

# Review of Homicides by Patients with Severe Mental Illness

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## **Introduction**

Although homicides committed by the mentally ill account for only a tiny proportion of all violent deaths in England and Wales, such events have been a focus of debate since the publication of the Ritchie report in 1994.

There have been many independent Inquiries since the Ritchie report, and opinion on their value remains divided. There is a feeling that their conclusions have become repetitive, and the current review arose from a desire to ensure that they have an impact on clinical practice. The intention of the present study is to review all available data, including independent homicide Inquiry reports, relating to patients with severe mental illness and a history of violence, in order to draw out practical lessons for services.

Two approaches add structure to the case review. The first is the application of the HCR20, a structured clinical assessment of violence risk. The second is Root Cause Analysis, which attempts to look beyond the immediate causes of serious untoward incidents. The intention is not to attempt a replication of the detailed work of an independent Homicide Inquiry, but to draw out underlying themes that are likely to be useful in the management of future cases.

## **Method**

### ***Case selection***

Cases were selected from the Confidential Inquiry into Suicide and Homicides by Psychiatric Patients (CISH) database using the following criteria:

1. A current patient of NHS mental health services in England and Wales committing a homicide during the last ten years
2. A diagnosis of “Schizophrenia or other delusional disorder” or of “Bipolar affective disorder” as recorded on the Homicide Form for the Confidential Inquiry.
3. Availability of Confidential Inquiry forms and at least one psychiatric court report relating to the homicide.
4. A history of previous violence known to the mental health team before the homicide occurred.

### ***Rationale for the case selection criteria***

The method of review is time consuming so it was not possible to look at all homicides. I chose to concentrate on those that should have been a priority for services, in that the patients had a major mental illness with psychotic features, and they had a history of violence which was known to the service looking after them.

I concentrated on recent cases because policies and practice in this area have changed rapidly and older cases may not be relevant. On the other hand, the cases could not be too recent as it takes time for them to get into the system and for the Inquiry to be conducted.

### ***Description and Analysis***

Data were gathered from all available sources, including CISH records, psychiatric reports prepared for the trial, the Homicide Inquiry reports, and clinical records.

The data were used to complete the HCR20, a structured clinical assessment of violence risk, for each case.

### ***The HCR20***

The HCR20 has been widely used in clinical populations and is a standard assessment within many forensic psychiatry services in the UK. It consists of 10 Historical, 5 Clinical and 5 Risk Management items relating to a patient. Each can be scored as definitely present, probably or partially present, or absent. A list

of the items is provided as an appendix. The items were chosen because each has been shown in the literature to be associated with an increased risk of violence. For example, substance misuse and psychopathy are two of the Historical items.

In broad terms, the H, C & R groups relate to past, present and future. The Historical items are concerned with past behaviour, personality and mental illness. The Clinical items relate to current mental state and behaviour, and the Risk Management items relate to estimated functioning in the future. The latter items include the feasibility of future plans, the likely presence of stressors and destabilisers in the patient's environment, the presence or absence of personal support, and the likelihood of compliance with treatment. Although these items relate to the future and are therefore predictions, they are not predictions that require a crystal ball. It is fairly easy to make such estimates in a patient who is well known to services, and these items have a high degree of inter-rater reliability.

The second part of the HCR20, having collected the data to complete these 20 items, is to suggest feared scenarios of future violence, with an assessment of the factors likely to make them more or less likely, leading on to a management plan. There is a predictive element to this exercise, but it grows out of a knowledge of a patient's actual or threatened violence in the past. I have not attempted this exercise on this sample, as the problem of hindsight made it too artificial and potentially misleading.

### **The Sample**

The CISH provided data for all cases fitting the criteria from 1995 to 2002. On manual inspection and consideration of further reports, a few of the cases did not fit the criteria and were discarded. The reasons for removing cases were doubt over whether there was a known history of violence, and persisting doubt over the correct diagnostic category. Exclusion of such cases left 25, with offence dates ranging from November 1995 to December 2002. As the results show, one or two marginal cases were left in the sample as an illustration of where the boundary was drawn.

## Preliminary Analysis of the Data

### Ethnic origin

**Table 1: Ethnic origin of total sample (N = 25)**

| Ethnic origin                | No. | %   |
|------------------------------|-----|-----|
| White                        | 16  | 68  |
| Black Caribbean              | 4   | 16  |
| Black African                | 2   | 8   |
| Indian/Pakistani/Bangladeshi | 1   | 4   |
| Other                        | 2   | 8   |
| Total                        | 25  | 100 |

It emerges from a detailed review of the cases that at least two are marginal for inclusion in the sample, and both are of White ethnic origin. If these cases were excluded, the distribution of ethnic origin would be further skewed towards over-representation of minorities.

### HCR20 Data - Historical Items

This section of the HCR20 consists of 10 items in the history that are likely to be related to an increased risk of violence. These items are:

- H1: Previous Violence
- H2: Young Age at First Violent Incident
- H3: Relationship Instability
- H4: Employment Problems
- H5: Substance Use Problems
- H6: Major Mental Illness
- H7: Psychopathy
- H8: Early Maladjustment
- H9: Personality Disorder
- H10: Prior Supervision Failure

It should be noted that the sample selection criteria ensure that all cases have H1 and H6. The criteria are listed here to demonstrate that it is not unreasonable

that a clinical team should have this sort of information available, particularly when there is a known history of violence.

**Table 2: Number of HCR20 Historical items present for each patient in the total sample (N = 25)**

| Number of items present | n. | %   |
|-------------------------|----|-----|
| 10                      | 10 | 40  |
| 9                       | 4  | 16  |
| 8                       | 1  | 4   |
| 7                       | 6  | 24  |
| 6                       | 2  | 8   |
| 5                       | 2  | 8   |
| <5                      | 0  | -   |
| Total                   | 25 | 100 |

### **HCR20 Data - Clinical Items**

The five Clinical items are:

C1: Lack of Insight

C2: Negative Attitudes

C3: Active Symptoms of Major Mental Illness

C4: Impulsivity

C5: Unresponsive to Treatment

Again, it is reasonable to suppose that this sort of information should be available to the team.

**Table 3: Number of HCR20 Clinical items present for each patient in the total sample (N = 25)**

| Number of items present | n. | %   |
|-------------------------|----|-----|
| 5                       | 15 | 60  |
| 4                       | 5  | 20  |
| 3                       | 2  | 8   |
| 2                       | 2  | 8   |
| 1                       | 1  | 4   |
| 0                       | -  | -   |
| Total                   | 25 | 100 |

### **HCR20 Data - Risk Management Items**

The five Risk Management items are:

R1: Plans Lack Feasibility

R2: Exposure to Destabilisers

R3: Lack of Personal Support

R4: Non-compliance with Remediation Attempts

R5: Stress

R1 perhaps requires further explanation. It refers to the need for an agreed, realistic care plan. One of the best illustrations of a positive score on this item emerges from the Ritchie report on the care and treatment of Christopher Clunis. He was discharged on several occasions with no proper care plan in place, and no reasonable expectation that he would be able to cope with life. This item alone does not, of course, mean that violence is inevitable but it is an indication that the situation is unstable and a crisis will arise fairly soon.

It is more difficult to complete these items in retrospect, than for the Historical and Clinical items. My point of reference was the last contact with the clinical team. At that time, were there feasible plans, was their current or likely exposure to destabilisers or stress, was there any personal support, and was the patient

compliant and with whatever treatment was offered? One hopes that these are the sorts of questions likely to be considered as part of a care planning meeting under CPA.

**Table 4: Number of HCR20 Risk Management items present for each patient in the total sample (N = 25)**

| Number of items present | n. | %   |
|-------------------------|----|-----|
| 5                       | 11 | 44  |
| 4                       | 6  | 24  |
| 3                       | 3  | 12  |
| 2                       | 1  | 4   |
| 1                       | 4  | 16  |
| 0                       | -  | -   |
| Total                   | 25 | 100 |

## Discussion of Preliminary Analysis

### Overall Numbers

The first point to make is that the number of cases is small, despite the fact that the study period spans seven years. The average is less than four cases per annum. Of course there is more to this issue than simple numbers but this figure must be seen in the context of other homicides. The overall homicide rate for England and Wales from 1995 to 1997 ranged from 584 to 650 cases per year, and by 2001/2002 it was close to 800 cases per annum. In other words, the cases with which we are concerned here account for less than half of one percent of all homicides in England and Wales.

It is important in this context to say more about case identification. The methodology of the CISH has been described elsewhere and should ensure that cases are not missed. The only added step in the current study was determination of whether or not there had been previous violence. The figures would have been biased if there had been unreasonable exclusion of cases on the grounds that there was no previous violence. My tendency was to include any record of previous violence. For example, in one case the only history of previous violence was a conviction for assaulting the police. The consultant concerned had assessed the patient at the time and concluded there had been only minor

attempts to resist when the police had arrested the patient for possession of cannabis. Despite this comment, the case stayed in the sample because there was a conviction for assault. The excluded cases had no history of violence as an adult in any available reports or records.

### **Ethnic Origin**

There is an over-representation of ethnic minorities relative to the general population. The marginal cases described above were both White British, so if they had been excluded the sample would have been more skewed.

The numbers are too small to draw any conclusions, but the data are obviously relevant to ongoing concern about possible over-representation of ethnic minorities among detained patients.

### **HCR20 Data**

The Historical items are important to the present study because they can be assessed reasonably accurately in retrospect. They concern aspects of the history that can be determined from the records, so if the information can be obtained now it could presumably have been obtained at the time.

Ten of the patients scored on all ten items of the History scale, and 20 patients (80% of the sample) had seven or more items present. The HCR20 is not an actuarial scale, and adding up the scores is not necessarily a good indication of overall risk of violence, but it is difficult to dismiss the presence in one patient of all or practically all of the historical factors that are known to be associated with an increased risk of violence.

Similarly, the findings for the Clinical and Risk scales were also high for many of the patients, although it must be borne in mind that these figures are less reliable when derived from records after the event. This reservation need not be overstated. Items such as non-compliance, lack of response to treatment, or negative attitudes are often easy to determine from records. Also, most errors arising from retrospective scoring will understate the problem. For example, lack of insight or the presence of symptoms may have been overlooked in the records, whereas a systematic inquiry at the time may have revealed them.

The first point to make is that these ratings are at the top end of the spectrum of risk. The HCR20 is not an actuarial instrument, so a high score cannot be directly equated to high risk. Even so, these cases are impressive in having all, or nearly

all, the factors that tend to predict violence risk. This suggests that homicides by the severely mentally ill are far from random events that could happen in any patient. Many of these cases were extraordinary patients before the homicide, when looked at in terms of violence risk indicators.

This conclusion is based on the assumption that most patients will not score at such high levels. The use of the HCR20 is at an early stage in the UK but early results from Prof Shelagh Hodgins and Prof Tom Fahy at the Institute of Psychiatry suggest that forensic patients generally score highly on the H items of the HCR20, whereas many patients within general services score highly on C or R items (personal communication). Most of the patients in the present sample resemble forensic patients in terms of their HCR ratings, although very few were under the care of a forensic service.

### **Would structured clinical risk assessment have made a difference to the outcome?**

This is the crucial question and a definitive answer is impossible from a study of this type. Still, a reasonable estimate is possible if one accepts the following assumptions.

First, the team concerned was not giving the case top priority. In some cases, there was an awareness of the high risks involved but the team felt they could not do more under present legislation. In such cases, more information about risk may not have made much difference, as it would have been no more than a re-statement of what they already knew. On the other hand, there were plenty of cases in which the team did not recognise considerable risks.

The second assumption is that the team would have been more cautious in management of the case if the people involved had available to them a stark assessment of the violence risks involved in the case. With these assumptions in mind, it is time to move on to consider in detail the management of individual cases.

## **Individual Case Reviews**

I have attempted at least a thumbnail sketch of each case. I have not attempted a comprehensive summary. Some are much longer than others, in order to illustrate important points.

After much thought, I have left out names and locations. All this information is in the public domain but repetition of the names involved may further stigmatise the patients concerned and hamper rehabilitation, as well as causing further distress to others involved. As it was necessary to include some circumstantial detail to illustrate particular points, it is inevitable that some of the cases can be identified by those who are familiar with the circumstances, whether from personal involvement or by reading press or Inquiry reports.

### **Cases in which all Historical risk items were present**

These are cases 2, 3, 4, 6, 9, 13, 18, 19, 20 and 27.

The importance of these cases is not that they must inevitably have a high, immediate risk of violence but they are potentially a high risk. To use a gambling analogy, the stakes are high. That need not be a problem if the team is playing safe but when there are also high Clinical and Risk Management scores, the situation is worrying and ought generally to be given the highest priority.

## **Case 2:**

**HCR20 Scores: H = 10, C = 5, R = 5**

**Main Issues: Stranger homicide for psychotic motives; family history of violent and antisocial behaviour; violence and personality disorder before onset of illness; extensive and serious criminality unrelated to illness; non-compliance; drug and alcohol misuse; team recognised extent of violence risk and made efforts to control it within existing powers; forensic services were involved; little more could have been done; role for community treatment order.**

This 29 year old man was from a family with a history of violent and antisocial behaviour. He had been in contact with services for several years, during with time he had been given diagnoses of schizophrenia, personality disorder, and drug and alcohol abuse. There was a long history of offending including serious violence (stabblings) both when psychotic and when well. There had been several admissions with rapid remission of psychotic symptoms on medication, then a refusal to take depot after discharge, followed by relapse in the community. There was close monitoring of the case, including use of a supervision order, and there was a detailed assessment only a few days before the offence.

The offence was the apparently motiveless killing of a stranger. The clinicians concerned and the Inquiry concluded that little more could be done without the power to enforce medication whilst the patient was in the community.

**Comment:** Structured clinical risk assessment would not have made a difference. The risks were recognized and managed as well as possible under existing law.

**Case 3:**

**HCR20 Scores: H = 10, C = 3, R = 2**

**Main Issues: Drunken killing of an acquaintance; violence and personality disorder before onset of illness; alcohol misuse; reasonable level of care and mental state stable at time of offence; no direct link between illness and offence.**

This 30 year old man had over ten years of contact with services with three well established diagnoses: shizo-affective disorder, severe personality disorder; and drug and alcohol misuse. He led an unstable life with frequent offending but his mental illness was under control at the time of the offence. He had a two day admission just days before the offence but was judged free of symptoms of mental illness.

The offence was a fight with an acquaintance late at night when both had been drinking. The patient had consumed more than ten pints of beer that night but had a good memory for events. According to witnesses and his account, no symptoms of mental illness were apparent at the time. He did not appear unwell when arrested and he remained free of symptoms when assessed on remand. Court reports agreed there was no direct link between his mental illness and the offence. They agreed that his antisocial personality and his excessive drinking were relevant to the offence.

Comment: Structured clinical risk assessment would not have made a difference. He was receiving a reasonable level of care in line with his current mental state and the killing bore no direct relationship to his illness.

#### Case 4:

HCR20 Scores: H = 10, C = 5, R = 5

**Main Issues: Killing of neighbour whilst floridly psychotic and under influence of drugs; violence and personality disorder before onset of illness; violent and chaotic family; failure to appreciate extent of violence risk; extensive drug misuse; non-compliance; early onset of illness and extensive service contact despite his attempts to evade it; need for multi-agency approach in young offenders.**

The patient is a 19 year old who grew up on a deprived estate within a violent family. His father left when he was young and mother's new partner was often violent to her. There were frequent changes of accommodation, sometimes to escape violent partners. He was moved around various caretakers within the extended family and had periods in foster care. Offending was common within the family and the local community. There is a strong family history of schizophrenia.

The patient was aggressive at school and was suspended at least once for theft. He left with no qualifications. He never worked and had no stable relationships outside the family.

He sniffed lighter fuel and other solvents when he was twelve. As a teenager he began to use amphetamines, cocaine, LSD and cannabis. Some of his offences were motivated by the desire to buy drugs. By the time of the offence he was consuming an ounce of cannabis a week, costing him between £70 and £100.

He funded his drug use by stealing car radios. He had twice been in youth custody after breaching community sentences. He had convictions for theft and going equipped, and for common assault on an adult stranger when he was thirteen. At the age of sixteen he moved to bed and breakfast accommodation because of his mother's complaints about his violence.

He was first seen at child guidance aged ten, but the family did not follow through the offer of treatment. Later he was described as "a sad and despairing little boy" when seen at school by a social worker.

By the age of 17 he had hypochondriacal and persecutory delusions and appears never to have been free of symptoms for any length of time thereafter. He was placed on Level Two of the CPA in January 1997 when discharged after a brief admission, with diagnoses of personality disorder and drug induced psychosis. There were problems with compliance and he was prescribed oral antipsychotic medication. He was often threatening and largely avoided contact with services until the killing in April 1997. He saw a triage nurse in A&E two weeks before the killing and was noted to have smashed up his mother's flat but did not wait to be

assessed. In the early hours of the morning he killed a neighbour for uncertain reasons. He was floridly psychotic and had been using drugs.

After the homicide his mother described frequent violence and threats at home but had not given this information to the team beforehand.

**Comment:** More could have been done in this case and structured clinical risk assessment would have helped. Once such an assessment is done, it shows that this patient had the highest possible ratings for risk of violence. The nature of his previous violence indicated that such violence may well be life-threatening. Had there been a clear statement of the risk of serious violence at the CPA meeting in January, there would probably have been greater efforts to follow-up the patient after discharge.

Risk assessment would not have solved all the problems. There was never likely to be voluntary compliance with treatment, so the legal context was relevant. Other issues include drug induced psychosis as a diagnosis, and the difficulty of working with families or carers who are themselves erratic or unreliable.

It is important also to acknowledge the multi-faceted aspect of the violence risk in this case. He presented a high risk for offending and violence before the onset of his psychotic illness and a range of agencies had struggled with the case. He was young and despite the frequency of violence did not have convictions that would or could have warranted a life sentence. It would now be an ideal case for a MAPPP, a multi-agency approach was necessary because of his youth.

## Case 6:

**HCR20 Scores: H = 10, C = 5, R = 5**

**Main Issues: Offending before onset of illness; co-morbid drug use and personality disorder; preoccupation with diagnosis and failure of services to appreciate extent of violence risk; non-compliance and loss of contact with services; possible benefits of community treatment order.**

This 31 year old man showed behavioural problems from an early age, having grown up in an atmosphere of marital discord and excessive physical punishment amounting to physical abuse. By the age of thirteen he had shown mood swings and serious violent behaviour, leading to a conviction for breaking the jaw of another boy at school. Shortly afterwards he caused a scalp wound to a girl at school and was placed on a care order. Further attacks led to placement at boarding school, where there was some improvement.

He had an unstable and unsettled existence after leaving school, moving between his parents' house, youth custody, hospital, B&B, hostels and sleeping rough. There were many short term relationships, often marked by conflict and violence.

He used cannabis regularly over many years and alcohol intermittently. Cannabis was blamed for several deteriorations in his mental state. From 1984 he had psychotic symptoms on occasion and by 1987 at least one psychiatrist had diagnosed schizophrenia noting that his symptoms were "made worse by cannabis and made better by antipsychotic medication". Another psychiatrist concluded he was unsuitable for treatment because he suffered from personality disorder.

In 1993 the GP requested urgent assessment when the patient's girlfriend said he was getting violent and was likely to kill someone. The locum consultant who saw him at home noted "a mild degree of psychosis" that may be drug-induced. He was detained in hospital on Section 2 shortly afterwards. There followed four years of intermittent contact with services, often after his arrest. He was rarely free of symptoms. He was usually uncooperative and non-compliant with his oral medication. He continued to smoke cannabis regularly. He was sometimes considered not to be detainable, for unspecified reasons, even though psychotic. Offences included threats, minor assaults and indecent exposure.

In December 1996 his GP struck him off his list. In early January 1997 social services closed the case after noting that he had declined help since August of 1996. The homicide occurred later in January. The victim was a pregnant woman with whom he was having a relationship. She died of head injuries but he denied involvement so the circumstances and motive remain unclear.

On remand he was floridly psychotic and he was transferred to a high security hospital.

**Comment:** Structured clinical assessment of violence risk could have helped because the care given to this man was unsatisfactory in many ways. There was no attempt to manage the case pro-actively, nor was there any attempt to address the risks posed.

A major problem was the diagnosis of drug induced psychosis, which acted as an excuse for inaction by mental health services. This issue will be discussed in more detail in a later section of this report. Personality disorder was also used as a reason for not providing more assertive treatment. The fact remains that the diagnosis of schizophrenia was made ten years before the homicide and the patient spent much of the intervening period in a psychotic state that was recognised by most psychiatrists who saw him.

A structured clinical assessment of risk would have drawn attention to the fact that this was a man who ticked all the boxes for violence risk. This is arguably more relevant and useful information than any presumed diagnostic label.

In the background is the issue of compulsory treatment in the community. Such limits were never actually reached in this case because of the laissez-faire approach to his treatment.

**Case 9:**

**HCR20 Scores: H = 10, C = 3, R = 5**

**Main Issues: Personality disorder and violence predating onset of illness; continued offending unrelated to illness; co-morbid drug use; reasonable compliance and stable mental state at time of offence; killed a neighbour during burglary; motive uncertain but not apparently psychotic; team did not appreciate extent of violence risk, much of it unrelated to mental illness.**

This 34 year old man had diagnoses of schizophrenia in conjunction with a severe antisocial personality disorder and drug and alcohol misuse. He was expelled from school for fighting and completed his education at a special school. He was in trouble with the law from the age of twelve years.

He presented with psychotic symptoms in 1986 and made a good recovery after a four month admission. He defaulted after a couple of appointments and was not compliant with depot from January 1987. By 1992 he was noted to be compliant with depot medication and settled in the community, although he had recently served a three year prison sentence for burglary.

There were several short relapses over the next four years, usually associated with non-compliance with medication, as well as use of cocaine and other drugs. He had infrequent and irregular contact with services.

He was brought to hospital by his mother in Feb 1997, about a month before the offence, having been violent to his sister. He had taken an overdose and had a range of psychotic symptoms. He was started on depot medication, responded well, and gave no concern when seen by a CPN just a couple of days before the offence.

He broke into a flat and killed the elderly occupant during the course of a burglary. He was disturbed by neighbours who noticed no evidence of mental illness. He was not mentally ill when examined on remand.

**Comment:** Structured clinical assessment of violence risk may have helped in this case because it would have made explicit the high background risk of violence. The team was comfortable with the level of care provided but may have been less so if they had been aware of the risks.

It is by no means clear that psychotic symptoms played a role in the offence but the killing followed shortly after a time of crisis. Also, in any holistic view of the patient, his tendency to behave violently was of central importance. The team's management of this problem was a source of disagreement between them and the family/carers, who were often the targets of threatened or actual violence.

### **Case 13:**

**HCR20 Scores: H = 10, C = 5, R = 5**

**Main Issues: Personality disorder and violence predating onset of illness; extensive co-morbid drug use; on a restriction order for previous violent offence; reasonable compliance; continued drug use and positive symptoms; unpredictable killing of pregnant girlfriend; possible role for structured clinical assessment of violence risk.**

This 39-year-old man showed disturbed behaviour in childhood including fighting at school, failure to form relationships, and drug use by the age of 12 years, when he was first referred to a child guidance clinic. His first conviction was for burglary and theft at 11 years and he was sent to a special school after an offence of indecent exposure at the age of 14 years. Aged 17 he was sent to youth custody for rape and aiding and abetting rape.

When seen for a court report in 1975 he was given a diagnosis of personality disorder and there was no evidence of mental illness. He was first noted to be psychotic in 1984 when he was given the diagnosis of drug-induced psychosis. At that time he had a ten year history of misusing drugs including cannabis, magic mushrooms, LSD amphetamines and heroin. Non-compliance and numerous admissions followed and he was first detained under the Mental Health Act in 1986, with a diagnosis of chronic paranoid schizophrenia. He was placed on a hospital order with restrictions in 1988 for offences of robbery, assault, taking a vehicle without consent and criminal damage (offences committed in November 1988). He smashed the window of a car after the female driver had just got in. He dragged her out and forced her to leave her handbag in the car then drove off. He was said to be so intoxicated with drugs that he could barely stand unaided.

He was treated in a medium secure unit and made good progress. He was compliant and achieved escorted leave within a year of the offence. A Tribunal granted a conditional discharge in June 1990. His care was transferred to local services. He was generally compliant and took depot medication regularly. However, there were several minor offences and a recall following a relapse in June 1993, the result of a slow deterioration thought to relate to his girlfriend having a child in October 1992.

Subsequent follow-up revealed positive drug screens for cannabis and amphetamines in 1994, plus misuse of procyclidine. He was placed on the Supervision Register in September 1994. He continued to take his depot medication most of the time. He was charged with common assault in November 1996 following a fight with his neighbour. He had a four day admission

shortly afterwards, when his mental state deteriorated. He was noted after discharge to be non-compliant with oral medication although he continued to take his depot. In September 1997 it was noted that his girlfriend was pregnant for the third time and he had mixed feelings about this. He was still using drugs and this thinking was disordered although his mental state was otherwise stable. Later that month he was admitted voluntarily with symptoms including paranoid thinking and the experience of receiving messages from the TV. He discharged himself after three days and remained suspicious of his carers when seen in outpatients in November, when he needed persuasion to continue with his depot. He was admitted in December after continued drug misuse and further deterioration in his mental state. He remained an inpatient until the homicide in February 1998. He was noted to have low mood, thought disorder and lack of insight, but he was thought to be doing well.

He returned as planned from three days leave on 12<sup>th</sup> February and continued to take depot medication, which was given on that day. His girlfriend called to say she was in labour and asked for him to attend. He was assessed and judged fit to attend. His parents took him from the hospital to her address. The girlfriend's parents and her other two children were also present, as was the midwife when the patient arrived. The girlfriend was not in labour and asked to go out to get some fresh air with the patient. He returned alone after about fifteen minutes, telling the others she was dead. He had strangled her and commented: "I had to do it because I was told. You knew because you looked at your watch". He also referred to thinking of doing it earlier, because of messages from the TV.

He was transferred to hospital. He was floridly psychotic and unfit to plead.

**Comment:** He had all risk factors present at the time of the offence. The team were concerned about his risk and he was monitored closely. This is one of those rare cases in which a restricted patient commits a serious offence, the overall incidence of grave offending in this group being around 0.5% per annum.

The offence was not predictable and no concerns were expressed by staff who knew him well, by his parents or the victim's parents, or by the victim herself who asked him to take her for a walk.

However, structured clinical risk assessment may have made a difference. He scored on all indicators of violence risk and there was the known idiosyncratic factor of his concerns about this pregnancy and a previous pregnancy. The management of this case can be seen as an example of taking calculated risks. He was known to be intermittently non-compliant, to misuse drugs, and to have little insight into his continuing psychotic symptoms. These facts were known to

the team looking after him, and to the Home Office Mental Health Unit, so one assumes they were judged acceptable. They look a lot less acceptable when viewed with the benefit of hindsight. It is possible that they would not have seemed acceptable at the time had the risk of violence been spelled out in a structured risk assessment.

It is also worth noting that he had been on a restriction order for almost ten years by the time of the homicide. For most of that time he had misused drugs, he had psychotic symptoms, and his compliance was variable. There was sporadic offending. Did familiarity with the case lead to some complacency in both the clinical team and the Mental Health Unit? There were many unsatisfactory aspects to the case, as an example of a conditionally discharged restricted patient, and there was a sense that these aspects were tolerated because they had been present for a long time. Structured assessment would have helped here by making explicit just how many risk factors were present in this case.

Having made these points, it must also be acknowledged that an offence of this type is extremely rare even within forensic psychiatric practice.

## **Case 18:**

**HCR20 Scores: H = 10, C = 5, R = 3**

**Main Issues: Young at time of offence; extent of delusions only became clear after homicide; conduct disorder and violence before onset of illness; no contact with services at time of offence.**

This 18 year old man was often in foster care as a child after his father deserted the family when he was seven and his mother could not look after him because of her drug and alcohol problems. He was expelled from school at 14 after many suspensions, often for fighting. He had no qualifications and never worked. He slept rough until he moved to live with his mother and stepfather (the victim) twelve months before the offence.

He had only one contact with mental health services, in May 1997 after taking an overdose. He was not thought to be psychotic. He was referred to the family service but did not attend.

On 27.1.99 he killed his stepfather. After the event he revealed persecutory delusions for 12 months, including a belief that his mother and stepfather were poisoning his food. The tensions within the house were also important. The victim was a heavy drinker and abusive when drunk. He bullied and assaulted the patient. The patient's mother was a heroin addict and provided little support. She may well not have noticed signs of mental illness that would have been apparent to a more alert observer.

Comment: It is debatable whether this case should be included in the sample, as there was no ongoing contact with services and the diagnosis did not emerge until after the offence. He was also very young at the time of the offence. It is not clear that structured clinical risk assessment would have made a difference. This is a case of schizophrenia presenting with a serious offence.

**Case 19:**

**HCR20 Scores: H = 10, C = 5, R = 5**

**Main Issues: Killing of fellow patient on ward with no apparent motive; violence and personality disorder before onset of illness; failure to appreciate extent of violence risk, even with hindsight; enforcement of ward policies; alcohol use on ward; need for structured clinical assessment of violence risk.**

This 26-year-old man had a history of poor parenting and a miserable childhood. There was physical and emotional abuse, much of it related to his father's alcoholism although his mother was also violent. His first conviction was ABH aged 13 years, when he shot someone with an air rifle. There were frequent changes of school so he never settled and truanted frequently. He was expelled from school for robbery aged 15 years and soon became a heavy user of amphetamines and cannabis.

He had paramilitary interests and sometimes wore Nazi clothing or memorabilia. He was known to collect knives and, unknown to staff, had a set of chef's knives with him in the hospital on the admission during which he killed a fellow patient. He had never worked as a chef.

He was diagnosed as suffering from paranoid schizophrenia at the age of 20 years. Over the five year history of contact with mental health services he had many admissions, usually associated with amphetamine abuse. He was placed on the supervision register because of concerns about the safety of his mother, whom he had repeatedly intimidated. He was said to be a loner but usually polite and not threatening.

In December 1998 he attacked a fellow patient in a hospital where he had been admitted earlier that month. The attack appears to have been unprovoked and unpredictable. The patient was lying on his bed and the victim was simply the next person to enter the room. There was no context of animosity or conflict between the two men, but the perpetrator had a row with another patient earlier in the day and seems to have confused the two men in a muddled way. The patient was never able to give a satisfactory account of his motivation. He had been drinking earlier that day. Also, he had been wearing a German military uniform on the ward, which had upset some of the other patients and appears to have contributed to the patient's paranoia.

His consultant described his admission to hospital as “a social admission”: he had been made homeless from the hostel where he lived, after allegedly committing a burglary. He was compliant with medication during the admission “for the first time in months”. The consultant also commented that there was “no track record of violence”.

He said he had taken no illicit drugs for a week (at other times he said a month) before the offence. On remand he was transferred to a high security hospital and settled, later showing no psychotic symptoms when free of medication. Reports agreed he suffered from a severe personality disorder but were equivocal on the question of mental illness and its role in the offence.

**Comment:** There are two main issues for prevention, both of which were emphasised in the Inquiry report. First, there is the question of nursing practice and maintaining a safe ward environment. The patient habitually dressed in a German uniform with Nazi regalia and, although he was generally polite, this is not acceptable conduct on a ward where it is bound to cause offence. He was drinking heavily on the ward, although he may have concealed it from staff. He was also able to bring in a set of chef’s knives. The message is that basic ward procedures go a long way to ensuring a safe and secure environment, even though one could never predict that breach of those procedures would lead to a serious violent incident.

The second major issue concerns diagnosis and the management of violence risk. The patient had a working diagnosis of schizophrenia so the post-offence re-assessment is largely irrelevant. The violence risk assessment in this case seems not to have gone beyond the fact that he had never done anything like this before. This is relevant but not sufficient. A structured clinical assessment of risk would have shown that this patient ticked all the boxes for violence risk. The offence could not have been predicted but the patient’s potential for violence could have been better appreciated. There were sufficient indications to justify the fuller assessment of violence risk, namely the fact he had been placed on the Supervision Register because of the risk to his mother.

**Case 20:**

**HCR20 Scores: H = 10, C = 5, R = 5**

**Main Issues: Conduct disorder, personality disorder and offending before onset of illness; chronic illness; drug and alcohol use; killing of father in response to psychotic symptoms; failure to respond to worrying signs; non-compliance; failure to appreciate extent of violence risk; lack of assertive treatment.**

There was a strong family history of severe mental illness and the patient's mother killed herself when the patient was eleven years old. He showed signs of conduct disorder from that time on. There was a serious act of arson at the family home at the age of eleven. He was disobedient and told lies. He was repeatedly cruel to pets. By 12 years he was in trouble with the police for petty theft. He presented difficulties at all his schools although he was generally disruptive rather than violent. He was expelled from one. The educational psychologist saw him on at least five occasions. After leaving he adopted a traveller lifestyle and was a loner who never held a job.

His personality changed at the age of about 18 and this was probably the gradual onset of severe mental illness. He lived rough most of the time but returned periodically to live at home with his father. In 1993 he is said to have set a large fire at his home. He drank a fair amount and used drugs occasionally but the main problem was a chronic psychotic illness.

From Aug-Dec 1996 he was floridly psychotic and in hospital, with auditory and visual hallucinations, after being transferred from prison. He did not attend outpatients after discharge and he refused depot medication. Follow-up proved impossible because of his lack of co-operation.

In April 1997 he was seen at the hospital and judged to show paranoid thinking but he was not considered detainable.

In September 1997 his father wrote to the team to express concern about him being paranoid and depressed, as well as saying strange things, for example: "Everyone says they are me". He was verbally aggressive and had shouted obscenities in front of his sister's young children. He was seen and agreed to take oral medication but did not attend for follow-up. He appears not to have been seen again until after the killing.

From 1997 there were increasingly frequent reports from the family of his bizarre mental state and behaviour. He damaged property for no apparent reason, the family was wary of him, and he once hit his stepmother for no reason. His father hid knives out of fear the patient may use them. A neighbour said it was impossible to have a coherent conversation with the patient. These reports came to light only after the killing.

In January 1999 he was convicted of possession of an offensive weapon and served a four month sentence. In March 1999 he was convicted of assault and served a month in prison.

The offence occurred in May 1999. He reported that a voice told him to kill his father so he stole an ice axe and did so.

**Comment:** There were lots of problems with the management of this case. The diagnosis was recognised early but he was never properly treated and appears never to have been free of symptoms. The family were aware of his state and communicated it to the hospital, at least prior to 1997.

A structured risk assessment may have helped by making the risks explicit but there were plenty of reports from the family and services do not emerge well from this case. The team appear not to have realised the risks and missed several opportunities to intervene, when it was decided that he was not detainable. Management at his last service contact was optimistic rather than realistic, and structured risk assessment may have helped by making a clear statement that he was unlikely to comply with medication and follow-up.

He was unlikely to comply with medication and would have needed compulsion in the community.

**Case 27:**

**HCR20 Scores: H = 10, C = 5, R = 5**

**Main Issues: Killing of his mother whilst floridly psychotic; violence and personality disorder before onset of illness; extensive and serious criminality unrelated to illness; poor continuing care after initial treatment of psychosis in prison; non-compliance; drug misuse; missed opportunity to recommend restriction order after previous violent offence; failure to appreciate extent of violence risk; managed by general services in community despite previous forensic involvement; possible role for community treatment order.**

This 25-year-old man's personal history is uncertain but he was brought up partly in the UK and partly in Nigeria. From the age of 12 he was in the UK. He truanted, got into a lot of fights at school and was expelled. He smoked cannabis from the age of 15 years and would come and go as he pleased at home. He had no qualifications and was soon involved in criminal activity. Whilst attending college he stabbed a fellow student, supposedly in a fight over drug dealing, and had left within two months of starting his course. He was given a four year sentence for the offence of wounding.

He was unemployed for some years and never held a job for any length of time. He was promiscuous and may have had children he did not see or support. He had no steady relationships.

In February 1996 he was given a 4.5 year sentence for robbery. He approached a Jaguar car, forced the driver out, punched him and stole his keys. He was motivated by wanting to obtain money for cocaine. During his sentence he suffered a psychotic breakdown and was transferred to his catchment area MSU in Jan 1997. He responded to medication and returned to prison in August 1997 but had to be transferred in April 1999 to another MSU, in the independent sector, after a further breakdown during the same sentence. This transfer was only four days before the end of his sentence so he became a "notional 37" hospital order patient from April 16<sup>th</sup>.

He committed a serious assault in September 1999, throwing hot water in the face of another patient who had allegation to staff that he was using cannabis. He was transferred to his local locked ward later in September but was still unwell. He fondled a female nurse and continued to use cannabis.

On 24.11.99 he was convicted of ABH for the Redford Lodge assault and sentenced to be detained under S37 (which was rather pointless as he was already detained on S37). He was transferred to an open ward in January 2000 then promptly went absent without leave with another patient.

He was discharged to his mother's home in June 2000 and placed on the Supervision Register. He was doing well on depot medication but discontinued it in August 2000 in favour of oral olanzapine.

His last contact with services was on 14.3.2001 when he was seen in the outpatient department. He was relaxed and friendly but non-compliant with his oral medication. He described frequent arguments with his mother. He was not seen again until after he killed his mother on 14<sup>th</sup> May 2001.

On the day of the killing his brother called the police. The patient had stabbed his mother and appeared psychotic. Reported statements included: "I'm going to be king of the world.....she's evil...". There was a previous history of threats to his mother and his brother.

**Comment:** This man had a well-established history as a violent criminal before he developed a mental illness. He had a severe personality disorder. He was never compelled to comply with medication in the community. Forensic services were involved but never took any long-term responsibility for the case and he was returned to the community through general services.

There was a strong case in favour of forensic services managing his care because his mental illness had first become apparent during a long prison sentence for violence and there were obvious risks. Structured assessment would have made those risks explicit. A community treatment order would have been useful but there was a missed opportunity to recommend a restriction order following the assault in the independent MSU. The case raises many issues, including follow-up of patients transferred back to prison after treatment in a MSU.

## **Cases with nine of a possible ten Historical risk items present**

These cases are also at the top end of the scale, and similar considerations apply to those in which all ten items were present. The stakes are high.

There are four such cases, numbers 1, 10, 22 and 24:

### **Case 1:**

HCR20 Scores: H = 9, C = 4, R = 4

**Main Issues: Offending and personality disorder predating illness; reasonable level of care and compliance; misuse of drugs; stable mental state at time of offence; high background risk of violence; killed mother's partner in row arising from attempt to protect her from domestic violence; relevance of mental illness to homicide uncertain; problem of hindsight in inquiries.**

This 29 year-old-man was born into a family with a well-established history of criminality and antisocial behaviour. Many of his relations had convictions for offences such as petty theft or shoplifting, and many had problems with heavy drinking or substance use. About a year before the index homicide his sister had been killed by her boyfriend, who then killed himself.

The patient had a delinquent adolescence and difficulties at school. He and a close friend committed many burglaries, beginning when they were fourteen. He never had a job. He had already served prison sentences before his psychotic mental illness appeared when he was 22 years old. By that time he had had two children by his former common law wife. This relationship began in his teens but ended before the onset of his illness and he appears to have had no other intimate relationships.

It took another four years for the diagnosis to be established, but by the time of the offence he had a three year history of regular contact with services and a clear diagnosis of schizophrenia. The case was complicated by regular (daily) use of cannabis, by his own antisocial behaviour, and by his involvement with his mother and her violent, antisocial partner. Nevertheless, the patient was compliant with depot medication, although less compliant with appointments, and he appeared stable. There was no detailed examination of his mental state for four months before the homicide but he was seen regularly by members of the rehabilitation team and attended a group at the Rehab centre on the day of the offence. He was well known and nothing untoward was noticed.

The patient killed his mother's partner in a fight, when he was attempting to protect his mother. The patient had gone on an errand to get drink for his mother, and when he returned her partner tried to take it for himself. It was not clear who struck the first blow. Both mother and partner were drunk. The patient had been smoking cannabis. There had been fights before over similar issues and the patient did not realise the man was dead until some hours later.

**Comment:** The tensions inherent in the patient living with his mother and her violent partner were well known to the team, who had tried to persuade the patient to move out. He stayed because he wanted to protect his mother. The Inquiry concluded that the team should have tried harder to persuade the patient to move out. Other issues include regular use of cannabis and the lack of a detailed mental state examination in the four months before the homicide.

The case is complex and the role of mental illness in the killing is not clear. Certainly this would be a common and understandable scenario for a killing, even if there had been no mental illness. The case raises questions about society's attitudes to domestic violence, to alcoholism, and to those who are marginalised. It is not clear why the focus of an Inquiry after the event should be on mental illness alone, rather than on these wider issues.

Within this difficult context, the mental health team knew about all the main issues and had taken decisions on how to deal with them. Examples include the attempts to persuade the patient to move away from his mother and her partner, and the considerable and successful efforts made to draw the patient into involvement with the Rehabilitation team despite his reluctance. The comments of the Inquiry are open to criticism as a classic case of hindsight. Once the outcome is known everyone can agree that more should have been done to get the patient to move away from his mother. At the time, the team's decision appeared reasonable in its balancing of risk on the one hand, and respect for patient autonomy on the other.

Despite these comments, it seems possible that a structured violence risk assessment would have helped in management of the case. As noted above, team members were aware of the risks and had balanced violence risk against other factors. An objective and explicit statement of the violence risks could only have helped them in this process and would have ensured that the decisions were fully informed. The assessment shows that this patient was at the top end of the scale for Historical, Clinical and Risk items. One can speculate about whether such an assessment would have led to different decisions in three main areas: the low frequency of detailed review of the patient's mental state; ongoing use of cannabis on a daily basis; and the patient continuing to live with his

mother and her violent partner. My own view is that the team was taking too many chances, with so many indications of violence risk.

My own preference for intervention would have been the daily use of cannabis, which cannot have helped matters. However, there was no simple response here. The patient's substance use was embedded in his personality, history, and family life and it would not have been given up easily. This case raises questions about the extent to which mental health services could or should intervene in the lives of patients who have a basic level of compliance with treatment and maintain a settled mental state. Structured clinical risk assessment cannot resolve these issues but would at least offer a degree of protection to services when they make compromises with messy reality. Involvement of a MAPPP would also help in making decisions that go beyond the purely medical.

## Case 10:

HCR20 Scores: H = 9, C = 5, R = 5

**Main Issues: Personality disorder predating onset of mental illness; extensive offending unrelated to mental illness; malingering to avoid criminal sanctions; poor compliance; killing of sexual partner when both had been drinking; precise role of mental illness unclear, may have been irrelevant; genuine diagnostic uncertainty; variable diagnosis and erratic management; insufficient priority given to the case; structured violence risk assessment would have revealed high risk of violence.**

A 45 year old man of Afro-Caribbean descent and born in the USA. His early life was disrupted but he often refused to give any information about it so the details are in doubt. He may have first had contact with services twenty years before the homicide but details are not available. He had at least four children by different women but no steady relationships. He worked in various unskilled jobs but never had regular employment. He was often in trouble with the law, mainly for petty offences but also for the theft of many cars.

His first well documented admission was in 1984 when he was over talkative and over aroused. He was preoccupied with God and with endings. Even at that time there was a suggestion that he was also manipulative and possibly not as ill as he first seemed. The consultant suspected a psychotic mental illness and applied for compulsory admission for further assessment but the social worker did not support the application. The patient was aggressive with other patients on the ward and he was discharged after a short time. The working diagnosis was manic depression or schizophrenia. The patient was given a probation order with a condition of psychiatric treatment shortly afterwards but no details of his progress are available. In 1985 he was admitted to another hospital, again with criminal charges pending, and he was described as "a cheat, fraud and trickster". Later in 1985 he was charged with selling a television he had rented and he was judged to be malingering and using symptoms in an attempt to evade prosecution.

His subsequent progress is not documented but he presented to services again in 1993 when remanded to prison on minor charges. There was reference to the definite presence of personality disorder and possible schizophrenia. He was referred to specialist services and given an appointment for after his release but he failed to attend. A report in connection with further criminal charges in 1994 (again for petty offences) noted no psychotic symptoms and concluded that his diagnosis was personality disorder. Another report later that year referred to his borderline intelligence (IQ = 76) and also the presence of symptoms possibly indicating schizophrenia. He was offered outpatient follow-up but failed to attend.

He was admitted for two weeks in August 1995, having been arrested for several car thefts and complaining to a police surgeon that he was hearing voices. He showed no signs of psychosis during the admission and was treated for anxiety. When seen in outpatients in September of that year he remained well although he was no longer taking the medication prescribed for his anxiety.

He failed to attend for his second and subsequent appointments and was next seen in December 1995 after his arrest for aggravated car theft, when he was admitted for four days but showed no evidence of mental illness.

He moved to a different part of the country and his GP referred him to local services in July 1996. He failed appointments but was eventually seen and diagnosed as suffering from schizophrenia. He was only intermittently compliant with his medication, he did not attend outpatients and he would not allow staff access to his flat. He was discharged from follow-up.

He next presented in June 1997 for a court report, again in connection with theft of a vehicle. He was diagnosed as suffering from schizophrenia which was so severe as to render him unfit to stand trial and the CPS dropped the charges against him. The diagnosis of schizophrenia was accepted by the community team looking after him and he was prescribed oral antipsychotic medication with which he was not compliant.

The offence was committed on 17<sup>th</sup> August. There was disagreement on his mental state after the offence, with one expert finding no evidence of psychosis and another concluding that he was so unwell as to be unfit to plead.

The homicide occurred in August 1997, when he killed a woman with whom he was having a relationship. The motivation and circumstances remain unclear. Both perpetrator and victim were drinking heavily and she died by falling from a window of the room they were in.

**Comment:** There was real uncertainty over the diagnosis in this case, with good evidence for antisocial personality disorder independent of any mental illness, and good evidence of the patient malingering and using symptoms to escape the consequences of his offending. On the other hand, there had been psychotic symptoms documented for over ten years and by the time of the offence the diagnosis of schizophrenia had been accepted by the last two community teams to assess him, both of which managed him as though that were the true

diagnosis. It is appropriate therefore to judge the case on the basis of management of schizophrenia.

An assessment using the HCR20 would probably have made a difference to the management of the case, which was too casual in the context of a high violence risk. For example, he was discharged from follow-up in the December before the offence because of his non-compliance. This would have seemed a bizarre and perverse decision in the face of a structured assessment of violence risk. The team looking after him at the time of the offence was giving him oral medication despite his known non-compliance, and again this would have been an odd way to proceed if the violence risk had been acknowledged.

One attractive aspect of the HCR20 is that it cuts through a lot of confusion about diagnosis, and delivers an assessment of violence risk that is largely independent of any precise psychiatric label. There is often a sense that mental health services become focussed on the diagnostic debate and distracted from the more important issues. In this case, where there was still the potential for dispute about the diagnosis even after the homicide, it would have been of enormous value to have available a clear statement that, whatever the correct diagnosis, this patient presented a high risk of violence.

## Case 22:

HCR20 Scores: H = 9, C = 4, R = 1

**Main Issues: Conduct disorder, offending and personality disorder predate onset of illness; misuse of alcohol; diagnosis of schizophrenia only became clear after the homicide; probably should not be included in the sample; stabbing of friend under influence of persecutory delusions after drinking heavily.**

This 21-year-old man had a history of child sexual abuse by his brother over a prolonged period between the ages of eight and thirteen. He grew up as a child who was always fearful and a loner, and he was the victim of bullying at school. There was a history of school phobia and truancy. He was expelled after committing a burglary and theft of computers from the school. He was later expelled from a college course for graffiti. He never had a job. He had a child by one woman, who was fourteen when their relationship began, and he had affairs with other women at the same time. He always lived with his parents. There was no family history of criminality or antisocial behaviour, although there was a family history of depression and other mental disorder.

In August 1998, about two years before the homicide, he was seen in outpatients with a range of problems. He was charged with stabbing someone, he had become depressed over the suicide of a friend, and he had smashed up a room in the house. He was seen twice and told the doctor he had been depressed for over a year and had cut himself. He showed no psychotic symptoms and was diagnosed as having mild depression and poor coping skills complicated by excessive intake of alcohol. When seen for the third time in October he appeared to have improved on antidepressant medication (although he revealed after the homicide that he had taken it only for a few days). When seen in December 1998, by which time he was in a young offender's institution serving two and a half years for grievous bodily harm, he was well. A court report prepared by a forensic psychiatrist in August 1998 also confirmed the absence of psychotic symptoms and noted his excessive alcohol intake. On probation in late 1999 and early 2000 he elicited no concerns and was "a model client" according to his probation officer.

The circumstances of the earlier stabbing were that the patient's girlfriend had alleged that the victim raped her when she was a child. The patient got into a fight with the man concerned, pulled a knife and stabbed him. The patient later reported other stabbings, of strangers, on two occasions when he was very drunk and had no apparent motive. These events were not known to services at the time.

The homicide occurred in September 2000 when he was out with a friend of similar age. They had been drinking heavily and the patient became paranoid and convinced that his friend was going to stab him, so he stabbed him first. After the offence he reported hearing voices for a long period of up to two years. Even after admission to a high security hospital there was doubt over the correct diagnosis. I was not able to track down a homicide inquiry report and it is possible one was never done, as he had not been in contact with services for about two years.

**Comment:** Assuming the correct diagnosis is schizophrenia, this is a case of the illness presenting with a serious and unpredictable offence. As there was no contact with services at the time, and contact two years earlier revealed no psychosis despite thorough assessment, it is difficult to make any comment about the likely effect of having carried out a structured clinical assessment of violence risk. Given all the uncertainties, it is debatable whether this case should have been included in the sample but it has been left as it illustrates the idiosyncratic, unpredictable nature of some of these offences.

**Case 24:****HCR20 Scores: H = 9, C = 2, R = 1****Main Issues: Offending before onset of illness; co-morbid drug addiction; homicide despite compliance with treatment and stable mental state; social influences on homicide; alcohol as a factor in violence.**

This 29 year old man had behavioural problems in childhood, including fighting, which led to his expulsion from school. He went on to acquire several criminal convictions before the emergence of his mental illness. His offending was mainly drug related. He was discharged from the army in 1993 for smoking cannabis, and he was later imprisoned for importing cannabis and cocaine. He became addicted to heroin and was treated with methadone but found it difficult to comply with the regime and used additional drugs. He developed hepatitis which caused him a lot of anxiety.

He presented with psychotic symptoms in April 1997, having cut his arm “to get the demons out”. During that first admission he assaulted another patient and a member of staff, following which he was taken away by the police and discharged as showing no signs of mental illness. In November 1997 he was seen in outpatients and noted to have been hearing voices for two years. He was prescribed oral antipsychotic medication. In July 1998 another consultant re-interpreted his symptoms as due to personality disorder and cannabis use but continued to prescribe oral antipsychotic medication and a mood stabiliser. He was discharged from the clinic but seen by a CPN. He was still taking both medications when seen in November 1999, having drifted out of contact when he changed address. In March 2000 he was noted to have stopped his antipsychotic medication and symptoms returned. Over the next two years the picture was dominated by his dependence on heroin, his struggles to stay on the methadone regime, and the diagnosis of hepatitis B in March 2001. He was often anxious but never floridly psychotic. His compliance with oral medication was good and he feared becoming psychotic.

The offence occurred shortly after Christmas on 27<sup>th</sup> December. He had been drinking heavily in the pub with friends when he was encouraged by others to join an attack on a man said to be a paedophile. He went to the man’s house with others, then beat him up and stabbed him. His family felt his mental state had been stable in the weeks leading up to the killing. There was no evidence of delusions or hallucinations at the time of the killing. He was last seen by services a couple of weeks before the offence and there were no concerns. He became floridly psychotic whilst in prison on remand.

**Comment:** This was a complex case in which the mental illness appears to have been peripheral to the homicide. Also, his main problem in the years before the homicide was opiate addiction rather than schizophrenia, as his mental illness was well controlled by oral medication with which he was generally compliant. It is not clear that a structured assessment of violence risk would have made any difference to management of this case. The psychiatric care was of a reasonable standard and appears to have had no direct bearing on the outcome.

### **Cases with five or six of a possible ten Historical risk items present**

By way of contrast, I present those cases with lower scores on the H items, cases 5, 12, 8 and 14. Note that they still have five or six of a possible ten items probably or definitely present, and two are inevitable due to the sampling criteria.

#### **Case 5:**

**HCR20 Scores: H = 5, C = 2, R = 4**

**Main Issues: Diagnosis not clear until after offence; no ongoing service involvement; misuse of alcohol; killed acquaintance under influence of a persecutory delusion after drinking heavily.**

This 27 year old man had a strong family history of schizophrenia and specific learning difficulties in childhood. There was no family history of criminality or antisocial behaviour. He had a caring family and a normal upbringing with the exception of needing a special school because of his learning difficulties. He was always a loner with poor social skills but had only one previous offence of damaging a car door. A group of boys were taunting him and he responded by kicking their car, for which he was fined.

He had a good work record in unskilled jobs but had lost contact with his family over the last few years and lived in a rather squalid bedsit. He drank too much but was able to carry on working.

The homicide was the killing of a man he had known for about six months. After they had both been drinking heavily he developed the delusion that the man had sexually assaulted him about a month earlier, and he stabbed him.

His only psychiatric contact was four years before the homicide when he attended outpatients for one month following the death of his father. The diagnosis was depression.

It emerged after the offence that he had suffered from delusions for some time, and the probable diagnosis was schizophrenia.

**Comment:** This case should not really be included in the sample as there was no previous violence, the diagnosis was not recognised until after the event, he had no ongoing contact with services and his only previous contact was treatment for depression four years before the event. No independent inquiry was held.

## Case 12:

**HCR20 Scores: H = 5, C = 1, R = 1**

**Main Issues: Unremarkable life before development of illness; drug and alcohol misuse; minimal previous violence; reasonable compliance and stable mental state; stabbed drinking companion after perceived insult to his mother; cannabis and alcohol use at time of offence; role of mental illness unclear.**

This 34 year old man had an unremarkable family history and a normal childhood apart from the disruption of emigrating to the UK from the Far East. He had no particular problems at school but left without qualifications and did unskilled work until he developed schizophrenia at the age of 25 years.

He had been in contact with services for about nine years by the time of the homicide and he was intermittently compliant. At the time of the killing he was taking regular injections of depot medication every three weeks with the next one due to be given four days after the date of the homicide. He had missed one of the four injections he should have had in the ten weeks preceding the offence.

The main complications of his case were related to drugs and alcohol, which he had used for many years. He had convictions for theft, burglary and possession of cannabis. His only violent offence was threatening behaviour and assault on a police officer, for which he received a one year probation order. He had no convictions since 1996.

The homicide occurred when he had been drinking (a couple of pints) and smoking cannabis and he killed a drinking partner who he believed had insulted his mother. There was a paranoid element to this belief although it may have had a basis in fact. There does not appear to have been any clear relapse of his mental illness, and his mother had noticed nothing out of the ordinary in the days leading up to the offence. He had a depot injection a couple of weeks before the homicide.

**Comment:** The Inquiry was persuaded that there had been a relapse before the offence but produced no convincing evidence to support that view. The panel made no specific criticisms of the patient's care but implied it could have been more cautious.

One of the Inquiry recommendations, accepted by the Health Authority, was: "A

standardised, brief risk assessment should be carried out on all [emphasis in original] patients receiving specialist psychiatric services and should be reviewed periodically (e.g. annually). Patients on higher level CPA and Supervision Register should be subject to a more comprehensive assessment of risks.”

This is a statement of good intentions but it is not clear how it would be implemented in practice, or if it would have made a difference in the present case. The fact is that the history of violence was unimpressive and the Clinical and Risk indicators on the HCR20 were at a reassuringly low level. There were no idiosyncratic features of the case to suggest a high violence risk. The issues in this case revolve mainly around drug and alcohol misuse rather than around mental illness. Even here, the situation was fairly stable, with no recent offending, and the patient would not have been a priority case for drug or alcohol treatment services.

The problem with the Inquiry recommendation is that a “standardised, brief risk assessment” is easier said than done. If it also to be effective, it should probably be a structured clinical assessment of risk, such as the HCR20. That is a sensible suggestion but it would have considerable training implications. One suspects that the Health Authority had rather less in mind when it accepted the recommendation. This identifies an important issue, that there is no general agreement on the definition of risk and therefore no agreement on what constitutes a risk assessment.

## Case 8:

**HCR20 Scores: H = 6, C = 5, R = 5**

**Main Issues: Stranger homicide arising directly from psychotic symptoms; normal before onset of illness; extensive violence and drug use after onset of illness; homelessness; extensive past efforts to manage violence risk, but possible failure to appreciate extent of violence risk; non-compliance; delay in intervention despite obvious deterioration; possible benefits of community treatment order.**

This 30-year-old man was essentially a normal student with an unremarkable family and childhood until he developed schizophrenia when he was twenty years old. The mental illness was of insidious onset and became very severe. He was never well again, he was never able to work, had limited insight and rarely complied with medication. He was often violent when he was unwell. He had a well documented history of attacks on fellow patients and on strangers. He had been on a Guardianship Order.

The offence occurred in October 1997 and he had stopped his depot medication in March of that year because it interfered with his sexuality. He was given oral medication but did not take it. His mental state was deteriorating for months before the killing. He lost accommodation several times, once because he set a fire.

The offence occurred when the police attempted to arrest him in his flat and he stabbed and killed one of them, acting on the delusional belief that they planned to rape him.

The Inquiry recommended tighter supervision and better attempts to increase compliance. The media focussed on the Inquiry's mention of incidents such as a GP once sending him medication in the post.

Comment: The Inquiry stopped short of recommending compulsory treatment in the community but it is hard to see why. The patient's history of previous violence including unprovoked attacks on strangers and vulnerable people, and would probably have been enough to warrant a restriction order in other circumstances.

The HCR20 assessment is complicated because of the early onset of mental illness. He does not score on historical variables relating to childhood disturbance, early violence and personality disorder/psychopathy. A case could be made for the latter two, as he functioned throughout his adult life as a man

with a personality disorder, but conventional practice is not to use personality disorder as a label when the personality change is clearly related to serious mental illness.

This is a case that illustrates why the HCR20 is not just about adding up numbers. He achieves the maximum rating on Clinical and Risk variables, which in conjunction with his history of serious violence identifies him as a high risk of violence when mentally ill. An assessment of this type would have made the risks explicit and would have encouraged the tighter supervision recommended by the Inquiry.

It is hard to avoid the additional conclusion that the key to safe management of this case was compulsory treatment in the community. When his history of violence, drug misuse and lack of insight is taken into account, the Inquiry's recommendations for encouraging compliance appear unrealistic in their optimism. Also, there are conflicting principles here. This was a patient from an ethnic minority refusing medication for a clearly stated, potentially valid reason: it interfered with his sexual potency. It is easy to say that mental health services should have overridden his wishes knowing that he went on to kill, but without the help of hindsight the decision is much more difficult. Either we want mental health services to respect patient autonomy or we do not. If the former, then they should not lightly go against a patient's wishes and it seems entirely proper that it should be a matter for a Tribunal when they want to impose medication on a man who clearly does not want to take it.

I recognise that this may be a minority opinion and it is not my role to repeat the Inquiry, and particularly not to claim that I can do a better job. Perhaps the way forward is for there to be a wider debate about when a patient's past violence reaches a point at which compliance really does become a matter of the public interest, rather than just an issue for the patient and the service? The MAPPPs may be relevant here and it seems likely that a patient of this type would now be referred to the local MAPPP. Even with MAPPPs, it is hard to see how this patient could be properly managed without the power to compel compliance, and the debate about when services should take control is rather academic if they lack the power to do so.

#### **Case 14:**

**HCR20 Scores: H = 7, C = 5, R = 5**

**Main Issues: Normal life until onset of illness; genuine doubt over correct diagnosis; secretive and non-compliant with assessment and treatment; misuse of alcohol; killed an acquaintance; combination of psychotic motive and victim genuinely bothering him; risk not fully appreciated and structured assessment may have helped; family were more concerned about violence risk than the service.**

This 31-year-old man was brought up in a conventional family and showed no behaviour problems, leaving school at 16 with a few CSEs. He had a reasonable work record as an unskilled labourer until he became unemployed in 1997. He had some problems sustaining intimate relationships, none of which lasted more than six months, but he had several such relationships and he had a child.

He was convicted of burglary and criminal damage at thirteen and of assault (a fight outside a pub) at the age of 17 years but there appear to have been no further convictions until early in 1998. He was . with his next conviction coming only when he was 32 in 1998 (details below).

He drank about six pints of beer every evening but was not dependent on alcohol, and there was no drug use beyond experimentation with cannabis in the distant past. .

He was first seen by services in 1996 after his GP requested a home visit. He was reluctant to allow the psychiatrist to enter or to interview him and no diagnosis could be established. No psychotic symptoms were apparent. His next presentation to services was after the offence early in 1998, which was an assault on a bus driver. The patient had been drinking heavily into the early hours the night before, and when he went out in the morning he thought the bus driver was deliberately annoying him. There are accounts of the bus driver saying something to him, whereas another account suggests he believed the driver deliberately made his brakes squeal. There were other symptoms of paranoia, including hearing noises in his flat when nobody was there. He reported feeling generally under threat and believing people were deliberately provoking him. The diagnosis was uncertain but he was given a probation order with a condition of psychiatric treatment.

The diagnosis remained uncertain. He was reluctant to allow full assessment and guarded his privacy closely. In April 1998 there was further deterioration, so

much so that an assessment was arranged to consider detention in hospital. The team conducting the assessment, which included a social worker and his GP, found no clear evidence of mental illness. It was decided that he should remain a patient of the specialist forensic service, until the diagnosis was clarified.

In late July he was assessed by a CPN from the court liaison service after an offence of breach of the peace. There were no psychotic symptoms but he smelled strongly of alcohol. A comprehensive assessment later that month concluded that he was probably suffering from a serious mental illness. He refused a trial of medication and was transferred back to the care of local services, as there was felt to be no risk of serious violence.

In October 1998 he expressed a variety of paranoid ideas and was noted to be living a fairly isolated existence in his flat, whilst drinking heavily in the evenings. An assessment early in that month concluded that he probably suffered from mental illness but did not appear psychotic and was not considered to be detainable under the Mental Health Act. He was subject to the CPA and had a full package of care including follow-up by CPN, psychiatrist, support worker and liaison with Probation. There was contact with the family, who sometimes expressed concern about his paranoid ideas and possible threats.

The homicide occurred in November 1998 when he killed an acquaintance, who was a heavy drinker and had apparently been bothering the patient for some time by coming round to see him when he was not wanted. At the time of the offence he was an unwelcome visitor in the patient's flat and there was an argument when both had been drinking, leading to a fight in which he tried to get the man to leave but ended up killing him.

**Comment:** There was real doubt over the correct diagnosis, which persisted after the offence and required a prolonged inpatient assessment before establishing a diagnosis of probable schizophrenia. The picture was clouded by heavy drinking. The mental illness had an insidious onset.

It is hard to involve the pitfalls of looking at this case with the benefit of hindsight. There were several detailed assessments, including prolonged supervision in the community by the forensic team and assessment for possible detention on at least two occasions, one only a few weeks before the homicide. All the decisions appear to have been taken carefully and all were reasonable.

It is likely that a structured clinical assessment of risk would have helped. The Historical factors were not in the extreme range but there was also concern about

all Clinical and Risk management factors. The structured assessment would have served as a reminder that this case was far from being under control, despite the high level of service contact.

There is also an issue about how family or carers are involved in a management plan. Their contribution here was to be more concerned than the clinical team about the risk of violence. Their concerns were justified by later events and it seems reasonable to suggest that a team should be particularly concerned whenever the concerns of carers or relatives are out of step with the concerns of the team.

## Other Cases

### Case 15:

HCR20 Scores: H = 7, C = 5, R = 3

**Main Issues: Family and social context of drugs, drinking and fighting; uneventful life until onset of illness; frequent violence in response to symptoms; misuse of drugs and alcohol contributed to his mental health problems; compliance reasonable and mental state stable; homicide was a pub fight involving his brother and friend as well; uncertain relationship between killing and mental illness, if any.**

This 27 year old man grew up in a close-knit intact family along with his two brothers, one of whom was also convicted of murder in connection with the homicide. All three brothers had a history of drug use and heavy drinking. He attended a normal school and left with four CSEs at the age of 16. There were no serious disciplinary problems although he truanted occasionally in his final year.

After completing a four year apprenticeship he worked as a self-employed carpenter but began to have problems at work in his early 20s, when he was twice sacked for hitting his boss and once for being unfit for work through drugs. He had used Ecstasy and cannabis and experienced psychotic symptoms at work.

He was convicted of ABH at the age of 18 when he punched a lifeguard who asked him to leave a swimming pool. Although he had no other convictions he was involved in numerous fights and assaults, often with his brothers. For example, at the age of 19 he was involved in a pub fight when his brother intervened to help a friend, and the patient joined in to protect his brother. At the age of 21 he was driving in a car with his brother and some friends when a pedestrian looked at them the wrong way so they drove back and attacked him, as a result of which the patient accepted a caution.

The patient was a heavy drinker from the age of 16 and took drugs from the age of 18, including cocaine and Ecstasy in large quantities. He took drugs with his brothers and friends, he never sought any treatment and does not appear to have believed he had a drug problem. He said he had not taken drugs, with the exception of cannabis, for a couple of years before the offence.

His mental illness had an insidious onset from the age of 19 years, when he was first aware of paranoid ideas. He was first admitted, as a detained patient, at the age of 25 years after he had broken windows at the home of his ex-girlfriend, about whom he had psychotic preoccupations. He was in hospital for six weeks and was discharged on oral and depot anti-psychotic medication in December

1996. He kept his appointments with the psychiatrist and he was compliant with the depot medication given regularly by his CPN.

The offence occurred in March 1998, The patient, his brother and friends were drinking in their local pub. The patient attacked a man he met that day in the pub. His stated motive was that the victim was a drug dealer attempting to sell drugs to the patient's brother, although both the patient and his brother had long histories of illicit drug use. The Claimant began the attack but his brother and a friend joined in. After dragging the victim outside the Claimant and his brother returned to the pub and smashed it up. As noted above, the brother and the friend were convicted of murder.

When seen ten days after the homicide the patient had no psychotic symptoms but he relapsed whilst on remand when his depot was stopped in order to clarify the diagnosis, the choice being between schizophrenia and a drug-induced psychosis.

**Comment:** Even with the benefit of hindsight I find it difficult to draw any lessons for mental health services from this complex case. The treatment of the mental illness appears to have been straightforward and psychotic symptoms played no part in the offence. One of the complications is that the patient had only one conviction yet he appears to have lived in a social where violence and illicit drugs were part of life. There were conflicting accounts of the index offence and the motivation for the attack. The brevity of this account is not a reflection of the material available. I have spoken to two psychiatrists who prepared medical reports on the two brothers but the picture remains the same.

**Case 16:**

**HCR20 Scores: H = 7, C = 5, R = 4**

**Main Issues: Mild learning difficulties; normal childhood; heavy drinking and violent offending before onset of illness; lost contact with services; killed wife in row arising from his delusions.**

This 28-year-old man grew up mainly in care after the death of his parents but had no serious behavioural problems in childhood. He had mild learning difficulties and worked only on training schemes, even before the onset of his mental illness in his early twenties.

He was a binge drinker and served a six year prison sentence for robbery at the age of 18 years. When drunk he burgled a flat and assaulted one of the residents. This was the first of his two previous convictions.

In 1994 he assaulted his stepfather and stepmother and damaged their home, resulting in criminal charges and a Hospital Order. He was diagnosed then as suffering from schizophrenia although it probably started years earlier. During this first admission he was described as having longstanding paranoid delusions. The delusions diminished but had not disappeared when he was discharged. He did well on medication but stopped it in August 1998 and deteriorated. He had drifted out of contact with services. He appeared to be doing well in terms of having an active social life, although he was not working.

He killed his common law wife (whom he had known for about a year) in December 1998 during the course of a row which arose from his delusions about her. There was a history of violence towards her. He was reviewed on remand by one of the doctors who saw him during his first (and only) admission, and he confirmed that the delusions present at the time of the offence were the ones with which he had presented to services four years earlier.

**Comment:** The main issue for the service was the way in which the patient drifted away from them and lost contact in the months leading up to the offence. I have not been able to track down a homicide inquiry.

**Case 17:**

**HCR20 Scores: H = 7, C = 5, R = 5**

**Main Issues: Stranger homicide arising directly from psychotic symptoms; normal before onset of illness; extensive violence and drug use after onset of illness; homelessness; non-compliance; delay in intervention despite obvious deterioration; possible benefits of community treatment order.**

This 31-year-old man was born in the UK to Jamaican parents. He had an unremarkable childhood and completed secondary education, his only problem being truancy in his last two years. He left at 16 with a few CSEs. He had a good work record in skilled manual jobs until he became mentally ill at the age of 19 years.

There were a couple of minor offences in his late teens but his offending escalated after the onset of his mental illness. Aged 26 he was arrested for stabbing a female acquaintance and set fire to his cell when on remand, resulting in his transfer to a medium secure unit. He was discharged to a hostel a few weeks later in January 1995, having been sentenced to a probation order with a condition of psychiatric treatment. The Inquiry was later to criticise this disposal, on the grounds that a hospital order with restrictions would have been more appropriate to such a serious offence.

Whilst on probation he was generally compliant with depot medication but uncommunicative. When the probation order ended in August 1995 he went to live with his mother. In September 1997 he stopped all medication, having been grudgingly and partially compliant until then. He was often withdrawn, socially isolated and apathetic. A CPN continued to visit him after he stopped taking his medication.

By early December 1997 he was relapsing with signs of hypomania and after voluntary admission ended with him discharging himself he was detained under Sect 3 on 15<sup>th</sup> December. His mother disagreed with the compulsory admission and had to be displaced as nearest relative.

During this admission, whilst at home on leave, he set fire to his car and burned himself, in an inept attempt to defraud the insurance company. This incident was thought to reflect his impaired judgment. In April 1998 he became violent when told he would have to take depot medication and it was necessary to call in the police to restrain him after he produced a screwdriver and threatened staff. He

was transferred to a medium secure unit and showed no insight into his illness or the seriousness of this incident.

He was discharged from the medium secure unit in December 1998 with a diagnosis of bipolar affective disorder and paranoid personality disorder. His medication was carbamazepine and risperidone, both taken orally. There had been real difficulties with his depot medication. Earlier objections had been based on weight gain, and he had developed breasts as a side-effect, so such an extent that surgical intervention was considered.

There were difficulties with his outpatient attendance soon after discharge and by February 1999 he was saying he wanted to sever all links with mental health services. Staff persuaded him to stay in touch but on 7.7.99 he reported that he had not taken any oral medication for about six months. He was again asking to break off all contact with services. His supervising consultant, a forensic psychiatrist, could find no definite signs of relapse. After discussion among the team there was contact with the patient's GP because of concerns that he may relapse in the immediate future. The seriousness of the situation was recognised by the psychiatrist, who consulted his medical defence society about his personal position.

On 6.8.99 the patient telephoned his consultant and asked to have access to his medical records. Although there were no other apparent signs of relapse apparent during the call, such a demand was known to be a possible early indicator of relapse in this patient. It emerged after the event that there had been several odd interactions with the GP around this time e.g. when the patient asked the GP to remove from his records all references to mental illness. The patient had also been to the police station to complain that hospital staff were following him around, but this information was not passed on to the team. The Inquiry details several failures of communication and of procedure relating to the CPA.

The homicide took place on 11<sup>th</sup> August 1999. The night before, the patient's sister had noted his wild demeanour and he presented at a general hospital complaining of sleeplessness and overactivity but did not wait to be fully assessed. Later that day he attacked and killed a stranger, an elderly man, immediately after he had stabbed a 12-year-old child and his father. The latter two victims survived but these offences were attempted murders. There was no interaction between victims and perpetrator before the homicidal attacks. He attacked the police who arrested him and was found to have started a fire and left the gas on at his flat, where he was restrained and arrested. The patient later linked his offences to an impending solar eclipse. He had believed the world was going to end and others were going to attack him so he had to get them first.

**Comment:** This is an example of the archetypal “stranger homicide” (see below under Discussion). In general terms, it is also a case in which there was a known violence risk that was not managed effectively. There were plenty of opportunities for earlier intervention and one of the lessons of the case is, in simple terms, that there is no need to wait for a florid relapse when a patient with a history of violence is non-compliant and allowing restricted access to his mental state. The previous stabbing was an indicator of what was potentially at stake here and there was too great a reluctance to intervene. If the case is worrying enough to prompt a call to the consultant’s defence union, it must at least warrant a Mental Health Act assessment.

Although a high risk was recognised, a structured clinical assessment may have been helpful. It would have made explicit the fact that, in a person with a history of serious violence, all the Clinical and Risk Management indicators were a cause for concern (reflected in the scores above of C = 5 and R = 5). The service proceeded on the basis that there were no grounds for detention but an explicit statement of the risk factors would have begged the question: if detention is not justified in a patient who ticks all the risk boxes, when is it justified?

The Inquiry pointed up many failures in communication and procedure but it is useful to look behind these operational or tactical issues to consider the overall strategy for managing violence risk in this case. The strategy was to monitor closely the mental state and intervene early in a florid relapse. Yet this was a patient who had never been forthcoming about his inner thoughts even when he was forced to comply. He was now refusing medication, had a recent history of covert non-compliance, and wanted no further contact with mental health services. He was willing to see his GP but only on the understanding that he had physical problems and his mental health was good – so much so that any reference to previous problems should be removed from the records. In other words, there had never been full access to his thoughts and it became virtually non-existent, so the only guide to his mental state was his behaviour – which was rarely observed.

In these circumstances, operational and procedural concerns miss part of the point. This was not an adequate strategy and could never have contained the violence risk, no matter how well it was applied. It must be remembered that a patient of this type, who concealed symptoms and lacked insight, was able to kill whilst on the admission ward of a high security hospital. As the mental state changes rapidly, and symptoms may be hidden at an interview, a reassuring presentation one day does not exclude the possibility of serious violence the next day, or even hours later. Close monitoring is not an adequate strategy for containing such a risk in the community and mental health staff are left in a difficult position when they rely on it (hence the consultant’s call to the defence union before the homicide).

The correct and inescapable strategy for managing the violence risk in this case was enforced compliance with medication. How could this have been achieved?

The Inquiry was critical of the failure to impose a hospital order with restrictions after an earlier stabbing. This comment has been made before by several homicide inquiries, so much so that it has become a well-worn subject of debate. The issues here were the usual ones. There was a readiness on the part of the CPS to reduce the original charges to less serious ones because the patient was so obviously mentally ill (he was unfit to appear in court on two occasions), and the patient's mental state improved with treatment so by the time the case came to court there was no indication for inpatient treatment.

Better liaison between agencies may help, and there are ongoing discussions on the related topic of prosecuting patients for offences committed whilst they are in hospital. The advent of MAPPPA also promises better coordination. But none of these developments addresses the fundamental problem, that this patient needed treatment for his mental illness but he did not need to be detained in hospital once he was taking medication. There is also an argument against the criminalisation of the mentally ill when offending is so clearly linked with psychotic symptoms, with no understandable motivation. The criminal justice system is based on notions of free will and moral choice and there will always be misgivings about labelling as a criminal a man whose violence derives from a malfunction of the brain.

This reluctance to criminalise the mentally ill is one of the positive aspects of our medico-legal system compared to that in the USA, and we should not abandon it completely. At the risk of repetition, the solution to this issue is surely a community treatment order. Had one been in existence, the team concerned would almost certainly have used it to enforce compliance with medication and these attacks would not have happened.

**Case 23:**

**HCR20 Scores: H = 7, C = 5, R = 4**

**Main Issues: Normal until onset of mental illness; frequent violence to family; killed father while floridly psychotic; had lost contact with services.**

A 31 year old man with a fairly uneventful childhood who developed schizophrenia in 1990 when he was a 20 year old student. He was poorly compliant with appointments and medication and drifted out of contact with services. His violence was mainly within the home, and he had attacked his father on numerous occasions before he killed him in 2001, acting under the influence of persecutory delusions. He had had no contact with services since 1997. He was unwell for much of the intervening time.

**Comment:** The inquiry report was critical of a failure to involve the family in his care at an early stage, as they did not know how to access help when they needed it. For present purposes there is little more to say about the case.

## Case 25:

HCR20 Scores: H = 7, C = 4, R = 4

**Main Issues: Homicide by a treated patient on a restriction order; homicide arising directly from psychotic symptoms; little antisocial behaviour before onset of illness; extensive violent offending and drug use after onset of illness; co-morbid cannabis use known to be associated with deterioration in mental state; failure of services to appreciate extent of violence risk; failure to intervene despite known positive symptoms and continuing use of cannabis over a long period.**

This 40-year-old man had a fairly uneventful childhood and first became mentally ill at the age of 21 years.

He was placed on a hospital order with restrictions in 1993 for offences of arson and possession of a controlled drug with intent to supply. He set at least seven fires over a three year period, some of which were related to deterioration in his mental state brought about by smoking cannabis. He spent several years in a medium secure unit before being conditionally discharged in July 1997. He was violent during the admission. In 1986 he had also attacked and threatened to kill a female police officer when he was mentally unwell.

The offence took place at the hostel where he had lived for five years. He attacked an elderly fellow resident for no apparent reason, grabbing him and cutting his throat. There was no history of bad feeling between them.

The patient was well known to staff and to those supervising him in the community. He was known within the hostel as a man who was sometimes sullen and often talked or laughed to himself. The main issue in his supervision had been his continuing use of cannabis. The team were concerned about it and had instituted urine checks "as a baseline" but they were always positive. There had been a brief re-admission due to cannabis use in 1997 and he had been asked to leave the hostel in 1998 because of continuing cannabis use. In July 2000 the team recommended a move to his own flat, despite continuing use of cannabis. This attempt at independent living failed about a year before the offence, when his mental state deteriorated, probably because he was using a lot of cannabis. He had a brief re-admission to hospital as a voluntary patient, and then returned to the hostel.

He was compliant with prescribed medication but, as noted above, there were persistent abnormalities in his mental state. An account from the hostel manager described him as often being awake all night, sitting talking to himself, staring

into space, and showing poor concentration. Another resident had complained he was banging on doors on the night before the offence.

The patient reported later that he had been thinking of killing somebody for two weeks, so went to a shop and bought a knife.

**Comment:** This is an extraordinary case, particularly as it concerned a restricted patient. The main concern throughout several years in the community was continuing use of cannabis, which had been closely involved in the offences that led to the restriction order in the first place. It is difficult to understand why this situation was tolerated by the team or by the Mental Health Unit of the Home Office, except that it seems to have become established over a long period of time. The attack on the fellow resident was not predictable, but the continuing disturbed mental state and use of cannabis was an unacceptable risk, given the history. Part of the problem seems to have been that the team just got used to the patient and to his drug use.

## **Discussion and Recommendations**

### **Structured Clinical Assessment of Violence Risk**

#### ***Methodological Issues***

A structured violence risk assessment instrument is a useful and informative way of looking at homicides by psychiatric patients. It was possible to complete the instrument in all cases, although the quality would undoubtedly have been higher had it been possible to carry out the assessment before the event, with the addition of data from an interview.

This limitation does not negate the findings. The nature of the HCR20 is that it encourages a search for risk factors. If there is more information, it may be possible to identify more risk factors, but the additional information is unlikely to negate factors that are already identifiable. In other words, the scores presented here may have been higher if the assessment had been done at the time, but they are unlikely to have been lower.

The value of the HCR20 in the present exercise, is that it gets round some of the problems relating to hindsight. A common criticism of Homicide Inquiries is that they look at clinical practice in a biased or distorted way because the “future” has already happened. There are many things in life we would do differently if we had the privilege of knowing how things would turn out, but this insight has no practical value. The HCR20 is different because it looks at the patient rather than at clinical decisions, and the criteria for each item have a degree of objectivity. This is particularly so for the Historical items, on which I have placed most reliance. For example, characteristics such as “Previous Violence” (H1), “Young Age at First Violent Incident” (H2), “Relationship Problems” (H3), “Employment Problems” (H4) or “Substance Use Problems” (H5) are not likely to have been altered by hindsight.

The only way in which hindsight is likely to elevate ratings is if the homicide leads to the collection of data that was not available before. It is one of the cruel ironies of a homicide inquiry that hundreds of thousands of pounds are expended on the collection of detailed information about a patient, when the service looking after him did not have the resources to gather data from so many sources. By contrast, the HCR20 relies on a limited set of variables and the data required ought to be available to any team looking after a patient with a history of violence. For example, the Clinical Items are: Lack of Insight; Negative Attitudes; Active Symptoms of Major Mental Illness; Impulsivity; and Unresponsiveness to Treatment. If the team do not have the information available to estimate these basic features of a case, they are not in a position to address risk. This is the sort of information that should be available to a team, rather than the detailed historical information collected by an Inquiry.

I was not able to complete the second part of the HCR20, which involves the construction of possible scenarios of violence and the development of a risk management plan. This would normally be undertaken at a CPA meeting and the problem of hindsight makes it an artificial exercise after the event. Prospective studies confirm the usefulness of this approach, and a paper by Dolan and Doyle, reporting positive findings, has been accepted for publication.

### ***The value of structured clinical assessment of violence risk***

Many of these Inquiries, and others before them, called for the introduction of better risk assessment procedures. Most Trusts have some form of clinical risk assessment in place but most do not have a true, structured clinical assessment such as the HCR20. The most basic approach involves ticking boxes relating to a patient's history and may offer a false sense of reassurance. An effective system requires systematic consideration of past history, present state, and future placement and stressors.

The Inquiries were certainly right to call for better risk assessment procedures. There was a sense in some of these cases that the team had no awareness of the level of risk they were dealing with. Even after the event, some commented that the risk had been low even when the indications of increased risk were obvious once a structured approach was followed.

A lot of the debate about violence risk assessment focuses on the accuracy of prediction but these cases reveal a more basic problem. Teams are often unable to formulate, describe or communicate an assessment of violence risk. Such an assessment is multifaceted and ought to include consideration of the type of violence, the likely victims, exacerbating and alleviating factors, and the duration and immediacy of any risk. Instead, assessments are limited to "low" or "high" and they are often wrong even in their own simple terms. The first step in improving risk management is to develop an agreed way of describing risk. Until there is a common language, it is impossible to make much progress.

**Recommendation:** Mental health teams need to develop a common way of formulating, describing and communicating violence risk.

**Recommendation:** All mental health teams should have access to a structured clinical assessment of violence risk and should incorporate its findings into the care management of patients with a history of violence.

## **Compliance and Compulsory treatment in the community**

From the small number of cases that form the sample for this report, this one issue stands out above all others. Risk assessment alone is not enough and there has to be an effective means of managing that risk. Given the nature of the sample, which is defined by the presence of serious mental illness, it is inevitable that medication and compliance are major issues. Non-compliance was an identified problem in most of these cases.

It is not surprising that discussions of compliance featured in most of the Inquiry reports, and there were a range of suggestions for addressing the problem. They include compliance therapy, motivational interviewing, better involvement of carers and relatives, use of restriction orders to deal with previous violent offending, and better monitoring to ensure compliance. All of these are good suggestions, and most services use these strategies and techniques to a greater or lesser degree.

However, when the cases are considered together, these suggestions are not an adequate response to the problem. The sample was defined by the presence of serious mental illness and previous violence but many of these cases had a well-documented lack of insight into their mental illness, accompanied by negative and hostile attitudes to services, and to authority in general. Some had criminal or antisocial attitudes that were well entrenched before the onset of mental illness. Even with persuasion, many of these patients were never going to comply voluntarily with medication. The task of persuasion in such patients is likely to be time-consuming, difficult and unsuccessful, particularly because the aim is compliance with medication over many years. It is reasonable to expect a team to sustain a high level of input to ensure compliance over a brief period but it is not reasonable to expect that effort to be sustained indefinitely. There are also resource implications. Should teams divert most of their resources to problems they probably cannot solve?

When we consider existing powers, it is easy but misleading to criticise individual decisions on detention. The 1983 Act is worded so as to allow the detention of practically any non-compliant patient with a mental illness, on the grounds of detention being necessary for the patient's health, but such detention appears pointless if it is just another turn of the revolving door, rather than the beginning of long-term, effective treatment.

The histories of many of these patients are peppered with brief admissions, and it is unrealistic so suppose the answer is to be found in yet another admission. Schizophrenia is a chronic relapsing condition and it follows that effective compulsory treatment will need to be administered on a long-term basis. In many of these cases, services were struggling with difficult and dangerous patients, sometimes with well-established histories of violence and other antisocial

behaviour before the onset of mental illness. If they are to take on and manage such people, services must be given the legal powers to do so effectively.

Added force is given to the case for compulsory powers by the fact that their absence has been mentioned so many times in homicide inquiries. Case #3 above is an ideal example. The Inquiry was thorough and identified only minor issues relating to the patient's care but came to the firm conclusion that the case could only have been managed safely if there had been the power to impose treatment in the community. It is a truism of risk management that risks become less acceptable once attention has been drawn to them. The Inquiry report on Case #3 was published in 1999 and, given the stated priority of reducing violence risk, urgent consideration should be given to introducing some form of compulsory treatment in the community.

Case 3 suggests that any such change in the law would have wide ramifications. A new law could have been used in that case to good effect but the impact on other cases may have been even greater. Case 3 was an example of team doing everything possible within existing law to measure and manage violence risk. In several other cases, there was a failure to address known risks of violence, deriving in part from a sense that nothing could be done about it.

By focussing on individual decisions not to detain a patient at a particular time, Inquiries sometimes miss the wider perspective. A sense of fatalism and futility pervades the management of some of these cases. The prospects for compliance are correctly assessed as poor and the illness is severe, chronic and relapsing, so a decision on a brief admission becomes relatively unimportant. It offers no solution to the long-term problems. Of course, that changes when a homicide occurs, but this is with the wisdom of hindsight. It is unrealistic to expect that teams will be able to know precisely when to intervene to prevent such events when they are managing high, long-term risks of violence in uncooperative patients.

The lack of such powers discredits the whole enterprise of risk management. There is understandable scepticism about the value of measuring a risk when one lacks the means to do anything about it. Also the focus on compulsory admission, because that is the only form of compulsion permitted, reduces the question to one of admission v. non-admission. If there were compulsory powers in the community, the focus would move away from an obsession with admission, to the more pressing question of safe management in the community.

**Recommendation:** There is a need for legal powers to allow compulsory treatment in the community of patients with a serious mental illness and a history

of violence and non-compliance.

### **Drug and Alcohol Misuse: Dual Diagnosis**

In all but two of the sample cases there were known problems of drug and/or alcohol misuse. The case descriptions above show how often intoxication was involved in the homicide itself. This is not surprising, in that intoxication is a well-recognised risk factor for violence. In community surveys of violence and mental disorder, substance misuse is reliably identified as having a stronger association with violence than does mental illness in its own right, and the combination of mental illness and substance misuse problems usually has the highest risk.

Whilst there is no doubting the importance of substance misuse, the association is complex and does not lend itself to simple solutions. There is a vast criminological literature on alcohol/drugs and violence, and the only simple message to emerge is that the links are strong but complicated. Apart from the direct effects of intoxication and the social decline that may result from spending money on substances rather than on life's necessities, there is a social dimension. Heavy drinking or drug use often takes place in a social environment where violence is not only acceptable but a preferred and respected method of resolving conflict. As cases 15 and 24 illustrate, the mentally ill are not isolated from that world. Leaving aside the complex questions in these cases concerning the possible effects of (treated) schizophrenia in leading to paranoid thoughts, impulsive aggression and violence, both concern violence that originated in the pub and involved the active participation and encouragement of friends or family in whom there was no question of mental illness.

Cases such as these show the complexity of the issues facing mental health teams attempting to address the risk of violence. It is obviously right for mental health teams to respect the family and cultural background and beliefs of patients, but there is a dilemma when that background includes heavy drinking and use of illicit drugs, in a subculture that condones violence in many situations. The cases summarized above show a range of responses to the problem, with different degrees of tolerance to the use of cannabis or alcohol. That is not unreasonable, given the complexity of the problem, but there was no sense of any systematic assessment or decision-making process.

The common response of Inquiries to substance misuse problems is to recommend the greater involvement of substance misuse services, or the setting up of specialist Dual Diagnosis teams. It is hard to disagree with this advice but it has far-reaching implications, given the frequency of the problem. The immediate question is therefore one of determining priorities.

In this respect it is useful to look at the way in which substance misuse figures in risk assessment schemes such as the HCR20. It is taken into account alongside other risk factors, both as a Historical indicator of risk, and as a Risk Management item, "Exposure to Destabilisers". It may also be scored under the Risk Management heading of "Stress" if substance abuse contributes directly or indirectly to the stresses facing a patient in the community. These include the social and financial stresses that may flow from substance use. In this way, the problem of substance misuse is assessed within the wider context of the patient's life and the overall violence risk.

Substance misuse in the context of serious mental illness and violence may greatly increase risk, yet there is little sign within these cases of it being considered as an indication for use of compulsory powers. The 1983 Act does not allow detention for substance use alone but it is an important indicator of the nature and extent of a mental illness, and the associated risks to others, so it should be included in any assessment for possible detention.

**Recommendation:** Substance misuse problems in patients with severe mental illness and a risk of violence should be assessed and managed within a structured clinical risk management plan. Proper consideration should always be given to the possibility of using the Mental Health Act in such patients.

**Recommendation:** In patients subject to a restriction order there should always be consideration of setting conditions relating to abstinence from drugs or alcohol and the standard procedure should be immediate recall if that condition is breached.

### **Setting Limits and Early Intervention**

To some extent, this general topic cuts across several other recommendations but it deserves emphasis. In several of these cases (e.g. Cases 8, 17, 19 and 20), including two conditionally discharged restricted patients (Case 13 and 25), there was a clear case for earlier intervention. The teams seemed to have no clear idea of where to draw the line when there was deteriorating behaviour, non-compliance or drug misuse. The restricted cases were particularly anomalous, with a history of known cannabis use for many years. It has become commonplace for CPA meetings to list signs of relapse or deterioration but the missing element seems to be a clear statement of when to intervene. It is pointless to identify early warning signs of relapse unless they lead to action.

Several factors appear to have impinged on the management of cases where limits were a factor. There was a sense of familiarity leading to complacency. For example, Case 13 had a long history of drug misuse so it became acceptable. In

Case 17, one wonders if the forensic team had become desensitised to the indicators of violence risk that were all too apparent.

Limits are important because they can make psychotic patients feel more secure when their own, internal boundaries are fragile. Also, if there is no attempt to set limits, it becomes impossible to access further information about the patient's mental state. For example, the suggestion to a patient that he should stop using drugs may lead into an exploration of his attitudes to drugs, his illness, and treatment, whereas no information is obtained if the behaviour is never challenged.

The argument against early intervention would be that it is too intrusive and would lead to unnecessary treatment. This argument is weak when there is a history of violence, and structured risk assessment of violence risk would also guide teams in deciding which patients should be given priority.

**Recommendation:** There should be early intervention when there are signs of deterioration or risky behaviours in patients with a history of violence. This principle should rarely if ever be ignored, even when a patient is well known to the service. If in doubt, the team should err on the side of caution.

**Recommendation:** When dealing with patients with a history of violence and serious mental illness, CPA meetings should set clear, operational criteria for intervention. These criteria should be communicated to patients and carers so they have clear expectations.

### **Forensic and Generic Services**

Forensic services were not directly involved in most of these cases at the time of the homicide and there were worrying aspects to those cases in which they did have responsibility. Of course, this is a highly selected sample and does not reflect the overall impact of forensic services in any way. Still, some general points can be made.

There would be a case for greater forensic involvement in those patients with the highest violence risk. Professors Fahy and Hodgins have suggested that the presence of many risk factors in the history (a high H score on the HCR20) is a good indicator of a forensic patient, whereas it is not unusual to find elevated Clinical or Risk Management scores in general psychiatry patients who are acutely unwell. This may be an over-simplification but it is a good starting point. Most of the high H scores in this sample did not have input from forensic services. Case 2 was an exception, where there had been

a recent opinion from a forensic psychiatrist that greatly strengthened the position of the team at the Inquiry.

**Recommendation:** The basis for referral of cases between general and forensic teams should be a structured clinical assessment of violence risk.

**Recommendation:** A forensic opinion should be sought in respect of those patients with the highest level of violence risk.

**Recommendation:** Forensic teams should manage patients in the community with a higher level of supervision than the general team can provide. They should intervene earlier when there is deterioration, because of the higher background risk of violence.

### **Diagnosis and the Medical Model**

Diagnosis is important in risk management because the identification of a mental illness implies the availability of an effective treatment. However, diagnosis is less important in the assessment of violence risk and is correctly considered as just one of many factors.

In many of these cases, a lot of time and effort was spent on the question of the correct diagnosis, whilst failing to recognise the violence risks involved in the case, irrespective of the precise diagnosis. It is often difficult and sometimes impossible to arrive at a definitive diagnosis in psychiatry, so the team needs to be able to assess and manage violence risk in conditions of diagnostic uncertainty. If there is an adequate risk management plan in place, based on a provisional diagnosis, a definitive label can safely wait.

There were particular problems over the diagnosis of drug-induced psychosis, which seemed to be approached with an emphasis on voluntary intoxication, and insufficient recognition that it is a psychosis with the same potential for disaster as in schizophrenia. Also, as many if not most patients with schizophrenia use drugs, usually to the detriment of their mental state, the distinction between schizophrenia and drug-induced psychosis is often impossible and of little practical importance.

Personality disorder also presents difficulties, as it was too often seen as precluding the need for a full assessment of risk.

**Recommendation:** Violence risk assessment should be undertaken early in a patient's contact with services. It will always be subject to revision as new

information emerges but it should never depend on the presence of a specific diagnosis alone.

**Recommendation:** The diagnosis of drug-induced psychosis should be discouraged or abandoned.

### **Involvement of Carers**

This is a complex issue, as illustrated by those cases in which carers opposed necessary intervention or participated in antisocial behaviour that made violence more likely. Notwithstanding these difficulties, there was a worrying lack of involvement of carers in some cases, and in others their clearly expressed concerns about violence were ignored. This is a particularly serious failing given that carers or relatives are most exposed to violence risk.

**Recommendation:** Concern about violence risk should be shared openly with patients and with carers whenever possible, supported by copies of care plans and other relevant documents.

**Recommendation:** The assessment of violence risk should be thoroughly reviewed whenever the carer appears more worried than the team.

### **The Inevitability of Violence**

I have focussed on ways in which care can be improved but the message from some of these cases is that serious violence cannot always be predicted or prevented. This is particularly the case when it is coincident with the mental illness rather than a consequence of it. The policy of social inclusion means that services now treat patients with a high background risk of violence, who would probably have been excluded twenty years ago. Documents such as “Personality Disorder: No Longer a Diagnosis of Exclusion” will inevitably lead to an increase in serious violence by patients, by making more violent people patients. When reviewing Inquiry reports one is confronted by the unfairness of some comments made with the benefit of hindsight, and the consequent damage to morale in general, as well as to the staff directly involved.

**Recommendation:** The Department’s strategy for managing serious violence by patients needs to recognise that it is sometimes inevitable and should offer support to staff as well as reassurance to the public.

## **Headline Recommendations**

### **1. Structured Clinical Assessment of Violence Risk**

**Recommendation:** Mental health teams need to develop a common way of formulating, describing and communicating violence risk.

**Recommendation:** All mental health teams should have access to a structured clinical assessment of violence risk and should incorporate its findings into the care management of patients with a history of violence.

### **2. Compliance and Compulsory treatment in the community**

**Recommendation:** There is a need for legal powers to allow compulsory treatment in the community of patients with a serious mental illness and a history of violence and non-compliance.

### **3. Drug and Alcohol Misuse: Dual Diagnosis**

**Recommendation:** Substance misuse problems in patients with severe mental illness and a risk of violence should be assessed and managed within a structured clinical risk management plan. Proper consideration should always be given to the possibility of using the Mental Health Act in such patients.

**Recommendation:** In patients subject to a restriction order there should always be consideration of setting conditions relating to abstinence from drugs or alcohol and the standard procedure should be immediate recall if that condition is breached.

### **4. Setting Limits and Early Intervention**

**Recommendation:** There should be early intervention when there are signs of deterioration or risky behaviours in patients with a history of violence. This principle should rarely if ever be ignored, even when a patient is well known to the service. If in doubt, the team should err on the side of caution.

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## **5. Forensic and Generic Services**

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## **6. Diagnosis and the Medical Model**

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**Recommendation:** The assessment of violence risk should be thoroughly reviewed whenever the carer appears more worried than the team.

## **8. The Inevitability of Violence**

**Recommendation:** The Department's strategy for managing serious violence by patients needs to recognise that it is sometimes inevitable and should offer support to staff as well as reassurance to the public.