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Case report

THE DEATH OF VICTIMS AS A RESULT OF SCHIZOPHRENIA OR OTHER SERIOUS MENTAL ILLNESS; WHAT HAVE WE LEARNT OVER THE YEARS?

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SUMMARY

From time to time, tragic cases occur when patients with serious Mental illness commit homicide. We describe two cases which are in the public domain.These cases are not isolated incidents but part of a broader, systemic failure to provide sustained, assertive, and well-resourced community-based mental health care. It is crucial that the techniques of Assertive Outreach we have discussed are not only adopted in principle but also fully integrated into everyday practice, backed by proper funding, staff training, and institutional support. Without this commitment, we risk continuing the tragic cycle of preventable deaths, where both patients with severe mental illness and innocent bystanders pay the price for gaps in the system. By applying assertive outreach models effectively, we have the opportunity to change the trajectory of care, ensuring that vulnerable individuals receive the intensive, proactive support they need to remain stable, safe, and ultimately, to prevent such tragedies from happening again.

Key words: *paranoid schizophrenia - assertive outreach – homicide - mental health management*

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THE CASE OF TENNYSON OBIH

In June 2007, Ikechukwu Tennyson Obih, a 29-year-old Nigerian immigrant stabbed A window cleaner, Stephen Chamberlain. He was stabbed in a random attack. A policeman, Jonathan Henry, who happened to be a Catholic in the Parish of Holy Ghost Church, which M.A, attends., attempted to arrest Tennyson Obih, but was stabbed to the heart and died.

At around 7:18 am on 11 June 2007, having begun his shift at 7 am, Jonathan Henry responded to 999 calls reporting a stabbing on George Street in Luton town centre. A window cleaner, Stephen Chamberlain, had been stabbed in a random attack (wikipedia). Henry approached the suspect from behind to attempt to arrest him but was stabbed in the chest with a 4+1⁄2-inch (11 cm) knife; he was stabbed a second time as he lay on the ground wounded.

Another window cleaner, David Knight, struck the suspect over the head with a window cleaning pole. Police back-up officers then used a baton round and two shots from a Taser to subdue the suspect (Burgess 2009). Henry was taken to Luton and Dunstable Hospital by ambulance but died of his injuries later that day (Smith 2007).

Ikechukwu Tennyson Obih, who suffered from paranoid Schizophrenia, a 29-year-old Nigerian immigrant, was convicted of Henry's murder on 26 March 2009 and sentenced to life imprisonment with a minimum tariff of 25 years by Mr Justice Bean (BBC 2009).

Obih abused alcohol and cannabis and from 2004 he heard voices and hallucinations and had delusions. During his trial the jury heard how Obih believed that he had special powers, could predict the future, and could make something explode just by pointing at it. He also distrusted the police.

Obih had denied the charge of murder, but admitted manslaughter on the grounds of diminished responsibility. The jury rejected this defence and found him guilty of the murder of Henry, the attempted murder of Chamberlain and the wounding with intent of Knight (he was found not guilty of the attempted murder of Knight). Obih was also convicted of aggravated burglary and assault occasioning actual bodily harm in a separate incident on the same day. The judge accepted that Obih's schizophrenia was a mitigating factor in the case, and recommended that he receive psychiatric rehabilitation at a high-security mental hospital (Burgess 2009).

Marjorie Wallace, chief executive of the mental health charity Sane, said: "This tragic case once again raises urgent questions about how people with severe mental illness can live safely in the community. Homicides by mentally ill people are rare, but Sane's own analysis of 69 homicide inquiries revealed at least one-in-three to be preventable." (BBC 2009).

M.A. had been the doctor that, several years before, first diagnosed Mr Obih with Schizophrenia. It had been particularly difficult to make the diagnosis, and this case was one in which it was necessary to create a timeline of past assessments and admissions to psychiatric services for bizzare behaviours in order to make the case for a developing psychotic illness, which have been described in previous papers (Agius 2010, 2023, 2024). The Early Intervention Team which M.A. worked with was designed to follow assertive principles of treatment,

and was able to treat him effectively with Rispedal Consta by injection. Thus we were able to treat him in the community. effectively by engaging with him and treating him effectively. However, for reasons of lack of resources, the team was disbanded in 2005. Obih was then treated in another community team, and he disengaged from services (Hussain 2010). As a result his treatment stopped and he fell out of sight and he resurfaced in the incident in which led to Mr Henry's death.

In the resulting trial, two eminent forensic psychiatrists agreed with my diagnosis and Obih was sent to a secure Hospital "at her majesty's pleasure" in other words till he was safe to the public. Also, M.A. and the team were complemented at the subsequent enquiry for the assertive care they had given him.

THE CASE OF VALDO CALOCANE

In June 2023, Grace O'Malley-Kumar, a medical student, and her friend, Barnaby Webber, also a University Student, were both attacked and killed by ValdoCalocane, also a patient with paranoid schizophrenia. while they were returning from a night out. Grace was an England hockey player, and died attempting to protect her friend. It has been proposed that she should be awarded the George Cross (Gilbody Dickerson 2024). School caretaker Ian Coates was also killed in the same incident.

It transpired that Valdo Calocane had been lost to follow up because he did not accept that he was ill, and refused injection medication because he was afraid of needles. He too was lost to follow up.

What M.A. proposing is to compare the two cases and then to argue that we have not learnt, in the intervening years, that patients with schizophrenia must be managed assertively, that they need to stay on medication, and that compliance with medication should be maintained. If they are considered a risk to the public, they should be admitted to hospital, until they are no longer a risk, and that sufficient resources must be available to ensure appropriate treatment.

It seems that the lessons of previous deaths have not been learnt.

ASSERTIVE OUTREACH

What is clear is that it is insufficient to let persons who are suffering from Paranoid Schizophrenia be discharged into the community with insufficient follow up. They need to be followed up by a Care Coordinator, using a Technique called Assertive Outreach. In this technique, the care coordinator fully assesses the needs of the patient, be they medication, financial, social, Housing, and even support to return to work. A full risk assessment is carried out, if risks are observed they are addressed, and this includes refusal to take medication, and risks to self and Others. Risks which are considered serious need to result in re-admission to Hospital until the risks are eliminated. Such work is difficult, painstaking, and expensive, but it is essential. It implies the provision of sufficient Case Coordinators to support all the seriously ill patients in the locality and sufficient beds to assure admission to Hospital where necessary.

In a Paper several years ago (Agius 2005), we had described Assertive Outreach Work. Patients experiencing severe mental illness, once their acute phase has subsided, can generally be supported safely at home or with their families, assuming they no longer pose a significant risk to themselves or others. In some cases, even during the acute phase, home treatment is feasible if a dedicated specialised team is available. The current evidence base for managing serious mental illness is well captured by the WHO declaration, which emphasises that mental health services are too often provided in institutional settings that offer limited choices for patients and their carers. Hospital admission should be considered a last resort. Many individuals with severe mental health conditions, especially those vulnerable or marginalised, face challenges in accessing and maintaining contact with services. Service structures frequently fall short of delivering evidence-based care in the least restrictive environment. Specialist mental health services must have the capacity and capability to care for people with severe disorders - such as schizophrenia, bipolar disorder, dementia, or major depression - in community settings (WHO 2004). Signatory countries to this declaration commit to developing and implementing specialist community services that are accessible 24/7, staffed by multidisciplinary teams, and include crisis services capable of delivering care at the patient's residence to prevent unnecessary hospital admissions. Only those with the most severe needs or risks should be admitted (WHO 2004). Numerous studies support home treatment approaches for serious mental illness (Kulkarni 1999; Burns 1993; Hoult 1983, 1984). However, the presence of specialised teams is essential. Therefore, it is advisable that countries lacking a history of Community Mental Health Services begin by establishing Community Mental Health Teams to build staff expertise in community care, followed by the introduction of home treatment teams once the workforce is sufficiently experienced and confident.

The ultimate goal of aftercare for patients with serious mental illness should be Recovery - enabling individuals to return to their preferred form of employment or education, or something as close as possible to their previous roles prior to illness. Recovery must be the central objective of treatment, and it is best evaluated by how well patients reintegrate into work or educational activities post-illness. The WHO declaration highlights that employment is vital for income, self-esteem, and social identity, and most individuals with mental health conditions desire and are capable of

working (WHO 2004). Similarly, the IRIS guidelines for treating young people with psychosis recommend that strategies facilitating patients' return to work or valued occupations should be developed during the critical early period (IRIS Guidelines 1999).

Another key objective of aftercare is supporting patients' reintegration into society, particularly by restoring social connections with family and friends, which are essential for a normal life. This standard encompasses addressing all social needs that enable the patient to become a fully contributing member of their community. The WHO states that mental health can be promoted, mental disorders prevented, and recovery achieved, although health resources are often inequitably distributed. Vulnerable groups, including children, the elderly, and minorities, frequently have the poorest access to care (WHO 2004). The WHO further commits to reducing societal stress and marginalisation, preventing suicide, and implementing targeted interventions such as education, support programmes, self-help groups, telephone helplines, and web resources for high-risk populations. Additionally, community development programs and empowerment of NGOs representing marginalized groups are crucial (WHO 2004). Social determinants like urbanisation, migration, and deprivation significantly increase the incidence of schizophrenia (Boydell 2003) and must be addressed. The IRIS guidelines advise comprehensive, collaborative assessment plans tailored to the needs and preferences of patients and their families, ensuring basic daily living needs - housing, finances, practical support - are met (IRIS Guidelines 1999). While NGOs and self-help groups play an important role in advocacy and support, they cannot replace government-funded mental health services or act as the sole community psychiatry resource. Therefore, these organisations should be part of a balanced government response to mental health needs.

To implement these standards effectively, each patient should be assigned a dedicated care coordinator responsible for ensuring comprehensive care delivery. This coordinator might be a nurse, social worker, psychologist, or occupational therapist who acts as the central contact point, collaborating with the patient and family to identify needs and develop care plans. Care coordination may take various forms, including 'brokerage case management' - where the coordinator operates mainly from an office, linking patients to services - or 'assertive case management,' where the coordinator actively ensures needs are met through direct, proactive engagement. The WHO commits to empowering mental health staff with responsibility for identifying and addressing patients' needs, either directly or through coordination (WHO 2004). The IRIS guidelines recommend early allocation of a key worker following referral to develop rapport and maintain continuity of care, preferably within an assertive outreach framework (IRIS Guidelines 1999). Absence of such coordination is linked to substandard care. The foundational study by Stein and Test (1980) demonstrated clear benefits of assertive case management over no case management after discharge. Later studies comparing brokerage case management teams found assertive case management to be more effective, though with somewhat less dramatic differences – likely due to improved care in brokerage models (Burns 1999; UK700 Group 1999). Key factors contributing to assertive case management's success include a single accountable key worker, continuity of care, medication compliance, strong multidisciplinary teams with integrated psychiatrists, and adherence to the assertive community treatment (ACT) model (Samele 2001). Recent research also shows that assertive teams treating young people with psychosis achieve better outcomes than standard community mental health teams, largely due to greater intensity of contact (Craig et al. 2004). The WHO declaration stresses the commitment to providing effective, culturally sensitive treatments with minimal risk (WHO 2004). When shaping mental health policies, countries must decide whether to prioritise brokerage-based community teams or invest in more resource-intensive ACT teams, which offer improved long-term outcomes. Regardless, a named care coordinator known personally to the patient and family remains indispensable.

CONCLUSION

Tragically, cases similar to those described above continue to occur every few years in the UK, despite repeated warnings and reviews following past tragedies. These cases are not isolated incidents and can be part of a broader, systemic failure to provide sustained, assertive, and well-resourced community-based mental health care. It is crucial that the techniques of Assertive Outreach we have discussed are not only adopted in principle but also fully integrated into everyday practice, backed by proper funding, staff training, and institutional support. Without this commitment, we risk continuing the tragic cycle of possibly preventable deaths, where both patients with severe mental illness and innocent bystanders pay the price for gaps in the system. By applying assertive outreach models effectively, we have the opportunity to change the trajectory of care, ensuring that vulnerable individuals receive the intensive, proactive support they need to remain stable, safe, and ultimately, to prevent such tragedies from happening again.

Contribution of individual authors:

All Authors contributed to the literature search and the drafting of the text.

All authors approved the final manuscript.

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Conflict of interest:

Mark Agius was, at one time, involved in the care of Tennyson Obih.

The names of the patients and victims concerned are taken from the Public records and news media of the time and are public knowledge.

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