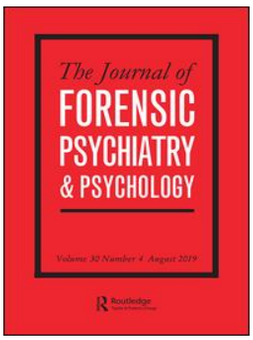

The Journal of Forensic Psychiatry & Psychology

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rjfp20

A sexual murder prevented? A case study of evidence-based practice

Paul V Greenall & James Millington

To cite this article: Paul V Greenall & James Millington (2021): A sexual murder prevented? A case study of evidence-based practice, The Journal of Forensic Psychiatry & Psychology, DOI: 10.1080/14789949.2021.1889014

To link to this article: https://doi.org/10.1080/14789949.2021.1889014

THE JOURNAL OF FORENSIC PSYCHIATRY & PSYCHOLOGY
https://doi.org/10.1080/14789949.2021.1889014

Routledge
Taylor & Francis Group

A sexual murder prevented? A case study of evidence-based practice

Paul V Greenall[a] and James Millington[b]

[a]Liverpool John Moores University, School of Psychology & Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK; [b]Greater Manchester Mental Health NHS Foundation Trust, Gardener Unit & University of Nottingham, Nottingham, UK

ABSTRACT

Clinical work with offenders with histories of sexual violence is an important aspect of forensic practice. A key feature of this is the clinical interview, which allows individual and offence-related issues to be explored. Research suggests that some sexual offences contain sexual motivations and may therefore be related to deviant sexual fantasies. This case study reports on the assessment and formulation of a patient detained in a regional secure unit. Although he had no previous sexual convictions, he had a history of being sexually violent towards others. During clinical interviews the patient disclosed having deviant sexual fantasies for several years relating to the rape and strangulation of women. These fantasies fuelled his daily masturbatory behaviour and he reported several attempts to enact them before his detention in hospital. Once in hospital the object of his sexual desires became a female nurse, whom he wanted to rape and strangle, the idea of which again fuelled his daily masturbatory behaviour. These disclosures necessitated preventative measures being taken by his clinical team and re-enforced the importance of giving due consideration to violent sexual fantasies and the importance of evidence-based risk formulations that inform the care and management of forensic patients.

ARTICLE HISTORY Received 18 May 2020; Accepted 06 February 2021

KEYWORDS Assessment; formulation; sexual homicide; sexual offending; case study

Introduction

Forensic clinicians often work with offenders with histories of sexual violence. These are among the most complex and challenging offenders to work with, as some present with dysfunctional schemas, distorted beliefs attachment and interpersonal problems, deviant sexual interests and attitudes, and emotional problems (Willmot, 2013). Additionally, some present with mental health problems (Lewis & Dwyer, 2018), personality disorders (Chen et al., 2016), psychopathic personalities (Logan & Hird, 2015) and diverse criminal histories (Soothill et al., 2000). Clinical work with sexual offenders usually involves the

CONTACT Paul V Greenall P.V.Greenall@ljmu.ac.uk

assessment and formulation of their history and future risk of sexual violence (Craig et al., 2008), plus interventions to help them avoid sexual recidivism (Wilcox et al., 2015). A key feature of this work is the clinical interview (Clarke, 2013). This allows clinicians to explore the offender's presentation and history, while allowing offenders to disclose or withhold information, particularly relating to previous offending or current sexual preferences.

This case study summarises the assessment and formulation of a man detained in a regional secure unit (RSU), who presented with a history of sexual violence. His history and clinical presentation will be summarised plus his disclosures regarding previous acts of sexual violence, some of which were deviant and potentially homicidal. These acts had previously and were currently fuelling his masturbatory behaviour and he wanted to repeat them. These disclosures necessitated preventative measures being taken by his clinical team and highlighted the importance of giving due consideration to violent sexual fantasies and the importance of evidence-based formulations informing the care and management of forensic patients.

Sexual violence

The Sexual Offences Act 2003 lists various contact and non-contact, penetrable and non-penetrable sexual behaviours, that are illegal due to the absence of consent and/or the inability of the victim to legally consent (Stevenson et al., 2004). Acts of sexual violence can occur between strangers or acquaintances, include physical violence, be aided by the administration of intoxicants and involve single or multiple offenders (Feist et al., 2007). The diverse nature of sexual violence means sexual offenders are a diverse group, exhibiting between and within-group differences. The focus of this case study, however, are those extreme cases that result in the victim's death. These killings are theorised as relating to several contributory factors. For example, dysfunctional/traumatic early life experiences negatively affect an individual's psychosocial and sexual development. This influences their internal world and hinders their ability to form pro-social adult relationships. The presence of alcohol, a deviant sexual preference, low self-esteem, a lack of empathy, social isolation and an inability to cope with stressful events, can exacerbate matters and drive the offender towards homicidal sexual violence. Situational factors including victim characteristics (e.g. lone female stranger), time of day (i.e. daylight hours) and the crime itself (e.g. presence of a weapon) can increase the chances of a sexual assault having a lethal outcome (see Chan, 2015, 2018).

Deviant sexual fantasies

A key feature within several theoretical approaches to sexual homicide (e.g. Arrigo & Purcell, 2001) is the presence of deviant sexual fantasies.

Although sexual fantasies, even deviant ones, are not the preserve of sexual offenders (Joyal & Carpentier, 2017), in some cases they can underpin acts of sexual violence (Bartels & Gannon, 2011). This was illustrated by MacCulloch et al. (1983) who examined a group of patients in a high-security hospital whose offences had sexual connotations or were clearly sexual. In most cases, it was found that prior to and at the time of their offences, patients had been creating fantasies identical to all or part of their offences. These fantasies included acts like rape, buggery, kidnapping, bondage, flagellation, anaesthesia, torture and killing and were reinforced by masturbation and progressed into real-life behavioural try-outs. These try-outs were required to maintain the effectiveness of the fantasies as a source of arousal and eventually culminated in the offence. Deviant sexual preferences were later found to be an important predictor of sexual recidivism (Hanson & Bussière, 1998) and associated with serious repetitive sexual violence (Prentky et al., 1989). Consequently, this factor is incorporated into some popular contemporary protocols (e.g. Hart et al., 2003) used in the formulation of sexual violence risk (Logan, 2016).

The present study

Studies into sexual offenders are typically retrospective in nature as they generally explore past events, such as offender histories or their offending. This study however is different. Being prospective in nature, it focuses on the possible futures for a man detained in an RSU and aims to answer the following research question.

- *Did the application of evidence-based practice prevent a serious sexual assault, up to and including a sexual murder?*

Method

This question is explored from an idiographic perspective using a single-case study design (Yin, 2014). In contrast to nomothetic research, which focuses on generalities arithmetic means and probabilities to identify 'laws' of human behaviour and/or to make predictions about how people behave in given situations, idiographic research explores uniqueness by examining what is relevant to the individual(s) in question (Ashworth, 2003). Ideographic research achieves this by gaining a thorough understanding of an individual or a few people, with the aim of this leading to a more general understanding of others. Single-case studies are an appropriate method for the exploration of unusual or extreme cases (Yin, 2014) as evidenced by several forensic studies (e.g. Bowden, 1996; Brankley et al.,

2014; Greenall, 2004; Johnstone & Huws, 1997; Karakasi et al., 2017; Logan, 2014; Loza & Hanna, 2006; McClellan, 2006).

Ethical considerations

A key aim of ethical research is maintaining the confidentiality of participants. When research involves multiple participants, their details are subsumed within the combined dataset, rendering the identification of individuals almost impossible. In single-case studies, however, this anonymising feature is absent and extra vigilance is required to maintain the confidentiality of the sole participant. To ensure this study adhered to ethical standards (Health & Care Professions Council, 2016), the following steps were taken. First, the patient's Responsible Clinician and clinical team lead agreed he could be approached about participating in this study. Second, the patient was seen and provided with information about this study and given the opportunity to ask any questions. He was advised that in order to maintain his confidentiality, all data would be anonymised and a pseudonym (*'Bill'*) would be used. Bill was happy with these arrangements and consented to his data being used. A member of his nursing team witnessed this process. Third, prior to submission to this journal, the hospital's Information Governance team saw a copy of the manuscript and agreed Bill's confidentiality had been maintained. Bill only wanted to see a copy of the published paper.

Case presentation

Bill is 24 years old, single and detained in an RSU under section 3 of the Mental Health Act 1983. He was admitted several months earlier from another RSU with a primary diagnosis of schizophrenia and possible borderline and antisocial traits, although his diagnosis was yet to be confirmed by his new clinical team. Bill came from a large family of full and half-siblings and his childhood included several negative features. His father and one brother had schizophrenia and his mother experienced problems with alcohol, deliberate self-harm, mood disorder and domestic violence. Apart from witnessing domestic violence, Bill was also physically abused at home. After his parents separated, Bill spent time living between them. During these years, he experienced poor parental management especially when living with his father, who allowed his sons to do whatever they wanted and who exposed them to violent pornography at an early age. At age 14 Bill was taken into care after experiencing further physical abuse. He then had several placements of short duration, ranging from a few weeks to several months. The reasons for the placement breakdowns was Bill's escalating levels of physical and verbal aggression

and his significant deliberate self-harm. Bill also misbehaved in certain placements to engineer a move when he did not like them. Bill's problems as a child were not limited to his home as his conduct in school resulted in his exclusion; from age of 11 he was a frequent user of cannabis and alcohol, and at age 15 he was diagnosed with conduct disorder.

Being on a civil section of the Mental Health Act, meant Bill did not have an index offence. However, his antisocial behaviour during his teens resulted in him receiving several convictions for various offences, including violence, property offences, acquisitive offences, public order offences and carrying an offensive weapon. Although Bill did not have any sexual convictions, allegations of antisocial and unlawful sexual conduct were in his records. In previous placements, Bill acted inappropriately towards female staff on several occasions. Examples include accessing internet sites about rape and documenting his sexually violent intentions towards one staff member whom he later threatened to rape. He obtained the personal details of another staff member so he could look her home up on Google Earth and send her text messages. He made inappropriate comments about staff having extra-marital affairs. He sent sexualised texts to staff, violated their personal space and touched staff inappropriately. Bill also admitted to sexually assaulting his younger sisters over several years during his teens and to attempting to rape a previous girlfriend. Although the authorities were aware of these allegations, no action was taken. Of note was Bill's explanation for attempting to rape his girlfriend; 'normal sex is boring'.

Management and outcome

At the time of the assessment, Bill had been making steady progress. He had escorted community leave and a move to a community step-down facility was under consideration. Although Bill did not have any sexual convictions, his history of sexual misconduct meant that as part of his care and management, an assessment and formulation of his sexual violence risk was required. This task was assigned to the first author and structured professional judgement (SPJ) was used to guide the exploration of Bill's sexual violence risk (Hart et al., 2003), his early life experiences (Borum et al., 2006) and the presence of protective factors (De Vogel et al., 2012). The assessment included consideration of several data sources, including Bill's health records, consultation with his clinical team, nursing staff on his ward and colleagues experienced in working with sexual offenders. Additionally, Bill was interviewed on several occasions, saw a draft report and agreed its contents before it was submitted to his clinical team. Finally, the second author provided clinical supervision during this process.

Self-disclosures

A key area of exploration during the clinical interviews was Bill's prior sexual misconduct and here he made some very serious disclosures. Bill reported that for many years he had experienced dreams and fantasies relating to rape and strangulation. He admitted to wanting to enact these dreams/fantasies because they were better than 'boring normal sex'. After such dreams, Bill would awake with an erection and masturbate while fantasising about them. The regularity of his dreams/fantasies was such that Bill was masturbating 3–4 times daily. Bill was not the only male in his family who experienced sexually violent dreams/fantasies, as he stated his father and one brother did too. However, his brother's girlfriend allowed him to enact his violent fantasies, while Bill had no such outlet. When asked what Bill would do if he had a willing girlfriend, he replied she would end up unconscious because he would tie her up and strangle her during sex. Despite recognising that strangulation can cause death, Bill reported that he often masturbated and fantasised about raping and strangling women. Previously, the object of his sexually violent fantasies was a female member of staff in a prior placement, but now it was a female nurse on his ward. Unfortunately, despite several requests to identify her, Bill refused as he knew this would result in one of them being moved to another ward. What he did confirm, however, was that on a daily basis he was masturbating to fantasies of raping and strangling this woman. Consequently, while the assessment was ongoing female staff on Bill's ward were alerted to the content of his dreams/fantasies and advised to exercise caution when nursing him.

Perhaps the most serious disclosure Bill made involved his admission that prior to his current period in hospital, he was in the habit of following women. Bill engaged in this behaviour on many occasions and it involved him following women whom he found attractive, in the evenings in isolated locations. On such occasions, Bill would follow a woman sometimes for about 30 minutes, walking behind her with his face covered with a scarf and having thoughts of grabbing her. Indeed, Bill admitted to almost grabbing a woman on one occasion. Fortunately, she became aware he was following her and ran off. Bill advised that had he grabbed her, he would have raped and strangled her, and she would not have been consenting, as that was part of his fantasy. On some occasions. when Bill went out to follow women, he took a rucksack containing rope, tape, bin-bags and a knife. On other occasions, he carried a hammer. Bill reported that following women excited him, and he would masturbate while fantasising about this when he returned home. On those occasions when Bill did not find an attractive woman to follow, he 'felt gutted'. Bill recognised that if he raped and strangled a woman he would be detained for many years. However, when

asked if he thought he would resume his following behaviour if discharged from hospital, he replied 'I don't know, anything could happen'.

Formulation

Formulation involves the generation of a hypothesis about an individual's problematic behaviour, which ensures therapeutic interventions are evidence-based (Sturmey & McMurran, 2011). Logan (2014) suggests the essential first step in this process is clarifying the 'risk of what?' question.

Risk of what?

Although Bill did not have any sexual convictions, he had a history of sexual misconduct involving threats and inappropriate communications, and he harboured deviant sexual fantasies involving tying-up raping and strangling women. On several occasions, he followed women in secluded public places, sometimes armed with weapons, with the intention of enacting this fantasy and almost achieved this on one occasion. The fact that Bill continued to derive sexual pleasure from these actions suggests they had a compulsive nature (Schlesinger, 2004) and future repetition was therefore a reasonable possibility.

The 3Ds

In Bill's case, the 3Ds formulation model (Logan, 2014) was used to explore *d*rivers (*motive*), *d*is-inhibitors (*predisposing or vulnerability factors*) and *d*estabilisers (*precipitating factors or triggers*) relevant to his sexual misconduct and future risk. First, Bill's actions were driven by a desire to satisfy his deviant sexual preference, which was underpinned and maintained by his dreams/fantasies, associated behaviours and frequent masturbation (MacCulloch et al., 1983). Second, Bill's dysfunctional childhood may have contributed to his negative attitudes, deviant sexual preference and his emotionally unstable, impulsive and antisocial personality (Craissati et al., 2020). These factors dis-inhibited Bill by leaving him with little interest in conventional sexual relations and by helping him to overcome any inhibitions/anxieties about being sexually violent, especially when intoxicated. Third, Bill's decision-making was destabilised by his deviant sexual preference, his chronic substance abuse, his personality and mental illness. These factors reduced his capacity to deal with situations that could trigger his sexual violence, such as mixing with female staff whom he found attractive and deciding to search for women to follow, rape and strangle. Again, early childhood experiences and the absence of pro-social peers, may have influenced his decision-making

and contributed to him holding pro-offending schemas (Beech et al., 2005).

Scenario planning

A key feature of SPJ formulations is the development of possible future offence scenarios, generally involving a repeat, a twist, escalation and desistance. These scenarios are not predictions about what *will* happen, but hypotheses about what *could* happen based on what is known about the individual and their previous history (Hart et al., 2003). In Bill's case three scenarios appeared reasonable.

Scenario 1 (repeat/twist): sexual assault of a female nurse

Bill's fantasies may have led him to sexually assault a female nurse on his ward. Warning signs would include Bill showing an interest in a particular nurse and attempting to obtain information about her in order to establish a 'relationship' and/or to feed his infatuation. Bill may have made inappropriate comments about or to this nurse and violated her personal space. He may also have tried to improvise situations whereby he was alone with this nurse and perhaps believing his infatuations to be real, he may have attempted to sexually engage with her leading to a sexual assault. Relational security arrangements (Royal College of Psychiatrists, 2015) on the ward should have prevented this from happening and/or terminated the assault at an early stage, ensuring it was a one-off event.

Scenario 2 (escalation): sexual assault of an adult female stranger

If discharged into the community, Bill's problems with interpersonal relationships and employment may have left him socially isolated. In response, he may have attempted to satisfy his deviant sexual desires by resuming his following of female strangers, especially when intoxicated. Over time, these behaviours may have escalated with Bill starting to follow women for longer periods and carrying weapons. Excited by this behaviour, Bill's following of women would have been reinforced through masturbation and if left unchecked, could have culminated in a serious, perhaps homicidal sexual assault (MacCulloch et al., 1983). Although Bill possessed a mental script as to how such an encounter may have unfolded, he had not given due consideration to how he would carry out the assault, how he may have responded if the victim resisted, and what would have happened afterwards. It would probably therefore have been a disorganised (Ressler et al., 1988) sexual murder, with the body and forensic evidence left at the scene and Bill quickly apprehended (Balemba et al., 2014).

Scenario 3 (desistance): no sexual violence

The alternative (null hypothesis) future involved Bill not engaging in further sexual violence. In this scenario, he may have continued to experience violent sexual fantasies. However, with the possible exception of the occasional inappropriate comment to female staff, he may not have acted on them and may have continued on his original discharge pathway and cooperated with his community management.

Risk management plan

Having identified two reasonable scenarios in which Bill may sexually offend in future, a risk management plan was designed to help him avoid these possible futures. Scenario two was immediately addressed by the cessation of Bill's escorted community leave and the suspension of his proposed move to a community step-down facility. In relation to scenario one a day-to-day management plan was designed and in accordance with SPJ guidelines (Hart et al., 2003) this covered the following areas.

Supervision and monitoring

Bill's detention in hospital afforded nursing staff every opportunity to regularly supervise and monitor him, including his whereabouts on the ward, his mental state, overall presentation, and his interactions with female staff. Any concerns could be shared with colleagues in Bill's clinical team.

Treatment

Along with medication, Bill could have been referred for group treatment aimed at helping him to explore the factors that contributed to and which were maintaining his problematic behaviour. Unfortunately, Bill was not motivated to attend such an intervention. However, he did agree to engage in further individual work with a clinical psychologist, to explore his sexual development and deviant sexual preference.

Victim safety planning

Until further progress was made in relation to understanding Bill's deviant sexual preference, female staff on his ward were advised to exercise caution in their dealings with Bill and to avoid being alone with him for the foreseeable future.

Discussion

Clinical work with sexual offenders usually involves the assessment and formulation of their history and future risk of sexual violence, plus the delivery of interventions to help them avoid sexual recidivism. In many cases, offenders will engage in this process and verbalise a desire to avoid further sexual offending and work with staff to achieve that aim. In doing this, some offenders are prepared to disclose and confront concerning aspects of their offending, such as for example, acknowledging a sexual interest in children. On other occasions, the concerning nature of an offender's disclosures do not relate to past events but future intentions, suggesting they may present an ongoing sexual risk to others.

Assessing Bill's fantasies

When considering an offender's fantasy-based disclosures, one option is to consider whether the content of the disclosures appear a reasonable future outcome, given what is known about the offender and their previous history. While some offenders may disclose unlikely future offending scenarios (e.g. becoming a serial killer), with Bill his fantasy about raping and strangling women appeared a reasonable future scenario, one he had given much thought to, one he had tried to enact on several occasions, and one that continued to give him much sexual pleasure. However, by developing an evidence-based formulation of Bill's presenting problem, this possible future was averted and perhaps a sexual murder was prevented.

A sexual murder prevented?

In order to advise a clinical team that a patient who is detained on a civil section of the Mental Health Act, with no sexual convictions, escorted community leave and progressing towards discharge is a potential sexual murderer, the clinician making this claim must ensure it has a sound evidential basis. This was provided by practising in accordance with hospital policy, best practices guidelines and relevant research. Although Bill did not have an index offence, hospital policy requires all patients to have a formal assessment and formulation of their risk, a requirement that is subject to regular audit to ensure no patients are overlooked. Moreover, although Bill did not have any sexual convictions, his history of sexual misconduct meant this aspect of his presentation had to be considered when his risk was being assessed. In accordance with best practice (Department of Health, 2007) hospital policy requires all assessments of violence risk to be guided by SPJ protocols and wherever possible, to be undertaken in collaboration with the patient.

The hypothesis that Bill had the potential to commit a sexual murder was supported by a body of research. For example, prior to his current detention in hospital, Bill was following a fantasy-based behavioural pathway very similar to that reported by MacCulloch et al. (1983). This pathway was reinforced by a process of (masturbatory) conditioning (Laws & Marshall, 1990) and had a clear upward trajectory that was leading Bill to contemplate and attempt a serious sexual assault of a female stranger, which could easily have resulted in her death given the presence of weapons (Nicole & Proulx, 2007). During this time, Bill's following of women was an example of what MacCulloch et al. (1995) called *'premeditated opportunism'*. When he went out to follow women, there was an intention on Bill's part to commit an act of violence, but the precise nature of the victim, method, or location was not predetermined (*ibid*.). Moreover, by following women in his own locality Bill was acting in accordance with research which suggests most sexual offenders (Beauregard et al., 2005), including stranger sexual killers (Greenall, 2018), offend close to their homes. In addition to his actions, certain aspects of Bill's presentation support the hypothesis that he had the potential to become a sexual murderer. For example, his dysfunctional/traumatic childhood, his deviant sexual preference, his poor mental health, his abuse of substances, his problematic personality and his diverse criminal history, accord with the wider research into sexual Killers (Beauregard & Martineau, 2017; Proulx et al., 2018, 2007). Indeed, Bill arguably bears more than a passing resemblance to what Proulx suggests is the prototypical sexual murderer:

> A childhood in neglectful and violent family environments; social isolation; overwhelming deviant sexual fantasies; negative personality traits (e.g., anti-social, narcissistic, borderline); avoidant and schizoid personality disorders; a modus operandi characterised by expressive and ritualistic violence (e.g., bondage, torture of their victims). (2018, p. 597).

However, although detention in hospital put an end to Bill's following of female strangers, it did not put an end to his deviant sexual fantasies. Rather once in hospital the focus of his sexual desires switched from female strangers to a female nurse. In doing this, Bill was responding to and taking advantage of his circumstance, by directing his sexual attentions towards available females within his environment. This time, however, he did not want to make a nuisance of himself with female staff as he had done previously, rather at this stage in his sexual development he wanted to rape and strangle one of them. Consequently, the hypothesis that Bill had the potential to become a sexual murderer appeared reasonable given what was known about him and his previous history.

Critical issues

Although two reasonable scenarios in which Bill may sexually offend in future were highlighted, the possibility of them being a false positives (Blackburn, 2000) leading to Bill's further detention in hospital must be recognised, along with some critical issues relating to the formulation. First, the account of Bill's violent sexual fantasies and his following of women was entirely his own self-report. Whether Bill was fabricating these accounts or not only he truly knows. However, it was felt that his disclosures could not be ignored as they were in accordance with the research on how violent fantasies can escalate into acts of serious sexual violence. Second, while Bill's disclosures may have been an accurate description of his sexual interests, the alternative view is that his violent sexual fantasies and associated behaviours arose in the context of his mental illness (Drake & Pathé, 2004) and could been reduced if not eradicated by the treatment of his illness. Third, given that Bill had not committed a sexual murder and therefore was not a sexual murderer, using research on such killings to inform the formulation may have been inappropriate. Perhaps more general research such as Marshall and Barbaree (1990), which offers a framework for understanding the link between problematic childhoods and later vulnerabilities to engaging in sexual violence, and which is still a highly regarded theory (Ward et al., 2006) may have been more appropriate. However, having identified that sexual murder was a potential future for Bill, consulting research into such killings was considered appropriate to determine whether this was indeed a reasonable future for him. Fourth, the usage here of a single-case study design to highlight the challenges presented by Bill may have its limitations. For example, a lack of scientific rigour may limit the generalisability of the findings to the wider population of sexual offenders. Additionally, as the authors were involved in the original assessment, the possibility of bias cannot be excluded.

Positive clinical impact

Finally, quality checklists and standards (e.g. Hart et al., 2011; McMurran & Bruford, 2016) require risk formulations to generate actions that make a positive difference. Risk formulations, therefore, should drive the risk management plan including developing strategies to facilitate positive risk taking, and the quality of risk formulations should be explored. In Bill's case, this was achieved by asking some key questions, such as

- *How will the plan for female staff to avoid being isolated with Bill be communicated to him and does he have sufficient insight to understand these restrictions?*

- What other changes to Bill's care plan are required and will he collaborate with them?
- *Will the possible link between Bill's deviant fantasies and his mental illness be explored, not only in relation to a direct link (i.e. hallucinations/delusions) but by considering whether his illness and fantasies had their origins in trauma, loss, lack of success, power, control etc.?*
- *How will Bill's clinical team reassess his risk and make positive risk decisions, such as amending the guidance to female staff or reinstating community leave?*
- *What changes in Bill's presentation will his clinical team need to see in order to be reassured that any amendments to his care plan can safely be made?*

It was by asking questions like these that the quality and impact of the formulation on Bill's care and management was monitored, to avoid potential mistakes.

Conclusion

An important lesson can be drawn from this case study, which is that clinicians in forensic settings should never take anything for granted when working with offenders with histories of sexual violence. What began as an almost routine assessment of a man detained under a civil section of the Mental Health Act and with no sexual convictions, ended with future scenarios involving potentially homicidal sexually violence, escorted leave and community discharge being stopped, and warnings issued to female staff. This case study sought to determine whether the application of evidence-based practice helped to prevent a serious sexual assault, up to and including a sexual murder. While we may never know the answer to this question, perhaps it can be answered by asking another. Had Bill's clinical team not swiftly acted as they did, had Bill not been closely monitored by staff on his ward and had his community discharge been granted, can we honestly say no harm would have come to pass? Certainly, had these preventative measures not been taken and had Bill subsequently committed a serious sexual assault, his defence would have been 'I warned them, but they didn't listen' and an inquiry would surely have followed.

Almost four decades ago, MacCulloch et al. cautioned forensic practitioners that 'if a man presents with sadistic sexual fantasies, admits to previous tryouts … and demonstrates a pattern of progression of offending and fantasy, then progression to killing would appear to be a strong possibility' (MacCulloch et al., 1983, p. 28). Bill has shown us that this remains good advice and forensic clinicians should therefore take such disclosures very seriously, when assessing and formulating offenders with histories of sexual violence.

Acknowledgments

The present authors are grateful to Bill for his participation in this study and to the reviewers of this journal for their comments on earlier drafts of this paper.

Disclosure statement

No potential conflict of interest was reported by the authors.

References

Arrigo, B. A., & Purcell, C. E. (2001). Explaining Paraphilias and lust murder: Toward an integrated model. *International Journal of Offender Therapy and Comparative Criminology*, *45*(1), 6–31. doi:https://doi.org/10.1177%2F0306624X01451002

Ashworth, P. (2003). The origins of qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 4–24). Sage Publications Ltd.

Balemba, S., Beauregard, E., & Martineau, M. (2014). Getting away with murder: A thematic approach to solved and unsolved sexual homicides using crime scene factors. *Police Practice and Research*, *15*(3), 221–233. https://doi.org/10.1080/15614263.2013.846548

Bartels, R. M., & Gannon, T. A. (2011). Understanding the sexual fantasies of sex offenders and their correlates. *Aggression and Violent Behavior*, *16*(6), 551–561. https://doi.org/10.1016/j.avb.2011.08.002

Beauregard, É., & Martineau, M. (2017). *The sexual murderer: Offender behavior and implications for practice*. Routledge.

Beauregard, É., Proulx, J., & Rossmo, D. K. (2005). Spatial patterns of sex offenders: Theoretical, empirical, and practical issues. *Aggression and Violent Behavior*, *10*(5), 579–603. https://doi.org/10.1016/j.avb.2004.12.003

Beech, A., Fisher, D., & Ward, T. (2005). Sexual murderers' implicit theories. *Journal of Interpersonal Violence*, *20*(11), 1366–1389. https://doi.org/10.1177/0886260505278712

Blackburn, R. (2000). Risk Assessment and Prediction. In J. McGuire, T. Mason, & A. O'Kane (Eds.), *Behaviour, crime and legal processes: A guide for forensic practitioners* (pp. 177–204). John Wiley & Sons, Ltd.

Borum, R., Bartel, P., & Forth, A. (2006). *Structured assessment of violence risk in youth: Professional manual*. PAR.

Bowden, P. (1996). Graham Young (1947–90); the St Albans poisoner: His life and times. *Criminal Behaviour and Mental Health*, *6*(S1), 17–24. doi:https://doi.org/10.1002/cbm.132

Brankley, A. E., Goodwill, A. M., & Reale, K. S. (2014). Escalation from fetish burglaries to sexual violence: A retrospective case study of former Col., D. Russell williams. *Journal of Investigative Psychology and Offender Profiling*, *11*(2), 115–135. https://doi.org/10.1002/jip.1406

Chan, H. C. (2015). *Understanding sexual homicide offenders: An integrated approach*. Palgrave Macmillan.

Chan, H. C. (2018). Sexual homicide: A review of the main theoretical models. In J. Proulx, E. Beauregard, A. J. Carter, A. Mokros, R. Darjee, & J. James (Eds.),

Routledge international handbook of sexual homicide studies (pp. 15–36). Routledge.

Chen, Y. Y., Chen, C. Y., & Hung, D. L. (2016). Assessment of psychiatric disorders among sex offenders: Prevalence and associations with criminal history. *Criminal Behaviour & Mental Health*, *26*(1), 30–37. https://doi.org/10.1002/cbm.1926

Clarke, J. (2013). Interviewing forensic clients. In J. Clarke & P. Wilson (Eds.), *Forensic psychology in practice: A practitioner's handbook* (pp. 39–58). Palgrave Macmillan.

Craig, L. A., Browne, K. D., & Beech, A. R. (2008). *Assessing risk in sexual offenders: A practitioner's guide*. John Wiley & Sons Ltd.

Craissati, J., Joseph, N., & Skett, S. (Eds.). (2020). Practitioner guide: Working with people in the criminal justice system showing personality difficulties (3rd Ed).HM Prison & Probation Service/National Health Service. Available at https://www.gov.uk

De Vogel, V., De Ruiter, C., Bouman, Y., & De Vries Robbé, M. (2012). *SAPROF. Guidelines for the assessment of protective factors for violence risk (English version)* (2nd ed.). Forum Educatief.

Department of Health. (2007). *Best practice in managing risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*. London: Department of Health, National Mental Health Risk Management Programme.

Drake, C. R., & Pathé, M. (2004). Understanding sexual offending in schizophrenia. *Criminal Behaviour and Mental Health*, *14*(2), 108–120. doi:https://doi.org/10.1002/cbm.576

Feist, A., Ashe, J., Lawrence, J., McPhee, D., & Wilson, R. (2007). *Investigating and detecting recorded offences of rape*. Home Office Online, Report 18/07.

Greenall, P. V. (2004). Life in a prison-based therapeutic community: One man's experience. *The British Journal of Forensic Practice*, *6*(1), 33–38. https://doi.org/10.1108/14636646200400004

Greenall, P. V. (2018). Stranger sexual homicide. In J. Proulx, E. Beauregard, A. Carter, A. Mokros, R. Darjee, & J. James (Eds.), *Routledge international handbook of sexual homicide studies* (pp. 154–170). Routledge.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, *66*(2), 348–362. doi:https://doi.org/10.1037/0022-006X.66.2.348

Hart, S. D., Kropp, P. R., Laws, D. R., Klaver, J., Logan, C., & Watt, K. A. (2003). *The risk for sexual violence protocol (RSVP): Structured professional guidelines for assessing risk of sexual violence*. Simon Fraser University.

Hart, S. D., Sturmey, P., Logan, C., & McMurran, M. (2011). Forensic case formulation. *International Journal of Forensic Mental Health*, *10*(2), 118–126. https://doi.org/10.1080/14999013.2011.577137

Health & Care Professions Council. (2016). *Standards of conduct, performance and ethics*. Health and Care Professions Council.

Johnstone, J., & Huws, R. (1997). Autoerotic asphyxia: A case report. *Journal of Sex & Marital Therapy*, *23*(4), 326–332. https://doi.org/10.1080/00926239708403936

Joyal, C. C., & Carpentier, J. (2017). The prevalence of paraphilic interests and behaviors in the general population: A provincial survey. *The Journal of Sex Research, OnlineFirst*, *54*(2), 161-171. https://doi.org/10.1080/00224499.2016.1139034

Karakasi, M. V., Vasilikos, E., Voultsos, P., Vlachaki, A., & Pavlidis, P. (2017). Sexual homicide: Brief review of the literature and case report involving rape, genital

mutilation and human arson. *Journal of Forensic and Legal Medicine*, *46*, 1–10. https://doi.org/10.1016/j.jflm.2016.12.005

Laws, D. R., & Marshall, W. L. (1990). A conditioning theory of the etiology and maintenence of deviant sexual preference and behaviour. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp. 209–229). Plenum Press.

Lewis, E. T., & Dwyer, R. G. (2018). Psychosis and sexual offending: A review of current literature. *International Journal of Offender Therapy and Comparative Criminology*, *62* (11), 3372–3384. https://doi.org/10.1177/0306624X17740016

Logan, C. (2014). The HCR-20 version 3: A case study in risk formulation. *International Journal of Forensic Mental Health*, *13*(2), 172–180. https://doi.org/10.1080/14999013.2014.906516

Logan, C., & Hird, J. (2015). Psychopathy and sexual offending. In D. T. Wilcox, T. Garrett, & L. Harkins (Eds.), *Sex offender treatment: A case study approach to issues and interventions* (pp. 267–285). John Wiley & Sons, Ltd.

Logan, C. (2016). Risk formulation: The new frontier in risk assessment and management. In D. R. Laws & W. O'Donohue (Eds.), *Treatment of sex offenders: Strengths and weaknesses in assessment and intervention* (pp. 83–105). Springer.

Loza, W., & Hanna, S. (2006). Is schizoid personality a forerunner of homicidal or suicidal behavior? A case study. *International Journal of Offender Therapy and Comparative Criminology*, *50*(3), 338–343. https://doi.org/10.1177/0306624X05285093

MacCulloch, M. J., Bailey, J., & Robinson, C. (1995). Mentally disordered attackers and killers: Towards a taxonomy. *The Journal of Forensic Psychiatry*, *6*(1), 41–61. https://doi.org/10.1080/09585189508409875

MacCulloch, M. J., Snowden, P. R., Wood, P. J., & Mills, H. E. (1983). Sadistic fantasy, sadistic behaviour and offending. *The British Journal of Psychiatry*, *143*(1), 20–29. https://doi.org/10.1192/bjp.143.1.20

Marshall, W. L., & Barbaree, H. E. (1990). An integrated theory of the etiology of sexual offending. In W. L. Marshal, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender*(pp. 257-275). Plenum Press.

McClellan, J. (2006). Case study: Ted Bundy, an offender-based comparison of murder typologies. *Journal of Security Education*, *2*(1), 19–37. https://doi.org/10.1300/J460v02n01_03

McMurran, M., & Bruford, S. (2016). Case formulation quality checklist: A revision based upon clinicians' views. *The Journal of Forensic Practice*, *18*(1), 31–38. https://doi.org/10.1108/JFP-05-2015-0027

Nicole, A., & Proulx, J. (2007). The factors distinguishing sexual murderers from sexual aggressors: A multivariate analysis. In J. Proulx, E. Beauregard, M. Cusson, & A. Nicole (Eds.), *Sexual murderers: A comparative analysis and new perspectives* (pp. 87–97). John Wiley & Sons, Ltd.

Prentky, R. A., Burgess, A. W., Rokous, F., Lee, A., Hartman, C., Ressler, R. K., & Douglas, J. D. (1989). The presumptive role of fantasy in serial sexual homicide. *American Journal of Psychiatry*, *146*(7), 887–891. https://doi.org/10.1176/ajp.146.7.887

Proulx, J. 2018. New directions in theories of sexual homicide and sexual sadism. In ProulxJ., BeauregardE.,CarterA.,MokrosA.,DarjeeR., &JamesJ. (Eds.), Routledge international handbook of sexual homicide studies (pp. 597–600). Abingdon: Routledge.

Proulx, J., Beauregard, E., Carter, A., Mokros, A., Darjee, R., & James, J. (Eds.). (2018). *Routledge international handbook of sexual homicide studies*. Routledge.

Proulx, J., Beauregard, E., Cusson, M., & Nicole, A. (Eds.). (2007). *Sexual murderers: A comparative analysis and new perspectives*. John Wiley & Sons, Ltd.

Ressler, R. K., Burgess, A. W., & Douglas, J. E. (1988). *Sexual homicide: Patterns and motives*. Simon & Schuster.

Royal College of Psychiatrists. (2015). *See think act: Your guide to relational security (2nd ed.)*. Available at https://www.rcpsych.ac.uk

Schlesinger, L. B. (2004). Classification of antisocial behavior for prognostic purposes: Study the motivation, not the crime. *The Journal of Psychiatry & Law*, *32*(2), 191–219. https://doi.org/10.1177/009318530403200204

Soothill, K., Francis, B., Sanderson, B., & Ackerley, E. (2000). Sex offenders: Specialists, generalists - or both? *British Journal of Criminology*, *40*(1), 56–67. https://doi.org/10.1093/bjc/40.1.56

Stevenson, K., Davies, A., & Gunn, M. (2004). *Blackstone's guide to the Sexual Offences Act 2003*. Oxford University Press.

Sturmey, P., & McMurran, M. (Eds.). (2011). *Forensic case formulation*. Wiley-Blackwell.

Ward, T., Polaschek, D. L. L., & Beech, A. (2006). *Theories of sexual offending*. John Wiley & Sons Ltd.

Wilcox, D. T., Garrett, T., & Harkins, L. (Eds.). (2015). *Sex offender treatment: A case study approach to issues and interventions*. John Wiley & Sons, Ltd.

Willmot, P. (2013). Sexual offenders. In J. Clarke & P. Wilson (Eds.), *Forensic psychology in practice: A practitioner's handbook* (pp. 172–189). Palgrave Macmillan.

Yin, R. K. (2014). *Case study research: Design and methods (5th ed.)*. Sage Publications, Inc.