\_lake\\_1\\_1386615](http://www.ipswichstar.co.uk/news/ipswich_needham_market_man_detained_indefinitely_after_pushing_wife_to_her_death_in_lake_1_1386615)

23 May 2012

A MENTALLY ill man who pushed his wife to her death into a lake at a Suffolk beauty spot told police he did it because she was “following him round like a sheep” a court has heard.

The body of 60-year-old Ruth Jacobs, who could not swim, was found floating facedown in shallow water at Needham Lake by anglers at around 8am on February 20 last year, Ipswich Crown Court heard.

Her husband Stephen Jacobs, 60, of Spinner Close, Ipswich had denied murder but admitted manslaughter by reason of diminished responsibility.

Judge John Devaux made Jacobs the subject of a hospital order under the Mental Health Act after hearing he had been suffering from a serious depressive illness at the time of the killing.

Judge Devaux said although a witness claimed weeks before Mrs Jacobs' death she had heard Jacobs say that if he was going to kill his wife he would drown her, he did not consider the comment was evidence of pre-planning or premeditation. He added that if it was made it was made light-heartedly.

Michael Crimp, prosecuting told the court Jacobs and his wife had lived together in Ipswich for 24 years and had been married for 16 years.

The couple had no children together but Mrs Jacobs had two grown up children from a previous marriage.

Mr Crimp said friends described them as “a happy couple who loved each other”.

Mrs Jacobs suffered from arthritis which affected her mobility and she was unable to work. Her husband was her full time carer and had given up his employment to look after her, said Mr Crimp.

In the weeks leading up to Mrs Jacobs' death friends noticed Jacobs had lost weight and that he appeared depressed.

A post mortem examination on Mrs Jacobs found she had drowned but there were no marks on her body to suggest someone had attempted to get her in the water by force.

Jacobs was arrested at Wissett Lake near Halesworth at 3.45pm the same day as Mrs Jacob's body was found after the police were called by a member of the public who was worried he was going to throw himself into the lake.

He told police: "We drove to Needham Market to the lake and she kept following me. She always followed me like a sheep so I pushed her in."

John Black QC for Jacobs said his client had been diagnosed as suffering from a serious depressive illness at the time of the killing and had been receiving treatment since his arrest.

He said Jacobs was now recovering from his mental illness and did not represent a risk to members of the public.

### **[An independent investigation into the death of B, a mental ill-health related homicide](http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/STEPHEN_JACOBS_Feb11.pdf)**

[http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/STEPHEN\\_JACOBS\\_Feb11.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/STEPHEN_JACOBS_Feb11.pdf)

Carried out on behalf of NHS England by ANNE RICHARDSON CONSULTING LTD EXPERIENCE, KNOWLEDGE AND EXPERTISE IN MANAGING RISK

NHS Midlands and East

9 September 2014

2.6. BACKGROUND TO THE CASE A (aged 59 at the time of the incident) had only been known to mental health services at the Trust for three weeks before the tragic incident which resulted in the death of B at his hand on 20 February 2011.

On that day, A appears to have pushed his wife, and she drowned in Needham Lake in Suffolk. The verdict of the Court was that A was guilty of manslaughter with diminished responsibility (by virtue of mental illness, severe psychotic depression)...

Whilst the early days of their relationship appear to have been described in positive terms (and A's family confirms that they were very attached to each other) it seems that there were a number of difficulties later on. Immediately prior to the incident, in the early part of January,

members of the family received a number of telephone calls from A which led them to think he was worried and unhappy and they had a sense that his health and wellbeing were deteriorating.

Members of his family, and A himself, were able to tell the investigation team about the couple's 22 years together. In particular, they related a significant level of abusive, controlling and bullying behaviour by B towards A. Not only was her health poor (with asthma, diabetes, arthritis, migraines, panic attacks and fainting fits) she seemed highly anxious. For example, she was not content for A to leave her alone, even in a different aisle in the local supermarket. On these occasions, she occasionally had what were described as "temper tantrums" and 'fits.' Once or twice she removed her clothes in public and/or threatened suicide. A described how he would occasionally have to remove a knife from her hand as she stood shaking in the kitchen. Occasionally, the police and/or ambulances were called.

In summary, it appeared that B was psychologically dependent on her husband and they were rarely apart. This is an impression that is reinforced in primary care notes as well as notes made by social care staff and staff of the Trust over approximately the same period (1992-2005). The information provided by members of A's family, coupled with accounts in the care records, and information from A's GP also suggest that he had been depressed for some time before the tragic incident which occurred on 20 February 2011. The GP had, for example, prescribed an antidepressant although the notes apparently suggest that he only took this intermittently... The investigation team has checked and verified this information, and it has been used to supplement the more detailed chronology of events which appears in Section 2.6 below.

## 2.7 Incident Chronology

Date	Event	Comment
1999	A is diagnosed with Irritable Bowel Syndrome and complains of back pain. Notes record frequent visits to his GP. He was prescribed Citalopram 20mg (an anti-depressant) but notes suggest that he took it only erratically.	
16/02/2011	A telephoned the crisis team to say he had felt low, but now was feeling better. Staff nurse X suggested he contact his GP which he agreed to do.	See comment 2.8.3:  ...there was no substantial evidence to suggest that staff in the crisis team responded inappropriately when A telephoned them on the 16 February just over two weeks after his S136 assessment.

		<p>Although, it is likely (with the benefit of hindsight) that A's telephone call on this day, just a short time before the tragic incident which resulted in the death of B, was, in fact, a signal that all was not well, it would have been routine practice to refer back to the GP without sound evidence of the need to respond any other way.</p>
18/02/2011	<p>Worried for his safety and disturbed by his frail appearance, members of A's family took him (after calling the crisis team and following their advice) to see his GP. A told the GP (in his daughter-in-law's presence) that he wanted to kill himself. The GP made an urgent referral to the crisis team describing how A's symptoms had deteriorated in the past 2-3 weeks, including anxiety about his bowels, and thoughts of suicide. He prescribed Citalopram. The family went home again. Members of A's family then left the couple alone for an hour, but continuing to feel concern for A's welfare, they returned to find B hitting him following an altercation...</p>	<p>See comments 2.8.3 (above), 2.8.4 and 2.8.5 (below)</p> <p>2.8.4: The crisis team made a judgement on 16 Feb 2011 when A called; that referral back to the GP was the most appropriate course of action.</p> <p>2.8.5: As it seems that there was insufficient evidence available at the time to warrant use of the Mental Health Act there was no alternative but to let him go home. See comments 2.8.6 and 2.8..7</p>
20/02/2011	<p>...When two representatives from the crisis team visited as agreed, A wasn't there. His son telephoned the team again to check whether, despite this, they would still provide support, which they reassured him that they would. However, when a representative from the crisis team went back for a second time, the police were already there, the house was cordoned off, and it was clear that there had been an incident. It appeared that A and B had gone for a very early drive to the lakes (it was still dark), something they periodically did, and A had allegedly pushed B into the</p>	<p>This was thorough and effective practice</p>

	water. He had then taken an overdose of her Stelazine. By 21:30 that evening, A was picked up by the police and taken to Ipswich Hospital. At interview he was still hazy about the events of that day although he was aware that he had had thoughts of suicide.	
21/02/2011	Having been contacted by the police, the consultant psychiatrist located A on the short stay acute admissions ward where he was receiving treatment for the effects of his overdose. The consultant and the `modern matron` completed a clinical assessment, judging A to be suffering from a profound level of depression with psychotic symptoms. He was subsequently detained under Section 2 of the Mental Health Act.	This was thorough and effective practice
28/02/2011	A's symptoms worsened initially, but by May of 2011 he was improving. His plea of manslaughter on the grounds of diminished responsibility (severe psychotic depression) was accepted.	

#### 14. Lee Anstice

Summary: Lee Anstice, a man with no history of aggression or violence, is upset by breaking up with his wife, Tracy. He feels suicidal in June, 2011 and so is admitted to Albany Lodge for mental health services. Around this date he is prescribed citalopram and zopiclone. He is diagnosed with psychotic depression (although a separate letter notes he is not psychotic) and discharged July 10. By mid-August LA is not doing well, complaining of anxiety, suicidal thoughts, and insomnia. August 24 he sees his GP who calls the Trust to ask why LA has been discharged, perhaps an indication that the GP has concerns about LA's mental state. Two days later he stabs his estranged wife to death, after approximately two months on citalopram. No mention of the medication is made in the news article, and the independent review does not consider its possible role in the tragedy. It finds that the incident was not preventable.

**Tracy Anstice murder: No evidence of husband's violence, report says — (BBC News)**

22 July 2015

<http://www.bbc.com/news/uk-england-beds-bucks-herts-33614396>

Health professionals could not have prevented the murder of a woman by her estranged husband in Bedfordshire, an independent report has said.

Tracy Anstice, 37, was stabbed outside her parents' home in Flitwick, Bedfordshire, in 2011. Lee Anstice, 50, was jailed for 24 years.

The report said there was no evidence that Anstice would be violent despite having suicidal thoughts.

It concluded the incident was neither predictable nor preventable.

Severely depressed

Mrs Anstice died when her husband stabbed her four times on 26 August 2011, with one blow penetrating her heart.

Lee Anstice denied murder, claiming he was hearing disturbing voices

On sentencing at Luton Crown Court in 2012, Judge Richard Foster said Anstice used military training to kill her "with brutal efficiency".

Anstice had denied murder and claimed he was severely depressed and hearing voices which had disturbed the balance of his mind.

Three years on, the independent report - carried out by Verita for NHS England - was called for because Anstice had been a mental health patient with five different health trusts involved in his care.

It looked to assess whether he had received appropriate care and whether any lessons could be learned.

The document said he turned up at the Luton and Dunstable hospital in June 2011 after telling his wife he intended to commit suicide.

It concluded, however, that there was no evidence to suggest he might become violent imminently. It said he had expressed hatred of his wife once, but had no history of violence or aggression.

The report also stated he was well enough to be treated in the community and could not have been sectioned under the Mental Health Act.

### **VERITA Independent investigation into the care and treatment of Mr Z - A report for NHS England, Midlands and East Region**

[http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/LEE\\_ANSTICE\\_AUG11.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/LEE_ANSTICE_AUG11.pdf)

Liz Howes, Tariq Hussain, Dr Peter Jefferys

May 2015

Introduction

On 26 August 2011, Mr Z, a 49-year-old man, stabbed and killed his estranged wife, by whom he had a daughter then aged eight. He was found guilty of murder and sentenced to life imprisonment with a recommended 24-year minimum term.

Mr Z had received inpatient and community care and treatment from five trusts:

#### Analysis

The initial decision to admit Mr Z on 17 June 2011 was made by the SEPT liaison nurse in A&E who learned that Mr Z's wife was employed by SEPT. After a clinical decision to arrange admission had been made, Mr Z's wife requested admission to a non-SEPT bed. Clearance from an on-call SEPT manager was sought and provided. It is clear from the internal reviews undertaken by SEPT and the multi-health agency report that there was a widespread belief within SEPT that such arrangements could be made in these circumstances.

Mr Z clearly needed an urgent admission and it was appropriate for the assessing clinician to take note of the request by Mr Z's wife for an out-of-area admission, given that she was employed by SEPT. The decision on where the admission should be was made late at night by senior management. It is clear that in 2011 SEPT staff believed that reciprocal arrangements for out-of-area admissions were in place to accommodate circumstances such as these. It would not have been appropriate, given the need to arrange immediate admission, for the manager on call to insist on fresh information from Mr Z or his wife about her employment once an available bed had been identified.

This was Mr Z's first contact with mental health services since 1994; therefore there were no issues about the need for continuity of mental health at this stage. Mr Z needed a brief assessment admission to reduce immediate suicide risk. The admission to a bed less than 20 miles from his home met with the trust protocol for out-of-area placement and had no adverse consequences at this stage...

Mr Z's initial management at Albany Lodge was appropriately focused on careful observation and monitoring of his mental state and suicide risk. It was followed by engagement with clinical staff from which two strands of focused work were pursued, both of which were appropriate. One strand was liaison with his wife including arrangements for contact with his daughter, which was appropriate. The second was more intensive psychological work led by a clinical psychologist examining his life situation more widely and adjustment to his changed circumstances. There is useful evidence in his clinical records that he engaged well with both these elements of his care pathway with apparent benefit during the admission. The need for antidepressant medication was carefully considered and Mr Z was appropriately given Citalopram, to continue after discharge.

Following successful periods of day leave and some overnight leave, which was managed appropriately, Mr Z's discharge was delayed. This was primarily because of difficulty re-engaging SEPT who needed to allocate a care coordinator. It was complicated by Mr Z's decision to live temporarily with his parents in Oxford on discharge. Determined efforts were made by the ward clinical team to keep SEPT informed and avoid an ill-prepared discharge. There is no evidence that the delay in discharge from the ward, had a significant adverse impact on Mr Z's mental state or prognosis. A SEPT CMHT care coordinator was

eventually allocated, who had never met Mr Z, and was given the lead in arranging initial follow-up on discharge with the Oxford CRHT team.

A discharge letter, despatched on the day Mr Z left hospital was sent to Mr Z's former GP, registration with a new GP in Oxford was planned, and to the designated SEPT care coordinator. The letter lists discharge medication and includes a diagnosis of severe depressive episode without psychotic symptoms. There is no reference to Mr Z's recent life events or of any risk to himself or others. The care plan and follow up arrangements simply refer to initial follow up by the Oxford CRHT whilst staying with his parents in Oxford and states that his named care coordinator would arrange further follow up as required. This represents the only formal written communication from HPFT relating to Mr Z's hospital admission made available to the professionals who were to take responsibility for his subsequent community care.

We have relied on the information provided in the multi-health agency investigation in relation to Mr Z's referral to the Oxford CRHT team. We concur with the investigation conclusions about the serious operational gaps and flaws relating to discharge and follow-up arrangements.

There was a period of six days between Mr Z's discharge from Albany Lodge and his visit to his GP on 24 August. Neither SEPT nor OHFT undertook a detailed assessment between his discharge from Albany Lodge and 26 August, the date of the incident.

The South Bedfordshire CMHT care coordinator contacted Mr Z to see if he had settled in Oxfordshire. Mr Z told the care coordinator that he had been discharged by the OHFT CRHT team on 10 July, the day he was discharged from Albany Lodge. The care coordinator made an appointment to meet Mr Z on 26 August at 3.00 pm. Mr Z had said that he was coming to Dunstable that day and could see the care coordinator as well.

On 24 August Mr Z went to see his temporary GP in Oxford. As a result of this consultation the GP contacted the OHFT CRHT team by phone on the same day. He wanted to know why Mr Z had been discharged. The person he spoke to was unable to give him any further information because Mr Z had never been formally referred and accepted onto the caseload, and advised him to contact the CMHT, because during working hours urgent assessments go through the team's duty worker.

The GP contacted the CMHT as directed and left a message on the answer phone requesting a call back by the end of the day.

The GP received no response, so on 25 August, after 5.00 pm, he faxed a referral to the City Central CMHT in Oxford. The referral requested an urgent assessment as Mr Z was having thoughts of self-harm, although he did not have a suicide plan. He had complained to the GP about poor sleep and anxiety. The GP wrote the following in his referral:

"Mr Z had insight and was not suicidal;

his mother was dispensing medication, which was citalopram 120mg once a day and zopiclone 3.75mg once or twice a night, and he had a prescription until the 24 August; and

Mr Z has an appointment with his care coordinator Friday 26 August”.

The referral was read by the duty worker on 26 August. He made three attempts to call Mr Z and left a message on his answer phone for him to call back.

On the same day, Mr Z failed to keep his appointment with his care coordinator in Dunstable.

When we met with Mr Z he told us that he received the message on his phone but by this time he had decided to kill himself so did not ring back.

Also on 26 August [the day of the murder], the psychiatrist from the OHFT CMHT called the GP to discuss the case in greater detail. The GP provided further information about Mr Z’s circumstances, including that he had taken an overdose due to the breakdown of his marriage and he had no previous psychiatric history before the marital problems. The GP said that in his clinical judgement Mr Z was a low risk to himself. The GP also reported that Mr Z had told him he had an appointment with his care coordinator in Dunstable for “today” (Friday 26 August) but the GP did not know the name of the coordinator or which CMHT.

#### Finding

We find that the incident was not preventable.

## 15. Terence Kirby / “T”

Summary: Chauffer TK has been married for 30 yrs to his 5<sup>th</sup> wife, Myrna. He has reported being depressed before; in 1990, when his son died, and again in 2008. In 2008 his GP prescribed him Fluoxetine and Diazepam for one month without following up. Myrna finds him difficult and controlling and is considering leaving him. Upset over this, and feeling mildly suicidal, he goes to his GP in late November 2012, and his GP prescribes Prozac (fluoxetine) again. On 10 December he returns to his GP who advises him re: alcohol use and blood pressure. On 16 December TK presents with active suicidal thoughts and plans. On Dec 17, 2012 he is admitted to a mental health service for older people. Dec 24 2012 TK is discharged and transferred to the care of the South East Crisis Assessment and Treatment Team (CATT). On January 4, 2013 the CATT team speaks to him on the phone. On Jan 11 his son finds his parents dead at their home; TK has suffocated his wife and hanged himself. The BBC reports the murder-suicide but Prozac is not mentioned. Similarly, the independent review notes the medication without considering that it was a potential contributing factor.

**Pensioner killed fifth wife then hanged himself because he couldn't face another divorce — (The Mirror)**

<http://www.mirror.co.uk/news/uk-news/pensioner-killed-fifth-wife-hanged-4117980>

16:32, 27 Aug 2014

Sam Rkaina

Chauffeur Terence Kirby and his wife Myrna had been married for 30 years but lived apart for two as their marriage floundered.

A pensioner with a string of failed marriages killed his fifth wife then hanged himself because he couldn't face another divorce, an inquest heard.

Chauffeur Terence Kirby, 70, and his wife Myrna, 57, had been married for 30 years but lived apart for two as their marriage floundered.

They were both found dead on January 11, 2013, when Mrs. Kirby's son Frederick called at his stepdad's home in Cheshunt, Herts.

She was in her nightclothes with a pillow over her face having been suffocated, while her husband was found hanging from the bungalow's loft.

Happier Times: Terry Kirby killed his fifth wife Myrna and then took his own life, the inquest heard

Philippines-born Mrs Kirby had filed for divorce in December 2010 and moved out and her husband developed a drink problem and depression as he struggled to cope.

He was admitted to hospital in December 2012 but then released for Christmas and was visited by his wife who returned to stay with him.

An inquest heard she told her husband there was a chance she might take him back despite finding him 'controlling' and being scared of him.

Mr Kirby told healthcare workers 'life would be perfect if the divorce was not going ahead' but continued to drink and was plagued by insomnia.

Controlling Husband: Mrs Kirby was afraid of her husband, the court was told but had filed for divorce.

His wife, a carer and regular churchgoer, called social workers on Boxing Day when she resisted his demands for alcohol, which she had hidden.

The inquest heard Frederick last heard from his mother on January 7 and the coroner said it was possible they could have died around two days apart.

Tests found Mr Kirby had 75mgs of alcohol in his blood - just below the legal limit of 80mgs.

His children had questioned whether he should have been released from hospital and if there was enough contact from community workers.

But Edward Thomas, the coroner for Hertfordshire, said Mr. Kirby had gone to hospital voluntarily and not been detained under the Mental Health Act and his wife had agreed to move back in over the Christmas period.

Gruesome Discovery: Police officers arrive at the property of Mr and Mrs Kirby, Great Cambridge Road, Cheshunt, at the time of the murder suicide.

He told the inquest at Hatfield that the killing of Mrs. Kirby had been 'an impulsive act' and said the presence of two mugs in the kitchen suggested there had not been an argument.

He said: "She explained there had been ups and downs and he had been abusive and had called her names. But he was never physically violent toward her. He was controlling.

"Her injuries show she was for example smothered with a pillow or a duvet."

"What is indicated is he didn't want a divorce. Clearly the impact of the divorce affected him and so did being described as controlling.

"We'll never know what actually happened on the day she died. His homicide and suicide was not predictable, there was no sign saying 'get me out of here'."

Mr Thomas ruled Mr Kirby's death was a suicide while Mrs Kirby's was an unlawful killing.

In a joint statement at the time of the couple's deaths their children said: "Our parents always wanted the best for us and were incredibly dedicated and loving."

The children all refused to comment after the inquest.

## **[An independent investigation into the care and treatment of a mental health service user \(T\) in Hertfordshire](#)**

[http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/TERENCE\\_KIRBY\\_JAN13.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/TERENCE_KIRBY_JAN13.pdf)

September, 2015

Chronology created from excerpts extracted directly from different sections of the report:

9.3 A referral was made by T's GP to a psychiatrist at Chase Farm Hospital in September 1989. M had asked the GP to visit as an emergency, and T was described as 'agitated, rather incoherent and uncommunicative' and talked of financial problems. This letter notes he has 'no past psychiatric history'. The GP reported prescribing Diazepam 13 5mg three times a day for three days. The notes do not record any response to the referral.

4.7 T...had been in a relationship with M since 1984, and they married in 1989. This was T's fifth marriage. M came from the Philippines, and she and T had a son and a daughter. Their son lived nearby in Hatfield and they saw him regularly. Their daughter lives in Canada, and T had visited her in 2012.

4.19 In October 2008 T presented to his GP as 'very very low', he said he had a similar episode 18 years earlier when his son died. At the time no obvious triggers were identified though he reported not sleeping since his mother in law died a month before. He said he was not close to her though. At this consultation T reported that he had low moods on and off throughout his life, and masked this with smoking and drinking at times. He said his mother had similar episodes.

4.20 The GP prescribed Fluoxetine<sup>14</sup> 20mg and Diazepam 2 mg three times a day. The GP notes state for 'review in two weeks'. There is no note of follow up by either the GP or T and only one month's prescription of Fluoxetine and Diazepam was issued.

4.9 The notes record that M said their marriage had its 'ups and downs' and she had left T on previous occasions due to his behaviour. She had separated from him about two years earlier [late 2010/early 2011], and was living in her own flat. A year later she had instigated divorce proceedings, which were due to be completed a few weeks after November 2012, when his mental health deteriorated.

1.7 T had a self-reported history of depression dating back over several years, but had no contact with secondary mental health services until November 2012. His GP made an urgent referral on 27 November 2012 to mental health services at Hertfordshire Partnership NHS Foundation Trust (HPFT). T presented with suicidal thoughts and a plan to use a rope to hang himself.

4.22 On 27 November 2012 T attended his GP again, and an urgent referral was made to the Hertfordshire Partnership NHS Foundation Trust mental health service single point of access (SPA). T completed a Patient Health Questionnaire (PHQ-9)<sup>15</sup> with a score of 25. This would indicate a severe depression. Question 9 on this scale is 'Thoughts that you would be better off dead, or of hurting yourself in some way' screens for the presence and duration of suicidal thoughts. T has scored 'for several days' on this question, all other answers are nearly every day, for example for Question 2 'feeling down, depressed, hopeless'. The results of the PHQ-9 were conveyed in the GPs referral letter, and he was described as having 'marked depression' and 'suicidal thoughts'.

1.8 He was initially assessed on 5 December 2012 by a community psychiatric nurse (CPN) from the mental health services for older people. At this assessment the CPN recommended that he be seen by a psychiatrist at outpatient clinic, and be referred to psychology. At this time he had suicidal thoughts but no plan. The plan of care was not actioned. **[NOTE: FROM THE DEC 17 note it is clear that fluoxetine, or Prozac) was prescribed at this visit.** He had taken Prozac before, in 2008, for at least one month.]

1.9 T presented on 10 and 16 December 2012 to the emergency department at Chase Farm Hospital Enfield, intoxicated and complaining of chest pain. He was discharged to the care of his GP on 10 December with advice to monitor alcohol use and blood pressure. On 16 December he presented with active suicidal thoughts and plans, and a mental health assessment recommended informal admission.

(Report page 42-43) December 17, 2012 ENFIELD ACUTE ASSESSMENT CENTRE (MH) LAMBOURN GROVE (bolding added):

Chase farm A&E notes: 11.50: Assessment by Enfield Acute Assessment Centre – part of Barnet, Enfield and Haringey Mental Health Trust: Mental health assessment carried out by CPN, thought to be at risk of suicide therefore decision taken to admit to Lambourn Grove - referral to HPFT CATT for admission.

Chlordiazepoxide 40mg Admitted to Lambourn Grove as an informal service user accompanied by his wife. Presented as: Low in mood, no eye contact...

Poor coping strategies and if wife leaves again then risk could again become high. Wife also disclosed to doctor (but did not want T to know): Separated from T for about a year and lives on income support , Has been staying with T over the past two weeks and helping him with food and washing due to mental illness, She was scared of him because of his shouting at her if she did not get him a drink, She has told him she will probably get back with him – she still loves him, Marriage had ups and downs and he was verbally abusive to her on occasions, Left him many times and one went to a refuge and also went to the police in 2007 because she was fearful for her life. Always went back to him because of children and because she loved him Never physically violent towards her but very controlling and forceful. Finally decided to leave him for good, got a flat and filed for divorce. T told her that second wife ‘put him in prison’ and wife said this is probably true as it is on his CRB form.

**Dec 17, 2012 notes include the following: Observations reduced to ten minutes, with plan to increase if necessary. Px Fluoxetine 20mg (started 2 weeks ago) Tamsulosin, Diazepam alcohol withdrawal reducing regime, Simvastatin, Amlodipine Dispersible Aspirin Thiamine 19/12**

1.10 T was admitted to Lambourn Grove, a mental health service for older people, on 17 December 2012, and went home on leave on 22 December 2012. He was transferred on 24 December 2012 to the care of the South East Crisis Assessment and Treatment Team (CATT), following discharge from the inpatient unit and a period of weekend leave. T had not returned for the planned review meeting and did not want to return to hospital.

1.11 CATT team contact was made by phone and home visits. T was seen on 5 occasions, and spoken to by phone on 3 occasions. There was more frequent contact by phone with M, who was staying with him.

1.12 T’s last contact was with a CATT community support worker by phone on 4 January 2013, when he declined a home visit. CATT staff made phone calls on 6, 7, 8 and 9 January; and a cold call to the house on 11 January 2013; none of these elicited a response.

1.13 A police welfare check was requested, and on 11 January 2013 Hertfordshire police attended the property. T & M’s son had already entered the property, and found his parents deceased.

1.14 Both were deceased. M was found in bed apparently suffocated, and T was found hanging from the loft hatch.

## 16. David Clairmonte

Summary: David Clairmonte has Crohn's disease, and is prescribed sertraline by his GP. He becomes suicidal, threatens to jump off cliff, gets into serious debt, takes illegal drugs, and breaks up with his girlfriend. His GP sends him to Luton & South Bedfordshire CRHTT. "Non-compliant with medication", he quits taking the sertraline in late May, 2011. He becomes agitated and disturbed, and on June 17 he burgles his father's home, entering by breaking a window. A few days later, he bludgeons 69-yr-old neighbour Fred Hodson to death during an attempt to get his PIN and steal from him. The independent review does not explore the potential role of the medication in the violence, and the news article does not mention it.

### **David Clairmonte burgled father days before Luton murder — (BBC News)**

<http://www.bbc.com/news/uk-england-beds-bucks-herts-17268847>

7 March 2012

David Clairmonte tried to obtain a loan in the hours before the murder

A man burgled his father's home days before he bludgeoned a widower to death, a court has heard.

David Clairmonte, 26, of Thornview Road, Houghton Regis, was jailed for life in January for the murder of Fred Hodson in Luton.

At Luton Crown Court earlier, he admitted to two burglaries, on 11 and 13 June, days before killing Mr Hodson.

Clairmonte was jailed for two years, to run concurrently with his 30-year term for Mr Hodson's murder.

Daniel Siong, prosecuting, said Clairmonte broke into his father's home in Statham Close, Luton, by smashing a conservatory window.

He took a 42in television, and two days later went back and in total took £10,000 worth of items.

His father was on holiday at the time.

In January, a jury heard Clairmonte attacked Mr Hodson for his Personal Identification Number, because he was desperate for cash.

He bound the 69-year-old's hands with electrical tape and led him from room to room, beating him 13 times around the face and head with a hammer he had found in the garden shed.

Clairmonte had denied murdering Mr Hodson, claiming he had stumbled on the "horrific" aftermath at the house in Vespers Close, Luton.

## Niche - An independent investigation into the care and treatment of a mental health service user (Y) in Bedfordshire by South Essex Partnership University NHS Foundation Trust

[http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/DAVID\\_CLAIRMONTE\\_Jun11.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2015/12/DAVID_CLAIRMONTE_Jun11.pdf)

August, 2015

### The Incident

1.5 On the early evening of 25 June 2011 Y went to the house of Mr Z in Luton. He had met Mr Z previously, when Y had worked on his roof with his father. Y attacked Mr Z with a hammer, allegedly to try to gain the PIN for his cash card. Mr Z was discovered by a neighbour and died in hospital later that evening from his injuries.

1.6 Y had two short periods of contact for assessment with secondary mental health services in April and June 2011.

1.7 He was initially referred to mental health services by his GP on 19 April 2011, after being found by police threatening to jump off a cliff. He was seen for assessment on 24 April 2011 by the Luton & South Bedfordshire Crisis Resolution and Home Treatment Team (CRHTT) and was assessed as not suicidal or a risk to others at the time. He refused to be referred to the community mental health team (CMHT) and was referred back to his GP.

1.8 On 23 June 2011 his GP again referred him to the CRHTT after he had attended Accident and Emergency at Luton and Dunstable Hospital (A&E) having cut his wrists, and presented to his GP with depression and suicidal ideation.

1.9 Y was assessed on 25 June 2011 by a nurse and healthcare worker from the CRHTT, and was offered admission to the short term mental health assessment unit (MHAU). The assessment noted that Y reported he had split from his girlfriend two weeks previously, that he had debts of up to £10,000, and was unable to work because of his physical illness (Crohn's disease<sup>1</sup>). It was also noted that he said he was on police bail for criminal damage to his girlfriend's home, due to return to the police on 28 June 2011. He was offered admission to the MHAU with agitation, restlessness, low mood and fleeting suicidal thoughts; for 'further assessment of his mental health state'. The assessment notes record 'if declined, to be offer [sic] home treatment'. The plan following the assessment was not agreed and documented.

1.10 The CRHTT received a phone call from Y's aunt later on 25 June 2011 stating that she had spoken to Y and he was refusing to come into hospital and was not at home. It was planned to visit Y the following day, and a telephone call was made to him by the CRHTT. There was no voicemail facility. At 10.20 on 26 June 2011 a phone call was made by the CRHTT to Y; he did not answer and there was no voicemail facility. The team then phoned his aunt who told them Y had been picked up by the police the previous night because he was disturbed at home. The family had called the police after Y threatened to harm himself whilst under the influence of alcohol.

1.11 Later that evening [June 25, 2011] Y was arrested on suspicion of the murder of Mr Z.

1.12 A Mental Health Act assessment was carried out in custody and he was judged to be fit to be detained and interviewed.

1.13 On 26 January 2012 Y was found guilty of murder, and sentenced to life imprisonment, with a recommendation that he serve 30 years. It was acknowledged in court that Y's brief contact with mental health services played no part whatsoever in the incident. Y entered a plea of not guilty of murder and there was no plea in relation to manslaughter due to diminished responsibility...

#### 4.7 Psychiatric history

4.7.1 Y's stepfather left the family home in December 1995, when Y was 10. His mother reported that Y had become withdrawn and would not speak to anyone in the family. His mother asked the GP to refer him for counselling. The GP wrote to Child and Family Services in February 1996, but there is no record of any follow up. Y's family reported that he wasn't ever seen by Child and Family Services.

4.7.2 A GP referral was made to the Community Mental Health Team at Beacon House, Dunstable, following a consultation on 19 April 2011. Y attended his GP's after being found by police attempting to jump off a cliff 2 days previously, and the police had instructed him to see a doctor.

4.7.3 Y reported making a suicide attempt in the past, but had not apparently discussed this with his GP.

4.7.4 He was seen at his home address by the Crisis Resolution and Home Treatment team (CRHTT) on 24 April 2011, and told them this crisis was mainly triggered by splitting up with his girlfriend, and that he also was unemployed and had financial difficulties. He said he had been drinking at the time, and wanted the police to shoot him because he didn't have the courage to kill himself.

4.7.5 Y was offered a referral to the Community Mental Health Team (CMHT) psychiatrist but he declined, saying he didn't want to be locked up, and was not mentally ill. He was advised to seek help for the anger problems he described, but refused, reportedly saying he didn't need any counselling or therapy. He said he would rather be treated by his GP, and the assessment report back to the GP suggested medication to help with sleep and fluctuating moods.

4.7.6 He was again referred to the CRHTT on 23 June 2011 after seeing his GP in the company of his aunt. Y had cut his wrists 2 days earlier and attended A&E for treatment. This GP had just taken Y on as a patient since his previous GP retired, and had met had only met Y once before, some years previously. The GP reported that Y had been prescribed Sertraline 80mg, and had been feeling better, but had stopped taking it about 4 weeks previously.

4.7.7 He was described by the GP as being suicidal and low in mood, but difficult to engage. The GP phoned the CRHTT to arrange an urgent appointment. The GP reported to the internal investigation that the CRHTT agreed to offer an assessment within four hours, and he recorded in the GP notes that it was his understanding that Y and his aunt would be together until this assessment occurred.

4.7.8 Y was contacted by the CRHTT on 23 June 2011. Notes record that he said he didn't want to see them at home on the initial date and time offered because he wanted his aunt to be present, and she was not available until 25 June. An appointment was arranged for 25 June 2011. He was seen at the CRHTT office in Lime Trees, Luton with his aunt on 25 June 2011

**4.7.9 Y was seen and assessed by a qualified nurse and a healthcare worker, accompanied by his aunt. The assessment recorded that he had suicidal thoughts, had split up with his girlfriend and had debts up to £10,000. Y reported that he had no money and had resorted to selling his property to live. The assessment reported him as being 'non-compliant with medication'. He described poor sleep due**

**to his Crohn's disease symptoms, and was taking painkillers (diclofenac9) for pain. At this time Y had been prescribed sertraline 50mg and diazepam10 4mg.**

4.7.10 The assessment took place with Y's aunt present, though staff also spoke to each of them independently.

4.7.11 Y told these staff that he had no history of contact with mental health services, and it was reported in the assessment notes that this was his first referral. This was not in fact true, as he had been assessed by the CRHTT in April 2011 after a similar GP referral. This assessment was referred to in the GPs faxed referral letter of 23 June 2011.

4.7.12 Y was noted to be restless, anxious and 'very disturbed', with low mood. Risk to self was recorded as 2 'medium' on the Trust's 'First contact/crisis assessment of risk' form. This form also recorded his risk to others as 1 'low'.

The recorded plan was to offer admission to the MHAU for 'further assessment and monitoring of his mental health'. A bed was booked at MHAU, and it was recorded that he should be offered home treatment if he declined. We interviewed the assessing nurse, who reported concern that Y did not know what medication he had been prescribed, or where his tablets were. The result of this assessment was a recommendation that he should be admitted voluntarily to the MHAU, where he could be helped with his agitation...

#### 4.4 Substance misuse history

4.4.1 Y disclosed to CRHTT staff that he had used cannabis in the past, but it didn't agree with him, and he was drinking 10-15 units of alcohol per day in June 2011, which was more than he usually drank. The assessment reports that Y said he had taken cocaine in the past, most recently about two months previously.

4.4.3 In a statement to the police his ex-girlfriend has claimed that both she and Y were drug users, using speed, cocaine and crack and Y had begun to steal to fund his drug use.

DATE	SOURCE	DETAIL
Not noted in report	Date would be some time between 2009 when "Y" went to his GP and was prescribed medication for Crohn's, and April 19, 2011, when the GP referred him to CMHT, Beacon House, for threatening suicide	Prescription issued for sertraline (Lustral, Zoloft) By June 23, 2011, the report noted that he had been taking sertraline but stopped 4 weeks previously, one month before the murder
16 or 17/4/11	GP notes	Caught by police trying to jump off a cliff- was advised to see GP, saw GP 19/4/2011 and talked of suicide
19/4/11	GP notes	Referred to psychiatry, beacon house, Dunstable asking for assessment
24/4/11	GP notes	Seen by CRHT team at home. Refused CMHT input, not suicidal at interview, advised to see GP for medication if

		needed.
23/6/11	SEPT notes	GP letter asking for Y to be seen again (mentions April assessment) was taking Sertraline but stopped 4 weeks ago. Cut to wrists & suicidal thoughts.

## 17. Tony McLernon

Summary: TM has been under the care of mental health services since the age of 8. He has a history of heavy drinking, violent outbursts, poor self-control and domestic abuse. Already taking "anti-psychotic" meds for an undisclosed period of time, in March 2010 his "low mood" is attributed to alcohol abuse. In October 2010 he is prescribed antidepressants for "mild depression", and he is subsequently sectioned for self-harming in public, and threatens suicide. He continues to drink heavily, argues with girlfriend Eystna Blunnie, gets her pregnant, they break up. She reports being afraid of him when he is drinking. After a few violent episodes he kills her. The medication is not mentioned in news articles, and the review report does not consider its possible role in contributing to the tragedy.

### **Tony McLernon Charged With Killing Pregnant Eystna Blunnie And Her Unborn Child — (The Huffington Post)**

[http://www.huffingtonpost.co.uk/2012/06/30/tony-mclernon-charged-wit\\_n\\_1639676.html](http://www.huffingtonpost.co.uk/2012/06/30/tony-mclernon-charged-wit_n_1639676.html)

30/06/2012

A man has appeared in court charged with the murder of a pregnant woman and the death of the unborn baby girl she was carrying.

Tony McLernon, 23, of North Grove, Harlow, Essex, is accused of killing Eystna Blunnie, who was found fatally injured in Howard Way in the town in the early hours of June 27.

He also faces a charge of child destruction after it emerged that 20-year-old Ms Blunnie, from Halling Hill in Harlow, was heavily pregnant at the time of her death.

Ms Blunnie was taken to Princess Alexandra Hospital in Harlow but died of multiple head and facial injuries.

Her profile picture on Facebook featured a recent ultrasound scan. She told friends she "could not wait" to be a mother and added: "Only 17 days and counting."

Essex Police said McLernon appeared before magistrates in Chelmsford and was remanded in custody to appear at Chelmsford Crown Court on Tuesday.

## OVERVIEW REPORT INTO THE DEATH OF Eystna Blunnie ON 27 June 2012: Report produced by Jackie Sully on behalf of the Safer Harlow Partnership

[http://www.hundredfamilies.org/wp/wp-content/uploads/2013/12/TONY\\_McLERNON\\_Jun12.pdf](http://www.hundredfamilies.org/wp/wp-content/uploads/2013/12/TONY_McLERNON_Jun12.pdf)

23 October 2013 (Updated 14 January 2014, 26 March and 30 June 2014)

Excerpts:

### EXECUTIVE SUMMARY

#### 1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the sudden unexpected death of Eystna Blunnie in Harlow, Essex on 27 June 2012. During the early hours of 27 June 2012, Essex Police and ambulance services were called to Howard Way in Harlow, following a report that a female was lying in the road having apparently been run over.

Enquiries eventually revealed the female to be Eystna Blunnie, who was nine months pregnant and just days away from giving birth. Eystna Blunnie had sustained a serious assault having gone out to meet the perpetrator TM in the early hours of the morning, and later died of massive head injuries inflicted during the assault.

In Feb 2013 TM was found guilty of the murder of Eystna Blunnie, and of child destruction. He was sentenced to life imprisonment, with a minimum term of 27 years.

#### 2 The Review Process

This summary outlines the process undertaken by the Harlow Domestic Homicide Review Panel in reviewing the death of Eystna Blunnie.

On 27 June 2012 Essex Police notified the Chair of the Safer Harlow Partnership of the death of Eystna Blunnie as the circumstances of the death fitted the Home Office criteria for the establishment of a Domestic Homicide Review. The Review was conducted in accordance with the Multi-Agency Guidance for the Conduct of Domestic Homicide Reviews 2011.

The Home Office was informed of the intention to conduct a DHR on 9 July 2012 and the first panel met on 2 October 2012.

The process has been completed and a report was submitted to the Home Office in October 2013.

### DOMESTIC HOMICIDE REVIEW OVERVIEW REPORT

OVERVIEW OF AGENCY INVOLVEMENT WITH Eystna Blunnie (victim) and TM (perpetrator);

Scope of the review

Eystna Blunnie was in an on/off relationship with TM for approximately eighteen months before her death, though for the final six months, both stated that the relationship was over. By this time however, Eystna Blunnie was pregnant with TM's child.

The DHR panel agreed that the period to be covered by this review should be from January 2010 until June 2012 which is the approximate time period covering Eystna Blunnie's relationship with the perpetrator, until the date when Eystna Blunnie was tragically murdered. Agencies were also requested to include any other significant incidents prior to this date that would or could have relevance for the review.

A summary of the individual agency contact with the victim Eystna Blunnie, and the perpetrator TM, is detailed within the first section of each organisational report. This information is taken from the IMRs and includes any other relevant details within the chronology of events. This section is followed by a summary of policy, procedure and individual practice. The final section of each agency review contains the author of the Overview Report's observations and analysis of the relevant issues identified within the context of each separate agency's involvement with Eystna Blunnie and TM.

1.1.6 In early February 2012 Eystna Blunnie reported to her midwife at a routine ant-natal appointment that she had split from her partner (TM) and that he had taken her maternity notes. PAH issued a duplicate set of notes to Eystna Blunnie.

1.1.7 Following an appointment where TM attended with Eystna Blunnie on 23/03/12, an incident took place on the labour ward. It was recorded that "TM appeared to be intoxicated". Several members of staff were concerned as they were both arguing loudly. Eystna Blunnie was asked if she had any concerns for her safety and she responded by saying that she "felt safe with him around, but didn't like him when he was drunk".

1.1.9 Eystna Blunnie attended another anti-natal appointment with her mother in early April 2012. The midwife challenged Eystna Blunnie's safety but was informed that Eystna Blunnie was now at home with her parents. Eystna Blunnie's mother informed the midwife that TM had a history of violence. Eystna Blunnie was advised to call the police if TM tried to make contact.

1.1.10 After a violent incident between Eystna Blunnie and TM in April 2012, PAH received the relevant DV/1 form from the police. The incident took place at TM's home and he was subsequently graded as high risk. Eystna Blunnie again had the opportunity to disclose any episodes of domestic abuse, but informed the community midwife that she was safe at her parent's home.

11.1.14 Towards the end of May Eystna Blunnie was still telling the midwives that she had no contact with TM and "felt safe" at her parent's home. 1.1.15; All other appointments with the midwives including two home visits note that Eystna Blunnie was doing well and seemed relaxed.

## 1.2 Agency involvement relating to TM

1.2.1 TM had five recorded attendances to the Accident and Emergency (A&E) dept. of the local hospital, two following an assault (though it is not clear whether TM was the victim or the perpetrator

on these occasions), one visit was as a result of self-harm, one as a result of alcohol and ecstasy abuse, and one was due to a football injury.

## 2 NEPFT (North Essex Partnership NHS Foundation Trust);

### 2.1 The following section of the report relates to TM only;

2.1.2 The Trust had the first contact with TM when he was eight years old, and he was seen by child and adolescent psychiatric services, following a referral by his then GP. He was assessed after parental concerns regarding behavioural issues, anxiety and hearing voices. At that time the diagnosis was that he did not have a psychotic illness, and was only offered additional support at school, where things did improve. He did not attend follow up appointments and the case was closed in July 1997.

2.1.3 TM had seven subsequent episodes of care with mental health and substance misuse services, and was actually discharged on 31/05/12. 2.1.4; NEPFT has a note on file that there was a domestic abuse disclosure made in 2007 by a previous partner of TM's in order that future partners could be made aware and "protected".

2.1.5 An earlier Multi Agency Public Protection Arrangements (MAPPA) report sent to NEPFT states that TM has a history of violent offending against intimate partners, and that he fails to understand the impact of his actions.

2.1.6 It was further noted that TM also fails to take responsibility for his actions and blames everyone else for what has occurred.

2.1.7 As far back as 2009 there were notes on TM's record of a referral due to fits of uncontrollable rage and heavy drinking. It was recorded that one way of coping with these outbursts was by punching the walls. TM also stated that he was worried about harming his own family at this time. Further appointments to work through these issues were offered, but TM failed to attend any of them. His GP was later informed that the case was closed.

2.1.8 It is understood that there is a prescriptive internal process to be instigated when patients do not attend planned appointments, but there is no evidence that this process was followed by NEPFT, and TM was discharged into the care of his GP. There was no real communication between the two NHS organisations regarding this transfer of care.

2.1.9 In 2010, TM's father contacted ADAS (Alcohol and Drugs Advisory Service) regarding TM's mental state. Mr. M senior stated that TM was drinking 23 cans of beer per day and that his violence was escalating. The family did not know what to do and felt particularly vulnerable.

2.1.10 ADAS made a referral to CMHT (Community Mental health Team) who undertook a full assessment of TM in March 2010. His "low mood" was attributed to alcohol abuse. TM stated that he was easily irritated and could react violently to very insignificant issues. He also disclosed that he did bare knuckle fights for money. TM had already completed a prison sentence at this time, and during the assessment, he admitted that he had been sentenced to prison for nine months for ABH (actual bodily

harm). He also stated that he was released on license but was recalled to prison when he committed an act of criminal damage. It should be noted that he made no reference to domestic abuse or violence to intimate partners in either of these disclosures.

2.1.11 A further assessment was completed at the end of March 2010 where TM admitted that he had been abusing alcohol for four years, drinking approximately 85 units per day, and was also using cocaine 1 to 3 times per week. This was the first time that drug use had been brought into the conversation. He was assessed as “at risk” of harm to himself and to others, due to his previous history of violence and continued street fighting. This was further exacerbated when he was under the influence of alcohol.

2.1.12 TM was referred back to ADAS as he was not prepared to take part in any programmes that required him to stop drinking completely. He stated that he was prepared to cut his drinking down to weekends only, but not to stop altogether. 2.1.13; In July of the same year TM was temporarily detained in Shannon House under Section 136 of the Mental Health Act. He was heavily under the influence of alcohol. It was recorded that he had been fighting with his brother and smashed some glasses, using some of the broken glass to cut his neck, though he denied that this was selfharm. He was released the next day when he was sober with recommendations to contact ADAS or CDAT again. TM failed to follow this up.

2.1.15 TM was discharged from mental health services in late December 2010, and did not appear again until 14 March 2012. TM was taken to A&E by his parents, under the influence of alcohol and ecstasy, and was allegedly threatening to kill himself. He was sectioned, assessed, but released the next day, as there was no underlying mental disorder diagnosed.

2.1.17 In June 2012 after his arrest, TM was visited by a social worker within Chelmsford Magistrates Court where he stated that he and Eystna Blunnie had been together for a year and that she was expecting his child. This was the first recorded acknowledgement that Eystna Blunnie’s child was his.

4.1.6 In March 2010 notes record that a referral was made from ADAS for TM to attend CDAT, but again TM did not attend.

4.1.7 In July 2010, TM was sectioned into the care of NEPFT for “cutting his neck in a public place”. An assessment was completed at that time but the conclusion reached was that the cause of TM’s problems was alcohol abuse and that he did not have any underlying mental health issues. He was left to self-refer to ADAS following this episode as he had failed to attend the previously booked CDAT appointment.

4.1.8 In October 2010 TM attended the practice with his mother, and was still reporting issues with anger management. Minor depression was identified and medication prescribed. Further support and psychotherapy were both offered.

4.1.9 Following TM’s prison sentence there are notes on his file relating to a discharge summary sent to the GP after TM’s release. This summary makes reference to TM’s mental health issues whilst in prison.

There is also a note on file in relation to the antipsychotic medication prescribed which is generally only used in secondary care, and is not usually prescribed within general practice/primary care.

4.1.14 The CMHT assessment concluded once again that TM had no underlying MH issues and that the cause of TM's problems was his excessive and habitual alcohol consumption. CMHT sent another referral off to CDAT and to ADAS, but noted that TM was poorly motivated to address these issues and to take responsibility for himself and for his actions. 4.1.15; In July 2012 the practice received a notification from the Mid Essex Criminal Justice Mental Health Team (part of NEPFT) that TM had undergone a mental health

4.3.4; It is factual that unless a person is sectioned under the Mental Health Act, they cannot be detained against their will. However someone who is continuously presenting with the same on-going issues to NHS generalist services, as well as to specialist Mental Health Services seems to be able to bypass the system by not attending any referral appointments or follow up consultations. A lack of timely interagency information, as well as no formal intervention process, enables this to continue.