

An independent investigation into the care and treatment of a mental health service user (T) in Hertfordshire

September 2015

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First published: September 2015

Niche Patient Safety are an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1 Executive summary

- 1.1 NHS England Midlands and East commissioned Niche Patient Safety, a consultancy company specialising in patient safety investigations and reviews, to undertake an independent investigation into the care and treatment of a mental health service-user (T) and the death of his wife M. The terms of reference are at Appendix A.
- 1.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005.
- 1.3 The main purpose of an independent investigation is to identify whether there were any aspects of the care which could have altered or prevented the incident. The investigation process will also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.4 In this instance, the incident has been investigated by the Trust, and has been subject to a Domestic Homicide Review (DHR). As a result of these investigations, the systems and process for risk assessment, carers' assessments and domestic violence awareness by the Trust have been examined.
- 1.5 Therefore the focus of this investigation is to assess the extent and reasonableness of changes made to practice, policy and governance arrangements to prevent, or at least minimise the likelihood of such a tragic incident happening again.
- 1.6 We would like to express our condolences to the family of T and M. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of T up to the point of the incident.

The Incident

- 1.7 T had a self-reported history of depression dating back over several years, but had no contact with secondary mental health services until November 2012. His GP made an urgent referral on 27 November 2012 to mental health services at Hertfordshire Partnership NHS Foundation Trust (HPFT). T presented with suicidal thoughts and a plan to use a rope to hang himself.
- 1.8 He was initially assessed on 5 December 2012 by a community psychiatric nurse (CPN) from the mental health services for older people. At this assessment the CPN recommended that he be seen by a psychiatrist at outpatient clinic, and be referred to psychology. At this time he had suicidal thoughts but no plan. The plan of care was not actioned.

- 1.9 T presented on 10 and 16 December 2012 to the emergency department at Chase Farm Hospital Enfield, intoxicated and complaining of chest pain. He was discharged to the care of his GP on 10 December with advice to monitor alcohol use and blood pressure. On 16 December he presented with active suicidal thoughts and plans, and a mental health assessment recommended informal admission.
- 1.10 T was admitted to Lambourn Grove, a mental health service for older people, on 17 December 2012, and went home on leave on 22 December 2012. He was transferred on 24 December 2012 to the care of the South East Crisis Assessment and Treatment Team (CATT), following discharge from the inpatient unit and a period of weekend leave. T had not returned for the planned review meeting and did not want to return to hospital.
- 1.11 CATT team contact was made by phone and home visits. T was seen on 5 occasions, and spoken to by phone on 3 occasions. There was more frequent contact by phone with M, who was staying with him.
- 1.12 T's last contact was with a CATT community support worker by phone on 4 January 2013, when he declined a home visit. CATT staff made phone calls on 6, 7, 8 and 9 January; and a cold call to the house on 11 January 2013; none of these elicited a response.
- 1.13 A police welfare check was requested, and on 11 January 2013 Hertfordshire police attended the property. T & M's son had already entered the property, and found his parents deceased.
- 1.14 Both were deceased. M was found in bed apparently suffocated, and T was found hanging from the loft hatch.
- 1.15 The Trust completed an internal Serious Incident (SI) investigation, and an Individual Management Review for the Domestic Homicide Review (DHR).
- 1.16 The Domestic Homicide Review report made recommendations for the Trust, and these have been incorporated into an action plan alongside the Trusts' own action plan.
- 1.17 This investigation has therefore reviewed the action plans arising from the internal investigations and the DHR. The investigation has sought evidence and assurance for the changes made to systems and processes following these investigations and action plans.

Our findings

- 1.18 T had been in contact with mental health services since November 2012. He was diagnosed as having an adjustment disorder (ICD.10 F43.2)¹ and mental and behavioural disorder due to harmful use of alcohol (F10.1).²
- 1.19 The urgent assessment requested by his GP on 27 November 2012 resulted in a home assessment on 5 December 2012, which, while documented and discussed at an MDT meeting, does not appear to have resulted in any active plans. The GP was not informed of the outcome of this assessment.
- 1.20 Between 10 and 16 December 2012 T presented twice at Chase Farm emergency department with chest pains, and intoxication with alcohol.
- 1.21 On 16 December 2012 he was assessed as having active suicidal thoughts, against a background of impending divorce proceedings initiated by his wife of 24 years. She also disclosed a previous history of threatening and controlling behaviour. A mental health assessment resulted in him being admitted informally to Lambourn Grove inpatient service for older people's mental health.
- 1.22 This unit cared for organic and functionally unwell patients, and T said he found it distressing to be among patients with dementia. He kept to his room, spending a lot of time reading, or in the company of his wife M, who visited regularly. T remained on 10 minute observations because of suicidal thoughts and plans, until 21 December 2012 when he was reviewed by the consultant psychiatrist.
- 1.23 He went on leave on 22 December, after initial agreement to go on 21 December. Initially he was pressing to be discharged but subsequently became unsure of whether he wanted to go or not. A CPA meeting was arranged for 24 December 2012, and he was expected to attend.
- 1.24 The CPA meeting on 24 December in fact went ahead without him, and he was discharged to the care of the South East Crisis Assessment and Treatment team (CATT) on this date. T and M were found dead at T's home address on 11 January 2013.

¹ The ICD-10 Classification of Mental and Behavioural Disorders, World Health Organization, Geneva, 1992. States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event (including the presence or possibility of serious physical illness). The stressor may have affected the integrity of an individual's social network (through bereavement or separation experiences) or the wider system of social supports and values (migration or refugee status). The stressor may involve only the individual or also his or her group or community

² The ICD-10 Classification of Mental and Behavioural Disorders World Health Organization, Geneva, 1992. A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis from injecting) or 0.1 Harmful use mental (e.g. episodes of depressive disorder secondary to heavy alcohol consumption).

- 1.25 The ensuing Trust internal investigations and then DHR review have made wide recommendations to improve practice in the CATT service, and to the management of carers' assessments and recognition of risk of domestic abuse. The Trust has implemented many of these and is addressing the few remaining recommendations.

Recommendations

This independent investigation has made five recommendations for the Trust to address in order to further improve learning from this event.

Recommendation 1:

The outcome of primary care referrals should always be communicated back to the service user's GP, and the GP should be kept informed of plans of care and progress through mental health services.

Recommendation 2:

Adherence to the Observation policy with respect to recording of clinical information and formal reviews should be monitored

Recommendation 3:

An information sharing agreement with Hertfordshire Police should be established.

Recommendation 4:

Information based on third party disclosures should be noted as such, and risk assessments should clearly note whether information is evidenced or not.

Recommendation 5:

The Trust should develop a strategy to ensure the safeguarding policy incorporates domestic abuse, and that staff fully understand and implement the policy .

2 Introduction

- 2.1 At 18.30hrs on Friday 11th January 2013 Hertfordshire police received a call from Ambulance Control to report a man found hanging at an address in Cheshunt, Hertfordshire
- 2.2 The call to ambulance control came from the son of M and T who was calling from their address, after going round to the house because he couldn't contact his parents by telephone.
- 2.3 It was soon established that two people were deceased at the address. On police arrival at the house they found M in bed in the front bedroom and T hanging from a rope tied to the loft hatch.
- 2.4 It was established at the Coroner's inquest in August 2014 that the cause of death for M was compression of the neck, and for T suspension. The verdict was that M was unlawfully killed by T, and T died by suicide.
- 2.5 T and M had been married for 24 years, although they had been separated since M left the family home in 2010 and instigated divorce proceedings in 2011.
- 2.6 T had a period of mental health care provided by Hertfordshire Partnership NHS Foundation Trust from November 2012 until his death on 11 January 2013.
- 2.7 We would like to express our condolences to the family of T and M. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of T up to the point of this tragic incident.
- 2.8 We would like to express our thanks to the family, members of staff of the Trust, and GP practice involved for their contributions.

3 Independent investigation

Approach to the investigation

- 3.1 The independent investigation follows the Department of Health guidance (94) 27³, on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix A.
- 3.2 The main purpose of an independent investigation is to discover whether there were any aspects of the care, which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services might be required in order to help prevent similar incidents occurring.

³ Department of Health (1994) HSG (94)27: *Guidance on the Discharge of Mentally Disordered People and their Continuing Care*, amended by Department of Health (2005) - *Independent Investigation of Adverse Events in Mental Health Services*

- 3.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.
- 3.4 The investigation was carried out by Carol Rooney for Niche, with expert clinical advice provided by Dr Susan Benbow. The investigation team will be referred to in the first person plural in the report.
- 3.5 The report was peer reviewed by Nick Moor, Director of Niche Patient Safety.
- 3.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance⁴.
- 3.7 We used information from T's clinical records and evidence gathered from the internal investigation report and police case summary. As part of our investigation we interviewed:
- Head of Practice Governance
 - Acute service line lead
 - Deputy Service line lead for older peoples' mental health
 - Patient Safety Manager
 - Head Of Social Care and Safeguarding
- 3.8 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature. We also conducted telephone interviews with:
- T's GP;
 - South East CATT team manager; and
 - Consultant Psychiatrist for older people's mental health (who is now the Adult Safeguarding Named Doctor).
- 3.9 We had access to the Trust's reports produced at the time of the internal investigation.
- 3.10 We wrote to all of the children we had contact details for, in the UK and Canada.
- 3.11 We met with T's eldest daughter C, who the family agreed would be the point of contact, and explained the purpose and process of the investigation and to give an opportunity for the family to contribute to the investigation.
- 3.12 A full list of all documents referenced, profile of the Trust and the investigation team are at Appendix D, E and F.

Structure of the report

⁴ National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

- 3.13 Section 4 sets out the details of the care and treatment provided to T. We have included a full chronology of his care at Appendix B in order to provide the context in which he was known to services in Hertfordshire.
- 3.14 Section 5 examines the issues arising from the care and treatment provided to T and includes comment and analysis.
- 3.15 Section 6 provides a review of the trust's internal recommendations and action plans, and DHR action plans, and reports on the progress made in addressing the organisational and operational matters identified.
- 3.16 Section 7 sets out our overall analysis and recommendations. A table of our recommendations is at Appendix C.

4 The care and treatment of T

Childhood and family background

- 4.1 T was born in the Paddington area of London in 1940, the oldest of four siblings. His mother had three further children after divorcing T's father, and he reported having a tough and unhappy childhood.
- 4.2 T left school at 15 and worked as an electrician's apprentice, then did a number of jobs before becoming a professional driver.
- 4.3 T was 72 at the time of his contact with HPFT. He had been married for 24 years to M, who was 56.
- 4.4 T had been married five times, having married his second wife twice. He had six children by three of his wives, and four stepchildren from his marriage to M, all of whom he adopted. A son from his first marriage died, leaving five natural children and four adopted children surviving him.
- 4.5 His first marriage ended in divorce after two years. T had a son and a daughter from this marriage. His son died in his thirties, and his daughter C lives in Essex. He reported having a good relationship with her. He saw her about every two weeks, although he saw her children less regularly.
- 4.6 T's second marriage ended in divorce after a year or so and he had two sons from this marriage, both of whom live in Antigua. He is reported to have seen them last in 2012, and had a good relationship with them. He subsequently remarried his second wife, but later divorced.
- 4.7 T's fourth marriage was short lived and there were no children. He had been in a relationship with M since 1984, and they married in 1989. This was T's fifth marriage. M came from the Philippines, and she and T had a son and a daughter. Their son lived nearby in Hatfield and they saw him regularly. Their daughter lives in Canada, and T had visited her in 2012.
- 4.8 T had four step children who were M's children from a previous marriage and he had adopted them. T's children were all in contact with each other, and

communication about the independent investigation took place through his eldest daughter C.

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

Employment and occupation

- 4.10 T did well at driving, and became a driver and chauffeur, sometimes taking tourists around London by car. He was still working as recently as four weeks before his admission to hospital in November 2012. He had not driven in the two weeks before his admission to a mental health unit.
- 4.11 T described himself as not having many friends, but was fine with that because he enjoyed gardening in the summer and reading and cooking in winter. He lived in a bungalow with a garden in Cheshunt, having moved there after M had a knee replacement.
- 4.12 T reported to staff that he was financially well situated as he continued to work. He owned three properties, one he lived in, one was rented out, and one in the Philippines. He had expressed concern that his financial position would change if M proceeded with divorce. T's daughter C expressed the belief that he was not in fact well off, and he would have lost everything if the divorce had gone ahead.

Physical health history

- 4.13 T told staff he had been a heavy smoker but had given up fifteen years previously. He reported he had not taken any illicit substances, and normally drank four units of alcohol with his wife at meals. It is not clear whether this amount referred to daily or occasional consumption.
- 4.14 The notes record that fifteen years previously he had drunk a litre of vodka a day for two to three weeks after losing his job. He had not drunk heavily again until two weeks before his mental health inpatient admission, when he reportedly started binge drinking.
- 4.15 T suffered a back injury after a traffic accident in 1988 and this caused recurring pain. He had been taking Simvastatin⁵ since 2006 for high

⁵ Simvastatin reduces the amount of cholesterol produced in the body. Simvastatin is used to help lower cholesterol in people with high cholesterol.
<http://www.nhs.uk/medicinesguides/pages/medicineoverview.aspx?condition=cholesterol&medicine=simvastatin&preparation=Simvastatin%2040mg%20tablets>

cholesterol, and Aspirin as an anti-platelet agent to reduce the risk of heart attack/stroke, given his high blood pressure and high cholesterol.⁶

- 4.16 A urology⁷ referral was made by T's GP in 2010, after a complaint of haematuria.⁸ He was diagnosed as having an enlarged prostate, possibly due to benign prostatic hypertrophy⁹, and prescribed Afuzosin.¹⁰ This was followed up with outpatient appointments, but it was felt he did not need any other investigations. An epididymal¹¹ cyst was later noticed on ultrasound, but no follow up treatment was necessary at that time.
- 4.17 Annual medical checks were completed by the GP for the DVLA¹², in order for him to maintain his taxi drivers' licence. The most recent of these was completed in January 2012.

Mental health history

- 4.18 A referral was made by T's GP to a psychiatrist at Chase Farm Hospital in September 1989. M had asked the GP to visit as an emergency, and T was described as '*agitated, rather incoherent and uncommunicative*' and talked of financial problems. This letter notes he has '*no past psychiatric history*'. The GP reported prescribing Diazepam¹³ 5mg three times a day for three days. The notes do not record any response to the referral.
- 4.19 In October 2008 T presented to his GP as '*very very low*', he said he had a similar episode 18 years earlier when his son died. At the time no obvious triggers were identified though he reported not sleeping since his mother in law died a month before. He said he was not close to her though. At this consultation T reported that he had low moods on and off throughout his life, and masked this with smoking and drinking at times. He said his mother had similar episodes.
- 4.20 The GP prescribed Fluoxetine¹⁴ 20mg and Diazepam 2 mg three times a day. The GP notes state for '*review in two weeks*'. There is no note of any

⁶ Low-strength aspirin is prescribed to help prevent unwanted blood clots from forming within the body. <http://www.patient.co.uk/medicine/aspirin-to-prevent-blood-clots-micropirin-nu-seals-aspirin>

⁷ Urology is the branch of medicine that focuses on the surgical and medical diseases of the male and female urinary tract system and the male reproductive organs.

⁸ Blood originating from the kidney or the collecting system, present in urine <http://www.patient.co.uk/doctor/haematuria-pro>

⁹ Benign prostatic hyperplasia is an increase in size of the prostate gland without malignancy present and it is so common as to be normal with advancing age. <http://www.patient.co.uk/doctor/benign-prostatic-hyperplasia>

¹⁰ Alfuzosin is prescribed for enlargement of the prostate gland in men. <http://www.patient.co.uk/medicine/alfuzosin-for-prostate-gland-enlargement-xatral>

¹¹ A small palpable lump in the testicle. <http://www.patient.co.uk/doctor/epididymal-cysts>

¹² DVLA <https://www.gov.uk/renew-driving-licence-at-70>

¹³ Diazepam is a medicine which is used in a number of conditions - an example is treatment of anxiety. <http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Anxiety&medicine=diazepam>

¹⁴ Fluoxetine hydrochloride is used to treat a variety of mental health problems. It is thought that Fluoxetine hydrochloride increases the activity and levels of certain chemicals in the brain. This can improve symptoms such as depression and anxiety. <http://www.nhs.uk/medicine-guides/pages/medicineoverview.aspx?condition=Depression&medicine=fluoxetine>

follow up by either the GP or T and only one month's prescription of Fluoxetine and Diazepam was issued.

- 4.21 T's daughter reported that about 18 years before his death he had a period of drinking heavily and was very difficult to live with. He was described as having a bad temper that was '*taken out on the children*' at times.
- 4.22 On 27 November 2012 T attended his GP again, and an urgent referral was made to the Hertfordshire Partnership NHS Foundation Trust mental health service single point of access (SPA). T completed a Patient Health Questionnaire (PHQ-9)¹⁵ with a score of 25. This would indicate a severe depression. Question 9 on this scale is '*Thoughts that you would be better off dead, or of hurting yourself in some way*' screens for the presence and duration of suicidal thoughts. T has scored 'for several days' on this question, all other answers are nearly every day, for example for Question 2 '*feeling down, depressed, hopeless*'. The results of the PHQ-9 were conveyed in the GPs referral letter, and he was described as having '*marked depression*' and '*suicidal thoughts*'.
- 4.23 T was later diagnosed with an 'adjustment disorder' but in our view he had a number of features suggesting a depressive disorder. These included: self-reported low mood; suicidal ideas and plan; reduced appetite and weight loss; possibly sleep disturbance; self-neglect (which was reportedly why M was staying with him). His alcohol use might have been secondary to low mood. His score on the PHQ-9 puts him into the range of severe depression and should highlight the need to assess risk. While the PHQ-9 is not a screening test, it can be used to monitor severity of depression and response to treatment.
- 4.24 The GP referral was noted by the central SPA team on 28 November 2012, and he was offered an assessment by the Mental Health Services for Older People (MHSOP) on 5 December 2012.
- 4.25 T was seen at home for assessment by a community psychiatric nurse (CPN) from the MHSOP on 5 December 2012. The notes of this assessment were not made until 31 December 2012, and they remained unconfirmed until 4 January 2013. A plan to refer to psychology and to arrange an outpatient appointment was noted, but these were not acted upon. The GP was not informed of the outcome of this assessment. The internal report notes that the CPN assumed that the psychologist present at the subsequent meeting when the case was discussed would pick this up as a referral. This did not occur, and the referral was never made. The CPN told the internal review that he was struggling to deal with the workload in a timely because of staff shortages, and management changes, but it was noted that senior staff did not consider this team to be under more pressure than similar teams in the county at the time.

¹⁵ The PHQ -9 is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment. However, it can be used to make a tentative diagnosis of depression in at-risk populations. <http://www.patient.co.uk/doctor/patient-health-questionnaire-phq-9>

Recommendation 1:

The outcome of primary care referrals should always be communicated back to the service user's GP, and the GP should be kept informed of plans of care and progress through mental health services.

- 4.26 T presented to Chase Farm Hospital Emergency department on 10 December 2012, complaining of chest pain and sweating lasting an hour. His blood pressure was noted to be raised, and Amlodipine¹⁶ 10mg was started. No cardiac concerns were noted, but a reference to *'transitory'* depression was included in the summary. A discharge letter was sent to his GP on 11 December 2012, advising that his blood pressure be reviewed in two weeks, and alcohol use be reviewed.
- 4.27 T presented to Chase Farm Hospital Emergency department for a second time on 16 December 2012, again complaining of chest pain. He was intoxicated on arrival and was expressing suicidal thoughts. The summary described him as living alone and binge drinking as a way of coping with his current impending divorce. He was referred to the Crisis Assessment and Treatment Team (CATT) team, who agreed to liaise with the Hertfordshire older people services bed manager. A discharge summary to his GP on 17 December 2012 noted that he had been feeling low and unmotivated. He was noted to have made plans for suicide and stated he had set aside a rope at home. T was referred for a mental health assessment the same day.
- 4.28 T was screened using the 'Psychosocial assessment form' at Chase Farm Emergency Department. He was noted to have been drinking alcohol heavily for one to two weeks, and had planned suicidal intent, having prepared a rope at home for suicide. He had been neglecting himself, and *'no protective factors were expressed'*. A discussion took place with the gatekeeping CATT Team and older people's bed manager for mental health in Hertfordshire. Admission to Lambourn Grove Unit¹⁷ was arranged for 17 December 2012.
- 4.29 On 17 December 2012 a comprehensive admission assessment at Lambourn Grove noted that he had been planning suicide by hanging, but since admission his wife M had said she would probably get back with him and he now feels much better. The risk assessment of his harm to himself indicated that he had acted with suicidal intent, he had *'poor coping strategies'* and *'if wife leaves he could become high risk again'*.
- 4.30 T stated on admission that he no longer had any intention of harming himself, 'not only because things are going well with his wife, but because he

¹⁶ Amlodipine is a medicine which is used in hypertension and angina. <http://www.nhs.uk/Medicine-Guides/Pages/MedicineOverview.aspx?condition=Blood%20pressure&medicine=Amlodipine>

¹⁷ Lambourn Grove, Mental Health Services for Older People (MHSOP): Inpatient Unit, HPFT

never thought he would go through with it because he knew he was a bit of a coward'. He was placed on an alcohol withdrawal regime, and placed on 10 minute observations in the ward.

- 4.31 M disclosed to the assessing doctor that she had been staying with T for the past few weeks to help him with washing and cooking because he had been neglecting himself. She had been living separately for about a year, and has now told him that she will probably get back with him. She stated that she has left him many times, and has been afraid of him because of his controlling and forceful behaviour toward her. She said she thought he had been in prison before, and although he had been verbally abusive to her, he had never been violent. M asked the doctor not to disclose that she had said this.
- 4.32 The consultant psychiatrist reviewed T on 21 December 2012 and agreed he could go home on leave. At interview he stated that he considered T to have "*reactive response rather than a mental health problem*", but that he should be under the care of the CATT team due to his recent suicidal ideation. The 10 minute observations were discontinued on this date, and reduced to every thirty minutes (general).
- 4.33 As T responded to his admission and the support of his wife he began to press to go home, saying he felt better and found the ward environment distressing. In response to his wishes the decision was taken to allow him to go home on weekend leave from Friday 21 December 2012 with an agreement he would return on Monday 24 December for a CPA review. However he was subsequently reported to feel 'wary' of going home and stayed until Saturday 22 December 2012. He had received assurances from staff that he could contact the ward at any time. A referral to CATT had been made, and he was due to be seen by CATT staff whilst on leave. No assessment was made by CATT staff before discharge, and there was no CATT representative at the review meeting on 21 December, or the transfer of care meeting on 24 December 2012.
- 4.34 A care plan was opened on the electronic system on 28 December 2012 which contained one item, '*management of distress*'. No interventions were noted, and a review date of 9 January was recorded.
- 4.35 CATT team contact was made by phone and home visits. T was seen on 5 occasions, and spoken to directly by phone on 3 occasions. There was more frequent contact by phone with M, who was staying with him. Staff notes record that T seldom answered his mobile phone or the landline. It was reported that it was not possible to leave a message on T's phone because it did not have a voicemail facility. It became the habit that M would respond to 'missed calls' on T's phone from her mobile. There were notes however of texts sent to M's number asking them to contact CATT.
- 4.36 There was no suggestion that T lacked capacity, and there was of course no lawful basis for compelling T to engage with services. However it would be reasonable to expect a care plan that described the actions to be taken if

there was a difficulty in engagement or communication. As noted in 4.34, there was no contingency plan in place.

- 4.37 T's last contact was with a CATT community support worker by phone on 4 January 2013, when he declined a home visit. CATT staff made phone calls on 6, 7, 8 and 9 January; and a cold call to the house on 11 January 2013, none of which were responded to.
- 4.38 A police welfare check was requested, and on 11 January 2013 Hertfordshire police attended the property. T & M's son had already entered the property, and found his parents deceased.

Contact with criminal justice system

- 4.39 We requested information from Hertfordshire police on any reports of domestic abuse or criminal activity.
- 4.40 Police report two instances when they were called by M regarding T.
- 4.41 In May 2009 M called the police during an incident in the home where T wanted her to let him in to the bedroom, and she wouldn't let him in. T was under the influence of alcohol. This was recorded as a 'non-crime' domestic violence incident with no further action.
- 4.42 In October 2010, when they were separated, M called the police to report that T had texted her twice, when she didn't want any contact with him. This was also recorded as 'non-crime', and the Domestic Abuse Stalking and Honour based Voice risk assessment¹⁸ is recorded as a 'standard' risk, which is at the level of '*current evidence does not indicate likelihood of causing serious harm*'.
- 4.43 There is no report of a prison term, or previous violence. Although we do not have the detail of his police record; there is an entry on the Police National Computer for 1965 referred to by the police, which was judged by them not to be relevant. They did not disclose the detail of this.

5 Arising issues, findings and analysis

- 5.1 In this section we review the interventions offered to T, and policies and procedures in place in the Trust when T was receiving care from mental health services.
- 5.2 We also looked at the Trust's current policies and procedures and other documentation, to consider adherence to policy and any changes that have been made since January 2013. We interviewed senior Trust managers who described how policies and procedures have been changed and

¹⁸ Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model <http://www.dashriskchecklist.co.uk/>

implemented. We conducted telephone interviews with T's GP and two practitioners currently working in MHSOP and SE CATT.

- 5.3 A full list of the documents reviewed can be found in Appendix D.
- 5.4 We have focussed on the points identified in the terms of reference and further areas that have emerged during our investigation. We have noted concerns about the care provided to T which did not feature in the Trust's internal investigation. The Trust has provided a significant amount of evidence for the implementation of the action plans arising from this case and we have reviewed this.
- 5.5 The terms of reference for this investigation relevant to this section required that we:
- Review the appropriateness of the treatment of the service user, in particular the frequency of visits and the level of staff undertaking the visits by the CATT;
 - Examine the effectiveness of the service user care plan including the involvement of the service user and the family and whether carers assessments were considered and undertaken;
 - Review the information sharing between the GP/Hertfordshire Partnership Foundation Trust and other health professionals.

Review the appropriateness of the treatment of the service user, in particular the frequency of visits and the level of staff undertaking the visits by the CATT

- 5.6 From our investigation we found that T was provided with appropriate initial treatment by his GP following his presentation with depression and suicidal ideation in November 2012. He was initially prescribed fluoxetine 20mg, and referred for an urgent mental health assessment, following a score of 25 out of 27 on the PHQ-9.
- 5.7 He was screened by the HPFT SPA service and offered an appointment for assessment by a CPN from the MHSOP on 5 December 2012.
- 5.8 While the CPN recorded that he should be referred to psychology and for an outpatient appointment, this was not acted upon, and there was no communication back to the GP referrer. We consider this is not an acceptable level of service, and should have been led to a referral and follow up.
- 5.9 We consider that the decision to admit T to a mental health unit on 17 December 2012, after his presentation at the emergency department for the second time, was also appropriate. However Lambourn Grove was at the time an admission unit for the care of older people with mental health issues, and the focus of care was on those with organic illnesses such as dementia.

It was not clear from either the clinical record or from interviews with staff, what the content of T's care was on Lambourn Grove. He was reported to keep to himself, and spend time reading or with his wife.

- 5.10 We have been made aware that the mental health services for older people have been reconfigured since this time. The service now has the flexibility to admit to either a 'frail functional' unit or to an acute working age adult unit. It was acknowledged with hindsight that Lambourn Grove was not the most appropriate setting for T's acute presentation, especially given the mix of patients with organic and functional illnesses. Inpatients with dementia or other organic illnesses are now cared for separately to those with functional illnesses.
- 5.11 Mental health services were described as accessible according to the needs of the service user. Senior staff interviewed as part of the investigation assured us that if a service user presented in a similar way today, they would be able to access the acute admission unit for adults of working age if appropriate, regardless of age.
- 5.12 Clinical nursing entries for the period from admission on 17 December 2012 to going on leave on 22 December 2012 are descriptive, commenting on his whereabouts, his dietary intake, sleep pattern and his visitors. He is noted to appear '*settled in mood and mental state*', '*pleasant on approach*' and '*brighter in mood*'. He was noted to be '*pleasant and interacting well with staff when they talk to him*'. There is no evidence of documented nursing clinical observations or assessment on T's mental state, nor any evidence of time spent with him by nursing staff to get to know him and explore his issues.
- 5.13 We have noted that the internal Serious Incident report has made the recommendation (5) that '*Lambourn Grove should review its implementation of the Named Nurse policy and consider how the role can be used effectively within the unit to ensure care and treatment of inpatients is well-coordinated and service users are able to identify their named nurse and have protected time with them*'. While we concur with this and accept that this recommendation relates to nurses developing a therapeutic relationship with service users, it does not address the content of nursing notes.
- 5.14 The Safe and Supportive Observation policy lists what nurses and other clinicians are expected to record daily: general behaviour, movements, posture, speech, expression of ideas, appearance, eating / dietary intake, mood, attitude and orientation, response to medication, and physical condition.
- 5.15 There should also be a recording of the following factors, according to the Safe and Supportive Observation policy, in any decision to review observation levels: current mental state, care plan, current assessment of risk, specific level of observation to be implemented, clear directions regarding therapeutic approach, timing of next review.

- 5.16 While an absence of self-harm or suicidal ideation was noted in four of the nine entries in this period, T remained on 10 minute observations until seen by the consultant psychiatrist on 21 December 2012. There are no records of observation levels reviews, and the Safe and Supportive Observation policy specifies that there should be a daily review, with a weekly MDT review.

**Recommendation 2:
Adherence to the Observation policy with respect to recording of
clinical information and formal reviews should be monitored**

- 5.17 The internal Serious Incident report notes a number of concerns in the planning and operational management of T's care. Eight recommendations were made regarding the working practices of the South East CATT service:

Recommendation 2. SE CATT must ensure that all services users admitted to the service are assessed by CATT prior to admission to ensure they meet the criteria for the service and that CATT has the capacity to meet their needs. If this is not possible then assessment must be carried out on admission supported by a full risk assessment and associated patient centred care plan.

Recommendation 3. The introduction of the revised CATT Operational Policy must be supported by a team training/development programme to ensure team members understand the new ways of working that are required of them and that there is a shift in the culture of the team. Ideally training that involves staff from all of the CATTs would ensure some cross fertilization and stimulate team development.

Recommendation 4. The CATT action plan developed following the T homicide/suicide must be fully implemented and embedded in practice. The CATT Service Line Lead must monitor progress on this and report to the Strategic Business Unit and also the Quality and Patient Safety Group and provide firm assurance that the actions are firmly embedded in CATT practice. This should include reports of the weekly audits carried out as part of the action plan.

Recommendation 6. SE CATT must ensure each service user under its care has a named key worker (as per the new Operational Policy) who is a qualified health or social care professional and takes responsibility for co-ordinating the care and treatment of service users. The named key worker should be clearly identified, known to the team members and the service user.

Recommendation 7. Subsequent reviews of the Care Co-ordination Policy, the Named Nurse Policy and the CATT Operational Policy should each cross reference with the roles of Care Coordinator, Named Nurse and Key Worker respectively. Consideration should be given to how each of these roles hands over to the next to ensure continuity from one service to the next.

Recommendation 8. Staff of Lambourn Grove and SE CATT must both ensure that any assessments routinely include consideration of any safeguarding issues for the service user and significant others and that MDTs include safeguarding on their assessment checklists automatically. This must be carried through to CPA discharge planning reviews.

Recommendation 9. Staff of Lambourn Grove and SE CATT must both also ensure that the needs and vulnerability of carers are actively considered, particularly in the light of the service user experiencing an acute episode of mental illness.

Recommendation 11. The interface and communications between CATT and CMHTs must be reviewed as part of the community services review currently underway in the Trust. Consensus and agreement must be reached by both on clear standards for the following:

- *Criteria for discharging service users from CATT to CMHTs;*
- *Timescale in which this can be achieved once it is known the service user is ready for discharge and*
- *A mutually agreed risk assessment relating to the proposed change in circumstances (i.e. transfer from one service to another).*

5.18 We consider that the findings of the internal Serious Incident investigation report adequately reflect the concern we have about the levels of care provided by CATT. There was an over reliance on community support workers, and no evidence of any qualified professional taking control of the situation to make a full assessment of progress on a daily basis. T was seen in person on four occasions during his period of care by CATT. After having been seen by a qualified nurse and a doctor at home on 27 December, the further three further home visits were carried out by community support workers. The last contact with T was on 4 January 2013, and a welfare check was not requested until 11 January 2013. The frequency of visits and the lack of accountability by qualified staff were highlighted and have been recommended for incorporation into a revised CATT operational policy.

5.19 However our earlier observation about the relevance and content of clinical nursing notes in Lambourn Grove also applies here. Notes largely describe the content of conversations with T and M, with few records of interventions or the outcomes of interventions.

5.20 We will consider these areas in the revised CATT operational policy, and include review of implementation of the subsequent action plan in Section 6.

Assessment of Risk

5.21 The initial assessment undertaken by the duty psychiatrist in December 2012 shows good history taking and positive attempts to understand T's presentation. Risk was thoroughly explored in relation to self; and it was noted he had active plans of suicide. Assessment of risk to others is confined to the disclosure from his wife M about her past fears for her safety and his verbally abusive and controlling behaviour. The concerns from M about her

safety were not discussed with T at her request, which presented the assessing doctor with a dilemma. The doctor did however correctly note M's own concerns.

- 5.22 While this was a thorough initial assessment, we consider that the Lambourn Grove clinical team and consultant psychiatrist should have followed up on this line of enquiry.
- 5.23 At this initial assessment, a measure of T's mood was recorded on the 'Geriatric Depression Scale (GDS)¹⁹ and he scored 17 out of 30. This gives an assessment of 'mildly depressed'. This scale was developed by Yesavage et al for use with older adult populations and is widely used. However according to Greenberg (2012) '*The GDS is not a substitute for a diagnostic interview by mental health professionals. It is a useful screening tool in the clinical setting to facilitate assessment of depression in older adults especially when baseline measurements are compared to subsequent scores. It does not assess for suicidality.*'²⁰ We consider that the GDS should be regarded as a screening tool only, and that people who score within the depression range on the GDS need to be assessed clinically.
- 5.24 Assessment of suicide risk is more complex than simply asking the person whether or not they have any intention of harming themselves. We believe T had a number of risk factors for suicide: male²¹; separated/ about to be divorced; alcohol use; low mood; stressful life event (the impending divorce) and a possible depressive disorder. He had thoughts of hanging himself and had identified a rope he would do this with, suggesting some degree of planning.
- 5.25 T was seen twice by medical staff during his five day period as an inpatient, once on 18 December 2012 by the junior doctor, and once on 21 December 2012 by the consultant in a team meeting. On both occasions M was present. There does not appear to have been any time spent by medical staff with T individually to clinically assess his risk to himself. Neither was there any reference to interpreting or repeating the previous assessments (PHQ-9 and GDS).
- 5.26 The Clinical Risk Assessment and Management Policy and Procedures for individual service users (August 2010) provided information, guidance and procedures for staff in the assessing and managing of clinical risk. Of the '10 underpinning values' referred to; the first was '*Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience, and clinical judgement*'. We believe if this principle had been correctly applied to T, a much more comprehensive assessment of

¹⁹ Yesavage et al (1982) Development and validation of a geriatric depression screening scale: A preliminary report [http://www.journalofpsychiatricresearch.com/article/0022-3956\(82\)90033-4/abstract](http://www.journalofpsychiatricresearch.com/article/0022-3956(82)90033-4/abstract)

²⁰ Greenberg (2012) the Geriatric Depression Scale (GDS). Try this: Best Practices in Nursing Care to Older Adults http://consultgerim.org/uploads/File/trythis/try_this_4.pdf

²¹ <http://www.samaritans.org/about-us/our-research/research-report-men-suicide-and-society>

his risk would have been developed, that would have identified the lack of any protective factors other than the apparent change of M's attitude to divorce.

- 5.27 A revised Clinical Risk Assessment and Management Policy for individual service users was issued in September 2013. This is structured around the Trusts' new policy template with clear **Rules** (internally agreed things that must be done) and **Standards** (national standards that must be followed).
- 5.28 There are now 'standard' and 'enhanced' structured risk assessment forms in the Trust's electronic clinical record (PARIS)²². The section on assessing risk of suicide now states that two important elements are important; knowledge of general risk factors for suicide and skills in making direct enquiries about suicidal intent. There is guidance on identifying situations and circumstances known to present increased risk, such as *'when there is an apparent improvement in health though history suggests that this may be short lived and requires careful monitoring over a longer period of time'*. We believe this approach will be helpful in guiding care for service users who may present in a similar way in the future.
- 5.29 A Dysphagia and Nutrition Screening Tool was carried out by nursing staff on 19 December. Although T had reduced appetite and loss of weight; these could also be symptoms of depression. The paperwork says that PEAT²³ requires it to be done within 72 hrs of admission. T was overweight on his BMI and said that he had reduced his intake and lost weight because of depression. This appears to be an assessment driven by processes for assessing nutritional needs in an elderly population in hospital, and we question whether this was an appropriate assessment for T.
- 5.30 On 24 December 2012 there is a diagnosis of *'adjustment disorder'* (ICD.10 F43.2)²⁴ and *'mental and behavioural disorder due to harmful use of alcohol'* (F10.1).²⁵ The consultant later states in the internal investigation interviews that he regarded T as having an *'adjustment disorder, rather than a depressive episode'*. An adjustment disorder (F43.2) is defined as *'experience of an identifiable psycho-social stressor, not of an unusual or catastrophic type, within one month of the onset of symptoms'* and/or *'symptoms or behaviour disturbance of types found in any of the affective disorders (except for delusions and hallucinations), any disorders in F4 (neurotic, stress related and somatoform disorders) and conduct disorders,*

²² PARIS is an electric patient record system <https://www.civica.co.uk/health-and-social-care/articles/PARIS/tags>

²³ PEAT refers to the Patient Environment Assessment Team nutrition standards <http://www.bapen.org.uk/pdfs/toolkit-for-commissioners.pdf>

²⁴ The ICD-10 Classification of Mental and Behavioural Disorders, World Health Organization, Geneva, 1992. States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event (including the presence or possibility of serious physical illness). The stressor may have affected the integrity of an individual's social network (through bereavement or separation experiences) or the wider system of social supports and values (migration or refugee status). The stressor may involve only the individual or also his or her group or community

²⁵ The ICD-10 Classification of Mental and Behavioural Disorders World Health Organization, Geneva, 1992. A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis from injecting) or 0.1 Harmful use mental (e.g. episodes of depressive disorder secondary to heavy alcohol consumption).

so long as the criteria of an individual disorder are not fulfilled. Symptoms may be variable in both form and severity'. The diagnosis of adjustment disorder suggests that T's mental health issues were a result of reactions to stressful life events rather than a depressive disorder. There are no distinct NICE guidelines for the treatment of adjustment disorder, and it is commonly diagnosed in primary care. According to Casey & Bailey (2103)²⁶, *'symptoms of low mood, sadness, worry, anxiety, insomnia, poor concentration, having their onset following a recent stressful event are likely indicators of a diagnosis of adjustment disorder, although it must be borne in mind that major depression can also present similarly*'.

- 5.31 We consider that regarding T's issues as an adjustment disorder could have led to a minimising of the suicidal risk. This diagnosis implies that if the 'stressful event' ie the threat of divorce was removed, then any risk of suicide would reduce. The assessment of risk prior to his discharge appears to have taken the view that, because M had allegedly changed her mind about divorce, T's risk of suicide had reduced.
- 5.32 However there was no objective clinical assessment of his suicide risk undertaken, regardless of the issue of diagnosis. The updated risk assessment on 21 December 2012 notes *'has threatened suicide, said there was a rope in the shed, but no actual self-harm*'. We consider that the knowledge of the degree of planning previously referred to at 5.24 should have triggered a full clinical assessment of T's risk to himself, to include a possible diagnosis of depressive disorder.
- 5.33 With regard to risk to others; *'has frightened wife before who has gone to women's refuges but no actual violence to her*'. This is referred to under risk to staff or carers, but it is noted *'wife happy to have him home*'. This is despite the fact that it was known that she was only staying at the house and had been living separately until she became concerned about him.
- 5.34 Consideration of risk to others formed part of the 17 December 2012 initial assessment, and 'no risk' was recorded with regard to carers, previous aggression, use of weapons, or previous dangerous acts.
- 5.35 We consider that this did not constitute a robust assessment of the risk to T himself or to M, given the history related by her about previous abusive and controlling behaviour. There was no police contact made to corroborate or clarify T's reported forensic history.

Recommendation 3:
An information sharing agreement with Hertfordshire Police should be established.

²⁶ CASEY, P. and BAILEY, S. (2011), *Adjustment disorders: the state of the art. World Psychiatry*, 10: 11–18.
<http://onlinelibrary.wiley.com/doi/10.1002/j.2051-5545.2011.tb00003.x/full>

Examine the effectiveness of the service user care plan including the involvement of the service user and the family and whether carers assessments was considered and undertaken

- 5.36 As described above, we consider that the care plans developed both in Lambourn Grove and by the CATT service were not adequately individualised or detailed enough to support T, and were not based on a thorough risk assessment.
- 5.37 Notes made by staff are largely descriptive, and do not obviously relate to a plan of care. CATT notes are descriptive, and interventions recorded are suggested responses to issues raised by T such as advice about sleep hygiene, rather than part of an overall care plan. There are records of suggestions that he contact CRI²⁷ and Relate.²⁸
- 5.38 The discharge summary records that the professionals at the CPA meeting on 24 December 2012 accepted crucial information relevant to the review from M over the phone. When she was called to ask if T was attending, M allegedly reported that he was '*not suicidal*', and she felt that '*sleep was his main problem*'.
- 5.39 T's poor sleep was discussed at the meeting, and it was considered that this was '*due to alcohol withdrawal and that hypnotics could not be prescribed at this time*'. This suggests to us that this insomnia still required management, whether it was due to alcohol withdrawal or a depressive illness.
- 5.40 Recommendation 1 of the internal report below focuses on the requirement for care plan and risk assessments to be assessed against the initial care plans and risks (see below). We consider however that there should be a recommendation that discharge planning always involves the service user directly.
- "1. Lambourn Grove should ensure discharge/ transfer of care reviews and associated care plans are assessed against the initial mental state assessment carried out on admission to the ward and the risk factors previously identified. This is to ensure that all the factors identified on admission have been addressed in the course of the admission and if not are properly covered in the discharge/ transfer of care review and care plan".*
- 5.41 We consider that it should be accepted practice that discharge planning/ transfer of care involves the service user fully, and that third party information is not relied upon as a basis for decision making. The Transfer and Discharge policy (January 2014) states '*when transferred from inpatient services to community services the 'service user and carer, as appropriate, are provided with verbal and written information which includes, contact*

²⁷ CRI is a leading charity providing treatment and support for substance abuse <http://www.cri.org.uk/>

²⁸ Relate is a charity providing couples and marital counselling <http://www.relate.org.uk/>

details of their care coordinator, medication and ongoing treatment, follow up arrangements, date of first contact and access to the relevant community team including emergency helpline'. Furthermore the CPA meetings as a minimum 'will include the service user, the carer (as appropriate), the Consultant Psychiatrist responsible for inpatient care and the care coordinator'. While this is the policy that came into place after T's transfer, we consider it is not good clinical practice to transfer a service user without any direct contact with them, and that the timing of this on Christmas Eve was ill advised.

5.42 T had a number of children living locally, however he had not initially informed his children of the nature of his admission. The clinical team were aware that T was very concerned about confidentiality, and appropriately did not pursue contact with his children.

5.43 The role of M in T's care has been examined by the internal Serious Incident investigation report, and recommendations made:

"8. Staff of Lambourn Grove and SE CATT must both ensure that any assessments routinely include consideration of any safeguarding issues for the service user and significant others and that MDTs include safeguarding on their assessment checklists automatically. This must be carried through to CPA discharge planning reviews.

9. Staff of Lambourn Grove and SE CATT must both also ensure that the needs and vulnerability of carers are actively considered, particularly in the light of the service user experiencing an acute episode of mental illness.

11. The interface and communications between CATT and CMHTs must be reviewed as part of the community services review currently underway in the Trust. Consensus and agreement must be reached by both on clear standards for the following:

- *Criteria for transferring the care of service users from CATT to CMHTs;*
- *Timescale in which this can be achieved once it is known the service user is ready for transfer of care and*
- *A mutually agreed risk assessment relating to the proposed change in circumstances (i.e. transfer from one service to another).*

13. The Trust must develop guidance and training for health and social care professionals relating to domestic violence. This must include the identification of risk factors and how to assess and respond to disclosures and behaviours that might suggest the possibility of domestic violence.

14. Protocols should be developed for initiating discussion regarding concerns about possible domestic violence that are separate from current Safeguarding procedures. This should be done in partnership with the local authority and Hertfordshire Constabulary Alternatively consideration should be given to expanding the definition of 'vulnerable adults' within the Safeguarding procedures so that it embraces anyone that might be subject to domestic violence".

- 5.44 We have not reiterated the issues regarding the clinical team's communication with M, and the question of a carer's assessment. We agree that the team should have had a discussion about whether M was a carer, and agree it would have been helpful to carry out a carer's assessment.
- 5.45 We note however that there is no record of attempts to establish whether M was in fact acting as a 'carer'. It is not clear whether she was willingly staying in the situation, or whether she felt obliged to stay in the house with T. There may have been cultural or religious influences on her approach to the situation, which may have influenced her attitude to divorce and marital relationships; but this was not explored by staff.
- 5.46 We do however wish to return to the issue of risk assessment and information gathering. The team appear to have accepted information offered by M on numerous occasions, without documented notes of checking for any objective evidence. This apparent acceptance, we believe, contributed to the confusion around the status of M in T's care, and also to a dearth of information gathered directly from T about his mental health, his history, the status of his marriage and financial pressures.
- 5.47 The team simply did not know what the couple's relationship was, and accepted the situation at face value. The discharge summary refers to a 'Forensic History' that reiterates the information told to the admitting doctor by M: that is that T's second wife had had 'put him in prison', and that she herself had been to the police in 2007. There is no evidence that this information was explored further; either to try to ascertain any risk to M, or to clarify with the police whether he had any convictions or history of risk to others.
- 5.48 The consultant considered whether M should be seen as a vulnerable adult, and as such be subject to safeguarding considerations. When this was explored it was found that M did not in fact meet the criteria The Hertfordshire Safeguarding Adults Board Inter -Agency procedure's definition of a vulnerable adult at the time.

Recommendation 4:
Information based on third party disclosures should be noted as such, and risk assessments should clearly note whether information is evidenced or not.

Review the information sharing between the GP/Hertfordshire Partnership Foundation Trust and other health professionals.

- 5.49 The GP's referral to Mental Health services was made on 27 November 2012 by fax and letter, headed urgent, and with a footnote to '*please address all return correspondence to referring clinician*'.

- 5.50 A telephone triage assessment was carried out by a community psychiatric nurse (CPN) and a 'needs agreement' was established, in line with the Care Coordination policy. It was agreed and documented that a referral would be made by the CPN to the MHSOP. There was no feedback to the GP referrer. The Care Coordination policy provides clear guidance on the completion of a needs agreement, but does not include any instruction or guidance about feeding back to the referrer. While this would appear to be self-evident, it is unlikely to be done systematically without policy guidance around the process. **See recommendation 1.**
- 5.51 The GP received a copy of a letter from the Trust's single point of access on 1 December 2012 advising that an assessment meeting had been arranged at T's home address for 5 December 2012. No feedback was provided on this assessment to the GP.
- 5.52 There was no further contact with the GP by the Trust until an administration letter was received informing the GP practice that T had been admitted to Lambourn Grove: this was not addressed to the named clinician.
- 5.53 A discharge letter was sent by fax on 24 December 2012 from the inpatient unit at Lambourn Grove. This was a short note from an administrator giving the date of discharge as 24 December 2012 to the home address, with a copy of the medication chart. The letter refers to T as 'her' and has an incorrect address in Watford, suggesting it was 'copied and pasted' but contained incorrect information. The GP nevertheless clearly understood that this referred to T, as it had his full name and correct date of birth.
- 5.54 The more detailed discharge letter completed by the consultant psychiatrist from Lambourn Grove is undated, and there is no record of it in the GP notes supplied to the investigation, however the SystemOne²⁹ notes record that a 'specialist clinical letter' from community mental health was received on 24 December 2012, which may refer to the consultant's discharge letter.
- 5.55 The GP stated they did not know of the planned CPA review on 24 December 2012. The Care Coordination policy guidance about reviews states that 'all agencies involved in care' should be involved CPA reviews. We consider in this case that it would have been appropriate to have invited the GP who referred T initially.
- 5.56 We have noted that the reference to T allegedly having been in prison and to having subjected M to verbal domestic abuse in the past, became incorporated into the team's approach to T. At the internal SI investigation interviews the consultant psychiatrist described him as an "aggressive dominant man".
- 5.57 We asked if the team would normally check this kind of information out with the police, and were told that this was not normal practice. This raises three issues, the first being the requirement for records and risk assessments to be

²⁹ SystemOne is the electronic patient record in use in primary care services across the NHS. <http://www.tpp-uk.com/>

based on accurate information. If the information is unsubstantiated, it should be noted as such.

- 5.58 The second point is the question of checking on information with the police. Those practitioners we spoke to were not aware of any information sharing agreement, and did not know how to access the police to ask for information. See Recommendation 3.
- 5.59 Our third point here is that, given this information was regarded as part of the history, we believe the team should have had separate discussions with M about her intentions and about any concerns she may have about risk to herself.

6 Internal investigations, DHR and action plans

- 6.1 There have been two Trust internal investigations into this incident; a serious incident investigation (SI) and an Individual Management Report (IMR). A Domestic Homicide Review has also been carried out into the deaths of T and M, and this section of the report will be structured around the relevant terms of reference for this independent investigation.
- 6.2 The terms of reference relevant to this section are to:

Review the DHR report and the Trust IMR and consider if the safeguarding/domestic violence processes in place are able to detect the possibility of violence in cases like this.

The DHR recommendations

- 6.3 In Hertfordshire the county Domestic Violence Strategic Programme Board assumes the responsibility for administering the process of Domestic Homicide Reviews (DHR)³⁰ and to inviting Community Safety Panel (CSP) representation from the area in which the victim (M) was last known to reside, which was Stevenage CSP. The decision was taken to establish a 'proportionate' DHR.
- 6.4 A Domestic Homicide review panel was established to oversee the DHR and was chaired by the Chief Executive Officer of Stevenage Borough Council.
- 6.5 While the two processes ran in parallel, it was agreed that one could not be subsumed into the other. However, the need to ensure synergy and consistency was recognised, and the Trust internal SI and IMR reviews were completed by the same team. The recommendations from the final DHR report have been accepted by the Trust and incorporated into the action plans developed.

³⁰ MULTI-AGENCY STATUTORY GUIDANCE FOR THE CONDUCT OF DOMESTIC HOMICIDE REVIEWS.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

- 6.6 The implementation of recommendations and action plans for all the investigations have been reviewed as part of this independent investigation.
- 6.7 The recommendations made in the Trusts' SI investigation are reflected in the DHR report, as an indication of remedial action by HPFT.

Trust internal investigations

- 6.8 There have been two Trust investigations into this incident, to meet the expectations of the NHS Serious Incident Framework³¹ and DHR expectations;
- the Trust's internal investigation (SI) completed in August 2013
 - the Individual Management Review (IMR) for the Domestic Homicide review completed in June 2013

Both were carried out by a team of senior clinical staff from the Trust, led by a Non-Executive director. None of these were involved in the care of T. An external management consultant co-ordinated the investigations and wrote the reports.

- 6.9 The terms of reference do not require us to review of the quality of this report. However, there are four areas of omission that we believe require noting:
- The chronology notes that T attended Chase Farm Emergency department on 16 December 2012, but omitted reference to his presentation in similar circumstances on 10 December 2012. Both the Chase Farm notes and Lambourn Grove notes made reference to the 10 December episode of care.
 - The GP notes were not accessed, nor was the GP involved in the investigation, which missed the potential for review of the communication between primary and secondary care.
 - The question of T's possible forensic history was not explored, nor was any comment made on the lack of attention to this in the assessment and care of T.
 - We have made recommendations about these three areas.
 - The final area of concern is the lack of attention to any possible cultural or religious issues that may have influenced M's approach to the marriage, and to her own ability to leave the situation. We would expect any assessment of the situation with regard to carer's assessments to include reference to cultural issues.

- 6.10 From the Trust investigations 15 recommendations were produced;

³¹ NHS Serious Incident Framework March 2013 NHS Commissioning Board

- 1. Lambourn Grove should ensure discharge reviews and associated care plans are assessed against the initial mental state assessment carried out on admission to the ward and the risk factors previously identified. This is to ensure that all the factors identified on admission have been addressed in the course of the admission and if not are properly covered in the discharge review and care plan.*
- 2. SE CATT must ensure that all services users admitted to the service are assessed by CATT prior to admission to ensure they meet the criteria for the service and that CATT has the capacity to meet their needs. If this is not possible then assessment must be carried out on admission supported by a full risk assessment and associated patient centred care plan.*
- 3. The introduction of the revised CATT Operational Policy must be supported by a team training/development programme, to ensure team members understand the new ways of working that are required of them, and that there is a shift in the culture of the team. Ideally training that involves staff from all of the CATTs would ensure some cross fertilization and stimulate team development.*
- 4. The CATT action plan developed following the T homicide/suicide must be fully implemented and embedded in practice. The CATT Service Line Lead must monitor progress on this and report to the Strategic Business Unit and also the Quality and Patient Safety Group and provide firm assurance that the actions are firmly embedded in CATT practice. This should include reports of the weekly audits carried out as part of the action plan.*
- 5. Lambourn Grove should review its implementation of the Named Nurse policy and consider how the role can be used effectively within the unit to ensure care and treatment of inpatients is well co-ordinated and service users are able to identify their named nurse and have protected time with them.*
- 6. SE CATT must ensure each service user under its care has a named key worker (as per the new Operational Policy) who is a qualified health or social care professional and takes responsibility for co-ordinating the care and treatment of service users. The named key worker should be clearly identified, and known to the team members and the service user.*
- 7. Subsequent reviews of the Care Co-ordination Policy, the Named Nurse Policy and the CATT Operational Policy should each cross reference with the roles of Care Coordinator, Named Nurse and Key Worker respectively. Consideration should be given to how each of these roles hands over to the next to ensure continuity from one service to the next.*
- 8. Staff of Lambourn Grove and SE CATT must both ensure that any assessments routinely include consideration of any safeguarding issues for the service user and significant others and that MDTs include safeguarding on their assessment checklists automatically. This must be carried through to CPA discharge planning reviews.*

9. Staff of Lambourn Grove and SE CATT must both also ensure that the needs and vulnerability of carers are actively considered, particularly in the light of the service user experiencing an acute episode of mental illness.

10. MHSOP should consider the access to psychological therapies that it is able to provide and whether older people are disproportionately disadvantaged in the access to psychological therapies available to them.

11. The interface and communications between CATT and CMHTs must be reviewed as part of the community services review currently underway in the Trust. Consensus and agreement must be reached by both on clear standards for the following:

- Criteria for discharging service users from CATT to CMHTs;
- Timescale in which this can be achieved once it is known the service user is ready for discharge and
- A mutually agreed risk assessment relating to the proposed change in circumstances (ie transfer from one service to another).

12. A standard must be established for contemporaneous record keeping together with an appropriate programme of audit.

13. The Trust must develop guidance and training for health and social care professionals relating to domestic violence. This must include the identification of risk factors and how to assess and respond to disclosures and behaviours that might suggest the possibility of domestic violence.

14. Protocols should be developed for initiating discussion regarding concerns about possible domestic violence that are separate from current Safeguarding procedures. This should be done in partnership with the local authority and Hertfordshire Constabulary. Alternatively consideration should be given to expanding the definition of 'vulnerable adults' within the Safeguarding procedures so that it embraces anyone that might be subject to domestic violence.

15. The Review Panel will provide the teams involved in the care and treatment of T with a feedback session identifying the findings of the review. However, consideration should be given to providing the teams with a reflective learning session in which the issues associated with learning from this incident can be safely explored to ensure effective learning from this very serious incident.

- 6.11 We concur with these recommendations and have not repeated them. However we note that the use of the term 'discharge' does not match the wording of the Transfer and Discharge policy, which terms a move from an inpatient unit to CATT service as a transfer of care, not a discharge.

Review of existing investigations recommendations and any action plans

6.12 The terms of reference for the investigation relevant to this section required that we:

- Review the DHR report and the Trust IMR and consider if the safeguarding/domestic violence processes in place are able to detect the possibility of violence in cases like this
- Review progress that has been made in implementing the recommendations and the learning from their internal investigation
- Involve the family as fully as is considered appropriate
- Consider if this incident was either predictable or preventable

Review the DHR report and the Trust IMR and consider if the safeguarding/domestic violence processes in place are able to detect the possibility of violence in cases like this

6.13 We have seen the most up to date action plan prepared by the Trust, interviewed the newly appointed Head of Social Care and Safeguarding and had access to reports and documents about safeguarding and domestic violence work in the Trust. We have also discussed the issues of safeguarding training and domestic abuse recognition with managers and practitioners.

6.14 A 'Review of Countywide Domestic Abuse Framework and Provision of Services' was carried out in Hertfordshire in December 2014.³²The County Community Safety Unit, with funding from Hertfordshire's Police and Crime Commissioner, commissioned the independent charity CAADA (now safelives.org.uk) to thoroughly review how domestic abuse services in Hertfordshire could be improved. CAADA are a national charity who regularly advise police and crime commissioners and local services across the country how to improve their response to domestic abuse. The review started in September 2014, and the report was published on 9 January 2015.

6.15 The Trust's approach to domestic abuse was reviewed along with other services, and it was noted that health funding on domestic abuse is low. Referrals from health services generally are in very low numbers, and are usually from primary care/health visiting.

6.16 The Trust participated in the review of services and described an action plan in development to address recommendations made. These are seen as supporting and extending the actions already in place regarding identifying risk of domestic abuse following the recommendations of the internal Serious Incident report regarding T.

³² Hertfordshire Domestic Abuse Review (2014) CAADA co-ordinated action against domestic abuse <http://www.safelives.org.uk/>

- 6.17 There is a Safeguarding Strategy Group which reports to the Trust Board through the Integrated Governance Committee, and a Safeguarding Strategy is in development.
- 6.18 We have seen a draft policy on 'Tackling Domestic Violence and Abuse', which is starting to define expectations around training, information sharing, communications and staff responsibilities. The draft does contain an expanded definition of 'vulnerable adults' as recommended, but the document shared with us was dated July 2014, and we suggest that a definitive policy is written and implemented without further delay.
- 6.19 The Safeguarding Adults from Abuse Policy issued in April 2014 has been updated to reflect new legislation & Hertfordshire Safeguarding Adult Board policy & procedure.
- 6.20 In our interviews with Trust staff, we specifically focussed on training and awareness of safeguarding issues and possible domestic abuse. We found it reassuring that practitioners were able to describe the benefits of the training they have received, and reflect against the issues in T's care.
- 6.21 A recent audit report on clinical risk assessment and management showed a high number of risk assessments in place and signed off by managers, but also that many have not been completed appropriately, for instance with blank sections.
- 6.22 This audit focussed on whether aspects of adult safeguarding had been appropriately identified, which gave positive results. The aspects of risk assessment which relate to this area were well completed. A key issue in the care of T was that he was rarely seen by himself without M, both on the ward and at home. We found a recognition that this situation would now be noted and challenged, and consideration given to trying to ensure that the patient is seen by themselves regularly for proper review.
- 6.23 This also audited the presence of GP letters that contain information about risk, which found a small percentage of GP letters about risk which had not been incorporated into the risk assessment.
- 6.24 It was reported to us that there is clear understanding that carer's assessments should be carried out. However the skills of completing these and finding the resources available were described as challenging. There was previously a dedicated resource for completing these, which was described as very helpful.
- 6.25 Service managers reported a system for information sharing with police, and a low threshold for accessing advice about safeguarding. We were not assured that more junior staff are aware of how to contact police with a query about a service user's forensic history.
- 6.26 Based on this information, our view is that the Trust is developing processes to detect the possibility of domestic abuse in a case such as this, but these are not fully formed or embedded in policy and practice.

Recommendation 5:

The Trust should develop a strategy to ensure the safeguarding policy incorporates domestic abuse, and that staff fully understand and implement the policy .

Review progress that has been made in implementing the recommendations and the learning from their internal investigation

- 6.27 We reviewed the Trust's progress report dated January 2015, which incorporates recommendations from the SI and DHR reports. The majority of sections were completed, relating mostly to the practices of Lambourn Grove and SE CATT.
- 6.28 The MHSOP locally is undergoing a reconfiguration, and it is evident from operational policy review, team meeting notes and interviews with practitioners that learning from this incident has been considered in making service changes.
- 6.29 The way in which urgent referrals are assessed and treated has been changed, taking out the requirement for the team to carry out 'duty assessments' which has enabled the MHSOP service to focus on treatment and recovery.
- 6.30 The Trust has changed its electronic patient record system from Care Notes to 'PARIS'. Within PARIS the initial assessment and risk assessment made after referral is now visible to all those who have contact with the patient.
- 6.31 The CATT operational policy issued October 2013 is in the 'RULE' and 'STANDARD' format, and gives clear instructions for staff working in the service. There is an assurance process in place for evidencing adherence to the policy. On reviewing these changes with CATT staff, it was very clear the changes made have been implemented, such as the requirement for CATT staff to be present daily on the wards, and to be physically present when a referral assessment is required.
- 6.32 A bespoke risk assessment training package for CATT staff has been developed and delivered in collaboration with the University of Hertfordshire, and we had evidence that these have been well attended.
- 6.33 A protocol on the management of telephone calls and responses is now in place, and any communication issues are raised daily in the MDT meeting. Safeguarding issues are noted on the information board, and any actions tracked.
- 6.34 We specifically asked about decision making around staff ensuring that they assess the service user (and the carer if needed) on their own. It was acknowledged that CATT staff were not aware of the fragility of the

relationship between T and M, and that for new service users this would certainly be part of the assessment process at CATT.

- 6.35 Access to Clinical Supervision within the CATT service has been radically improved, with monthly reports to management on implementation.
- 6.36 The structures for Practice Governance are well embedded across the Trust, and it was clear that there is close working between the patient safety and practice governance structures to share learning and implement changes.
- 6.37 We have seen evidence of organisational learning from this and other incidents. The Patient Safety Manager has a clear communication structure for sharing learning through the quality and governance systems. Reflective learning sessions have been completed with both Lambourn Grove and SE CATT teams, and the lessons learnt have been shared more widely at fora for senior nurses and for medical staff.
- 6.38 The newly appointed Patient Safety Manager has recently reviewed all mental health homicide incidents and produced a thematic analysis for the Trust to review.
- 6.39 Recommendations 13 and 14 regarding training and protocols for the recognition and appropriate management of concerns regarding domestic abuse are partially completed. **See section 6.16 to 6.27 above for more detail.**

Involve the family as fully as is considered appropriate

- 6.40 We wrote to all of the children for whom we had addresses, in England and Canada, inviting their involvement in the investigation. It was agreed in the family that T's eldest daughter C would be the point of contact for us in this investigation.
- 6.41 The lead investigator met with C at her home. C described having been contacted by the Trust and had read a copy of the internal report. The family still maintain their belief that T's risk of suicide was not taken seriously enough. T had not shared his situation with her, and had not initially told her that he was in a mental health unit. C believes there would have been serious financial consequences for him if the divorce had gone ahead.
- 6.42 C was also concerned with the circumstances of M's death, and the timing of T's subsequent hanging. Whilst we have seen a copy of the post mortem reports, we cannot comment on the detail of these events, as it is beyond the scope of our investigation.
- 6.43 We gave the family an opportunity to comment on an initial draft of the report.

Consider if this incident was either predictable or preventable

- 6.44 Throughout the course of this investigation we have been mindful of the requirement, within NHS England's Terms of Reference, to consider if the incident which resulted in the killing of M was either predictable or preventable. The information accessed by the investigation team would have been available to secondary health care services who were supporting T and to authors of the Serious Incident report.
- 6.45 In our consideration of the predictability and preventability of the homicide one of the questions that we have asked ourselves was if it was reasonable to have expected agencies and individual clinicians to have taken more proactive steps to obtain a more comprehensive and accurate understanding of T's situation? Additionally if based on the information that was known at the time did clinicians take reasonable steps to assess and manage T's risks? We have also applied consideration of these issues to the suicide, as these are related events.
- 6.46 The benefit of hindsight³³ has been useful as it has enabled us not only to develop a more comprehensive account of the events that led up to the incident itself but also to highlight issues within the treatment and management of T by primary and secondary health care services.
- 6.47 We have considered whether, based on the information available at the time, the homicide on the 11 January 2013 was predictable or preventable.

Predictability

- 6.48 Predictability is '*the quality of being regarded as likely to happen, as behaviour or an event*'.³⁴ We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. In Munro et al's definition, *if a homicide is judged to have been predictable, then the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it*.³⁵
- 6.49 With regard to the homicide, there is no history of violence to M, and no reports of concerns of violence to her. The two police incidents referred to by M have no violent elements, and any other police information was judged not to be relevant. Therefore we consider the homicide was not predictable.
- 6.50 With regards to T's suicide; In the months leading up to the incident there were several significant events that were known to secondary mental health services;

³³ Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

³⁴ <http://dictionary.reference.com/browse/predictability>

³⁵ Munro E, Rungay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000)176: 116-120

- T presented to his GP with thoughts of suicide and a plan evidenced by him obtaining a rope;
- In the three weeks after the GP referral for secondary mental health care, T attended A&E departments twice under the influence of alcohol, expressing suicidal thoughts;
- T later said M had agreed to stop divorce proceedings and told Trust staff that he no longer felt suicidal partly because of this.

6.51 Referencing the definition of a homicide that is judged to have been predictable where there is a '*probability of violence, at that time, high enough to warrant action by professionals to try to avert it*'.³⁶ We concluded that, even based on the partial information that was known at the time by services, there was significant evidence to indicate that T had high risk factors for suicide, but no risk factors for homicide.

6.52 We concluded that based on the information that agencies should have obtained it was highly predictable that T could become acutely suicidal if M was to restart divorce proceedings. M had told professionals that she would 'probably go back to him', and was observed to be wearing her wedding ring. There is however no history of violence, offending or domestic abuse that would have given any indication that M was at physical risk from T.

Preventability

6.53 Prevention means to '*stop or hinder something from happening, especially by advance planning or action*' and implies '*anticipatory counteraction*'³⁷; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

6.54 Our investigation has identified some missed opportunities by secondary health care services where important information could have been sought. This information would have enabled a more accurate assessment of T's risk factors and would have alerted agencies not only to the possibility of suicide, but also to other potential risks and support needs.

6.55 We consider it highly likely that T would become suicidal if the divorce proceedings were reinstated/ continued. We do not know if this is what occurred between T and M, however we do know that risk assessments were based on the assumption that M had stopped divorce proceedings, and that this had influenced the clinician's assessment of T's risk.

6.56 We know that the marital situation was unclear, and T was considered to have poor coping mechanisms. However, we conclude it was likely that

³⁶ *ibid*

³⁷ <http://dictionary.reference.com/browse/predictability>

events which led to the death of T would have been preventable, if his depressive disorder had been treated more appropriately.

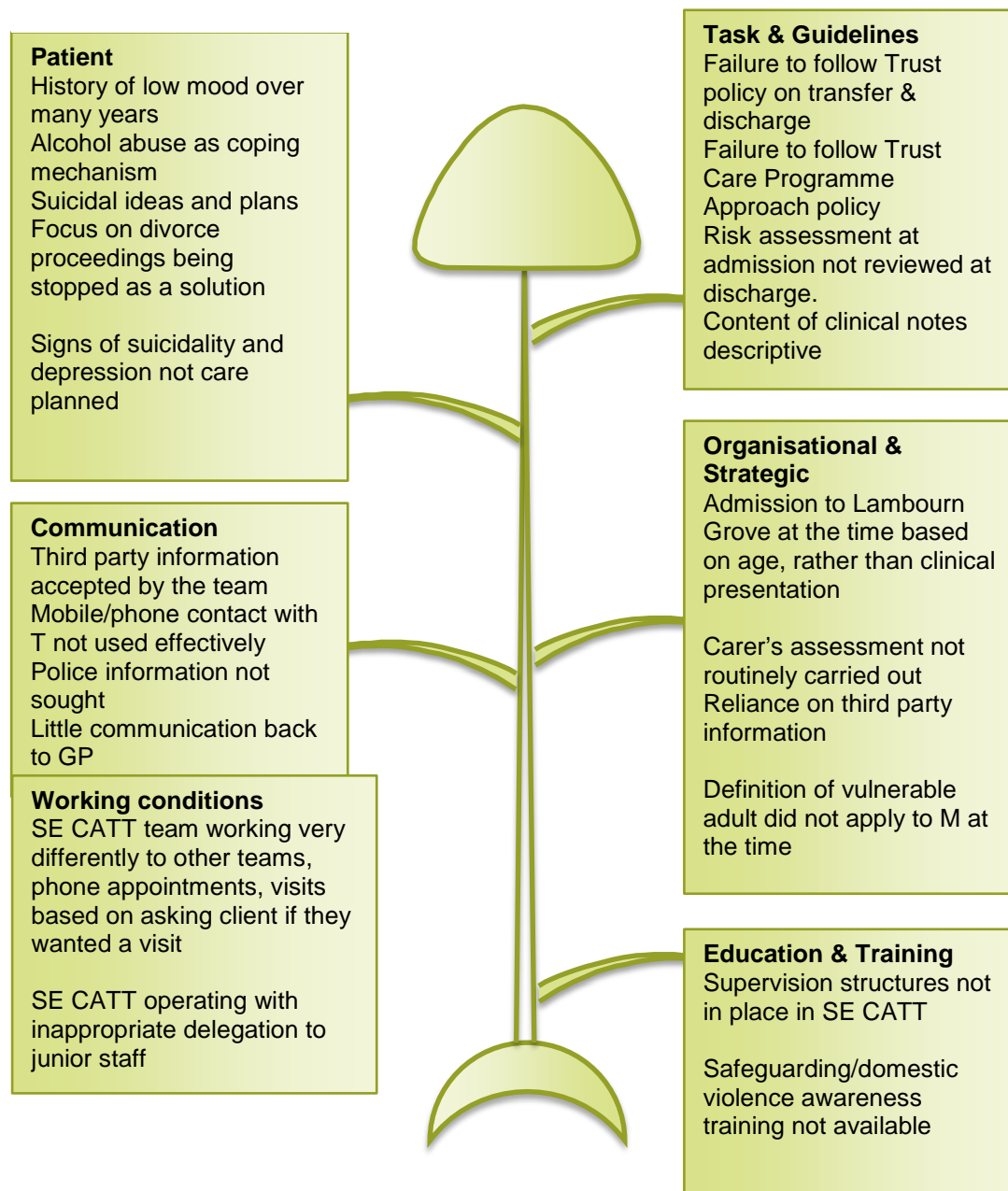
- 6.57 We do not consider that any act or omission on behalf of the Trust that could have prevented the homicide of M, in the sense of a deliberate action being taken to avoid a predicted or likely event.

7 Overall analysis and recommendations

- 7.1 There are several ways in which the Trust and individual practitioners could have improved their understanding and engagement with T. A more comprehensive understanding of his history and presenting mental health and psychosocial issues could have been gathered by spending individual time with him. There was superficial enquiry into his marital situation, and into his own home and financial circumstances. Despite this, we found nothing to suggest that the homicide was predictable or preventable.
- 7.2 In particular, there was recognition that there were psychological issues which may have been helped by accessing psychological support, but the focus of risk assessment was on his marital situation. Risk to himself was thought to have decreased because M had suggested that she might get back with him, but this was known to be an unstable relationship and it could reasonably have been expected that if she did return the relationship would be likely to break down again, as she had got as far as living apart from him for over a year, and instigating divorce proceedings.
- 7.3 His abuse of alcohol was not explored in any depth, or considered as an issue of dual diagnosis.
- 7.4 The transfer to CATT was not managed in a structured way, and T did not have a care plan based on an assessment of his needs that had been discussed with him. This resulted in an uncoordinated approach to his care.
- 7.5 It was acknowledged in hindsight that T was rarely seen without M while he was an inpatient, and this continued when he was at home under the care of CATT.
- 7.6 We have concerns about the risk assessment of suicidality in older persons, and suggest that the absence of self-harm should not be seen in isolation as evidence of reduced risk of suicide.

7.7 A 'fishbone'³⁸ diagram summarising the issues is shown below:

Fishbone Analysis



³⁸ Root Cause Analysis (RCA) tools: analysing to identify contributory factors and root causes <http://www.nrls.npsa.nhs.uk/resources/?entryid45=75605>

Good practice points

- 7.8 The Trust has a well embedded structure of practice governance that ensures standards are set and monitored; practices are audited and outcomes are actioned; provides a network of practice governance facilitators allocated to work within services; with the Practice Governance Lead reporting directly to Board members.
- 7.9 The newly appointed Patient Safety Manager has recently reviewed all mental health homicide incidents and produced a thematic analysis for the Trust to action.
- 7.10 Systems and structures for learning from adverse events are well established.
- 7.11 Chase Farm Hospital Emergency department provided timely discharge information to T's GP after treating him in November 2012.

Appendix A – Terms of reference

An external verification and quality assurance review is intended to be a verification of the internal investigation with limited further investigation to enable the review team to fulfil the terms of reference. This may be undertaken via a desktop review and is unlikely to involve detailed interviews with staff.

This investigation should focus on the areas highlighted by the Trust report, quality assure the internal investigation; and concentrate on the subsequent actions taken by the health economy.

- Review existing investigations recommendations and any action plans
- Review progress that has been made in implementing the recommendations and the learning from their internal investigation
- Review the appropriateness of the treatment of the service user, in particular the frequency of visits and the level of staff undertaking the visits by the CATT
- Examine the effectiveness of the service user care plan including the involvement of the service user and the family and whether carers assessments was considered and undertaken
- Review the information sharing between the GP/Hertfordshire Partnership Foundation Trust and other health professionals
- Review the DHR report and the Trust IMR and consider if the safeguarding/domestic violence processes in place are able to detect the possibility of violence in cases like this
- Involve the family as fully as is considered appropriate
- Consider if this incident was either predictable or preventable
- Provide a written report to NHS England that includes measurable and sustainable recommendations
- Assist NHS England in undertaking a brief post investigation evaluation.

Appendix B – Chronology

Chronology of the care and treatment of T, based on information taken from Care Notes, GP notes, Chase Farm notes

DATE	SOURCE	PRESENTATION AND INTERVENTION
28.11.12 SINGLE POINT OF ACCESS	GP notes	Single Point of Access (SPA) received a referral from T's GP requesting an urgent assessment, describing T as having <i>'marked depression and marked suicidal thoughts'</i> with <i>'concrete thoughts of self-harm, including thoughts about hanging and overdose'</i> . GP had commenced antidepressants.
5.12.12 MHSOP - COMMUNITY	Care notes	Seen at home by MHSOP CPN: <ul style="list-style-type: none"> • Smart, well groomed, house very clean and tidy • Complained of low mood and insomnia • Had suicidal thoughts and a plan at time of seeing GP but not at this time – if thoughts return he reads a book or goes out for a walk • Case subsequently discussed in Multi-Disciplinary Team meeting when decision was made to: <ul style="list-style-type: none"> ○ Arrange an out patients appointment ○ Refer to Psychology <p>Not actioned</p>
10.12.12 CHASE FARM A&E	Chase farm A&E notes	Presented at Chase Farm Hospital having experienced chest pain which lasted an hour. Drinking heavily & reports feeling depressed. Raised BP, and px Amlodipine 10mg. Discharged to GP, asked GP to check blood pressure in two weeks and review alcohol abuse.
16.12.12 CHASE FARM A&E	Chase farm A&E notes	Presented at Chase Farm Hospital with chest pain. Intoxicated, expressing suicidal intent. Notes 'similar presentation to 10/12/12'. Referred for mental health assessment.
17.12.12 ENFIELD ACUTE ASSESSMENT CENTRE (MH) LAMBOURN GROVE	Chase farm A&E notes Care notes	11.50: Assessment by Enfield Acute Assessment Centre – part of Barnet, Enfield and Haringey Mental Health Trust: Mental health assessment carried out by CPN, thought to be at risk of suicide therefore decision taken to admit to Lambourn Grove - referral to HPFT CATT for admission. Chlordiazepoxide 40mg Admitted to Lambourn Grove as an informal service user accompanied by his wife. Presented as: <ul style="list-style-type: none"> • Low in mood, no eye contact. • Well kempt, declined offer of supper, not hungry Began one to one continuous observations initially, due to suicidal presentation. Full mental health assessment carried out by CT3 Doctor. <ul style="list-style-type: none"> • Wife left him a year ago and initiated divorce proceedings which triggered current episode of mental health problems • Since wife visited and returned home to care for him leading to T to feel more positive • Poor coping strategies and if wife leaves again then risk could again become high. <p>Wife also disclosed to doctor (but did not want T to know):</p> <ul style="list-style-type: none"> • Separated from T for about a year and lives on income

		<p>support</p> <ul style="list-style-type: none"> • Has been staying with T over the past two weeks and helping him with food and washing due to mental illness • She was scared of him because of his shouting at her if she did not get him a drink • She has told him she will probably get back with him – she still loves him. • Marriage had ups and downs and he was verbally abusive to her on occasions • Left him many times and one went to a refuge and also went to the police in 2007 because she was fearful for her life. • Always went back to him because of children and because she loved him • Never physically violent towards her but very controlling and forceful • Finally decided to leave him for good, got a flat and filed for divorce • T told her that second wife 'put him in prison' and wife said this is probably true as it is on his CRB form. <p>Observations reduced to ten minutes, with plan to increase if necessary. Px Fluoxetine 20mg (stated 2 weeks ago) Tamsulosin Diazepam alcohol withdrawal reducing regime Simvastatin Amlopidine Dispersible Aspirin Thiamine 19/12</p>
18.12.12 LAMBOURN GROVE	Care notes	<p>Experienced some alcohol withdrawal symptoms, treated with prescribed medication. Medical review found:</p> <ul style="list-style-type: none"> • Good eye contact, good communication • Mood euthymic (not depressed, reasonably positive), not feeling low • No delusions or hallucinations • No suicidal thoughts <p>Plan: Continue with ten minutes observations and review in ward round</p>
19.12.12 LAMBOURN GROVE	Care notes	<p>Nutritional state assessment revealed T had lost 17 kg (2 stone 9 pounds) over past year. Plan to monitor weight weekly and discuss at MDT review.</p> <ul style="list-style-type: none"> • Observed as calm in mood and behaviour, described as bright later in day • Compliant with medication • No withdrawal symptoms • Occupied with reading, telephone calls, watching television <p>Ten minute observations continued</p>
20.12.12 LAMBOURN GROVE	Care notes	<p>Continued to be compliant, good self-care and no suicide ideation expressed. Pleasant on approach and appeared brighter in mood. Visited by wife with whom he spent the afternoon and had dinner and watched television together. Daughter also visited. Some unhappiness and irritability in mood recorded in the evening when all the toilets were engaged. Later settled Continued on ten minute observations.</p>
21.12.12	Care notes	Medical review:

LAMBOURN GROVE		<ul style="list-style-type: none"> • No longer suicidal • Never harmed himself in the past and denies any intention • T stated that he had made a cry for help previously • Expressed wish to go home and wife happy with proposal <p>Plan: T to go home on weekend leave (<i>today Friday</i>) and to return on 24.12.12 (<i>Monday</i>) for CPA review.</p> <p>South East CATT contacted by ward requesting support for T whilst on leave from ward over the weekend.</p> <p>T decided he would go home the following day, 22.12.12 (<i>Saturday</i>).</p>
22.12.12 LEAVE FROM LAMBOURN GROVE	Care notes	<p>Went on weekend leave under care of CATT. Went with his wife.</p> <p>T made aware he can call CATT if he feels he wants to harm himself. Wife advised to give T sufficient medication for the weekend only.</p> <p>T due back at Lambourn Grove on the 24.12.12 at 10.30 am for discharge CPA</p>
23.12.12 CATT	Care notes	<p>Visited by CATT Community Psychiatric Nurse (CPN), visit arranged by phone by CPN: Seen in the presence of his wife. T reported he had difficulty sleeping which left him feeling tired. Was pleased to be home and expressed he had found the ward a more distressing place to be, although it had served its purpose for him. CATT advised that he may be asked to work with them for a while as he was not better but well enough to be home. T agreed that it would help him to ensure his antidepressants were on the way to helping him; as yet they had no positive effect but he had been taking them for only three weeks.</p> <p>T recognised the dangers of long term sleeping tablets but felt that this was key to him getting better as he was better able to cope if he had eight hours sleep. He was advised that the doctor who would see him the following day (at the CPA review) and might be able to prescribe promethazine short term – if not T would explore over the counter sleeping aids. T described by CPN as a little anxious and flat.</p>
24.12.12 LAMBOURN GROVE	Care notes	<p>Wife called Lambourn Grove to say she was visiting T and that he was sleeping that morning and did not want to go to CPA review. She reported that he was sleeping 'poorly'. She said he was eating well and not expressing any suicidal ideas but insomnia was his main problem.</p> <p>Decision to continue with CPA review in T's absence.</p> <p>CPA review meeting at Lambourn Grove:</p> <p>Reported at CPA by nursing staff that T was:</p> <ul style="list-style-type: none"> • Self-caring • Good dietary intake • Kept to himself • No withdrawal symptoms <p>T's insomnia was discussed at the review and thought to be the result of alcohol/benzodiazepine. Decision taken not to prescribe sedatives.</p> <p>Consultant Psychiatrist had a telephone conversation with T's wife which reported:</p> <ul style="list-style-type: none"> • Eating well, • Seeing CATT • Not drinking • T says he is not suicidal • Insomnia main problem – no discussion of hypnotics with CATT • Wife visits every day.

<p>CATT PHONE CONTACT</p>		<p>Diagnosis: Primary: Adjustment Disorder, Secondary: Mental and Behavioural Disorder due to harmful use of alcohol. Plan:</p> <ul style="list-style-type: none"> • Discharge to CATT and community team • Recommendation for community team to refer to Relate • Medication: <ul style="list-style-type: none"> ○ Continue fluoxetine ○ No benzos/hypnotics (or promethazine) prescribed as might reduce seizure threshold. <p>Discharged from Lambourn Grove to SE CATT CATT: 17.15: CATT CPN Telephoned T on his wife's mobile as only number available but there was no reply to the call. 20.04:T's wife telephoned CATT to say he had not slept well and was sleeping that morning and did not want to attend the CPA review meeting. She reported T to be presenting with no concerns. She requested that CATT contact them on 26.12.12.</p>
<p>26.12.12 CATT PHONE CONTACTS</p>	<p>Care notes</p>	<p>01.45: T's wife telephoned CATT sounding distressed. Spoke with CATT Social Worker. T's wife reported T had a few drinks (wine) on Christmas Day and could not sleep. Reported feeling harassed by him as he wanted her to go out and get him alcohol. Social Worker spoke with T who was in bed and reported he sounded calm and not drunk. T was advised that it was not a good idea to drink anymore and unwise to ask his wife (an elderly woman) to go out alone at 2.00 in the morning. T agreed and said he would rest in bed, even if he could not sleep. Plan recorded as:</p> <ul style="list-style-type: none"> • Night CATT to contact South East (SE) CATT next day regarding a home visit and review of medication and sleep hygiene. • T and wife have CATT numbers <p>8.50: Telephone call received by SE CATT Community Support Worker (CSW) with message from Night CATT regarding intervention with T earlier at 2.00 am and requesting home visit to be arranged. 10.15: CSW telephoned T but no reply and he was unable to leave a message. 11.40: Further telephone call made by CSW and no reply. 12.25: Telephone call to CATT CPN from T's wife saying T is awake at night and sleeping during the day and she is finding it difficult to cope with. Advised CPN would check Care Notes and call her back. 12.28: Telephone call to T's wife by CATT CPN but no answer and no facility to leave a message. Plan: CATT to attempt to make contact later that day. 13.42: Telephone call from T's wife to same CATT CPN as above to discuss T's difficulty sleeping at night. CPN discussed sleep hygiene with her and T. T reported last alcohol intake was the previous afternoon (Christmas Day). CPN informed both that the matter would be discussed the next day by the team and they will be updated with outcome; Plan:</p> <ul style="list-style-type: none"> • T to call CATT as required • Discuss with CATT doctor and update T
<p>27.12.12 CATT HOME VISIT</p>	<p>Care notes</p>	<p>Medical review by CATT Staff Grade Psychiatrist: T seen at home with his wife present. T reported their relationship problems and they were in the midst of divorce proceedings</p>

		<p>which were just a few weeks away. Reported he did not want divorce and he would be back to normal self if his wife called off the divorce. He realised the consequences of a divorce which he described as having financial and mental implications for him, saying he may have to lose the house. He had recently taken to binge drinking due to the stress. He denied any active thoughts of suicide and wanted his marriage to work.</p> <p>Plan:</p> <ul style="list-style-type: none"> • Zopiclone 3.75 mgs at night for 7 days • No changes to other medications (Fluoxetine, Amlodipine, Tamsulosin and Multi vitamins. • CATT to continue support
28.12.12 CATT PHONE CONTACT	Care notes	<p>15.00 T telephoned by CATT CPN on his wife's phone as team had no telephone number for T. The phone was unavailable and there was no voice mail facility. On the same day it is recorded the CATT Administrator issued 'Having Your Say' form and Care Plan following CPA Review. The latter was confirmed by a CATT CPN.</p>
29.12.12 CATT PHONE CONTACT	Care notes	<p>15.25: CATT CPN telephoned T via his wife's mobile phone (only number CATT has) to see how he was and offer a home visit. No reply to phone and no facility to leave a message. 15.40: CATT CSW received a telephone call from T's wife, returning the earlier message that had been left. T's wife reported T still craving alcohol and she had found a bottle hidden – when she took it and poured it away he became abusive towards her. CSW offered a visit for the following day which was accepted by T's wife who requested a visit after 13.00. The CSW advised she would call at 10.00 next day to confirm visit.</p>
30.12.12 CATT PHONE CONTACT		<p>9.50: Telephone call made by CSW (not stated whether call was to T or his wife) to confirm home visit that day between 15.00 and 16.00.</p> <p>Afternoon home visit made to T by CSW (<i>different to one who made morning call</i>) T's wife present throughout visit. T asked about Alcohol Team and CSW told him it is called CRI (<i>Crime Reduction Initiatives</i>) and that he would get further information about it for T.</p> <p>T reported he still had difficulty sleeping and had only one Zopiclone tablet left. He reported they had not helped much but he had been told he could double the dose if needed, CSW agreed to ask doctor for further prescription. No other concerns reported. T doing his best not to sleep in the day time.</p> <p>Arrangements were made for CATT to telephone at 10.30 next day on 31.12.12 to arrange to deliver prescription for Zopiclone on 31.12.12.</p>
31.12.12 SMHSOP PHONE CONTACT CATT HOME VISIT	Care notes	<p>Telephone call from Community Mental Health Nurse SMHSOP/Care Co-ordinator to carry out Seven Day Discharge follow up. Phone was busy but later spoke to T's wife who said T had had a bad night and was sleeping so could not talk. Wife confirmed CATT would be calling in the afternoon with higher dose of medication.</p> <p>14.30: CATT CPN made a home visit to deliver prescription. Discussion to be held with Consultant Psychiatrist regarding efficacy of prescribing medication to help with alcohol craving. (<i>NB record of this visit in unconfirmed clinical note</i>)</p>
2.1.13 CATT HOME VISIT	Care notes	<p>Home visit by CATT CPN to review T.</p> <ul style="list-style-type: none"> • Main concern remains insomnia – however last two nights with Zopiclone 7.5 mgs he was awake for only 1.5 hours.

		<p>Occasional dozing at some time in the night and occasional ten minute dosing during the day.</p> <ul style="list-style-type: none"> • Denied any alcohol use over previous 48 hours but occasional episodic cravings but feels able to manage. • Advised to approach GP regarding acamprosate (<i>a medicine that helps to fight the desire to drink alcohol</i>) if felt necessary. • No current concerns regarding low mood. • No suicidal ideation. <p>Plan:</p> <ul style="list-style-type: none"> • Inform CATT medical staff of above to facilitate further action.
<p>3.1.13 CATT PHONE CONTACT</p> <p>HOME VISIT</p>	Care notes	<p>7.00: T telephoned the night CATT to report that he had another night when he had no sleep at all. The CPN who spoke with him suggested he should have called earlier to discuss some sleep strategies but T said he was not calling for advice as he had tried the things usually suggested. He just wanted to inform the team. The CPN advised him to call his local CATT in the day time to discuss further management of his insomnia as it was an ongoing issue. T agreed to do this.</p> <p>10.50: Telephone call to T from CATT Staff Grade Psychiatrist. T reported the insomnia was still his main problem and he was sleeping only 1.5 hours at night and was wide awake after that. He felt quite exhausted and tired in the mornings and reported he felt depressed as a result of the lack of sleep. T added that the increase in Zopiclone did not make any difference at all.</p> <p>Options for insomnia discussed including a small dose of Quetiapine.</p> <p>A Team discussion resulted in Quetiapine 50 mgs at night being prescribed and a prescription was provided.</p> <p>A CATT CSW visited T in the afternoon and delivered five days' supply of Quetiapine. He also gave T the number for the CRI.</p> <p>A telephone call was planned for the 4.1.13.</p>
<p>4.1.13 CATT PHONE CONTACT</p>	Care notes	<p>Morning (recorded 14.19): Telephone call from CSW to T. T said he slept better the previous night and declined the offer of a home visit. State he and his wife were going out for a while.</p>
<p>7.1.13 CATT PHONE CALL NO RESPONSE</p>	Care notes	<p>Afternoon (recorded 14.16): Telephone call from CSW to T. No answer and no facility to leave a message.</p>
<p>8.1.13 CATT PHONE CALL NO RESPONSE</p>	Care notes	<p>Morning (recorded 11.04): Telephone call from CSW to T. No answer and no facility to leave a message.</p> <p>Second phone call made, this time wife's mobile number. No answer and no facility to leave a message. Text message sent to T's wife's phone by CSW giving CATT's number to contact.</p> <p>Telephone call or cold call home visit to be made, possible, on 91.13</p>
<p>9.1.13 CATT HOME VISIT NO RESPONSE</p>	Care notes	<p>17.00: Home visit to T's home by CATT CPN recorded as a clinical note, but not confirmed. Call recorded as having been made as T had not responded to contact calls. House found in darkness, dog could be heard barking. A note was left for T to contact CATT.</p> <p>To consider welfare check the following day if no response by then.</p>
<p>11.1.13 CATT</p>	Care notes	<p>10.04: Entry states phone call made previous day to T's wife but no response</p>

		<p>18.30: Telephone call to Police from CSW to ask for a welfare check on T.</p> <p>21.15: Telephone call from Police to night CATT stating:</p> <ul style="list-style-type: none"> ○ Have been to do a welfare check on T as requested by day CATT ○ Initially rang the doorbell but could not gain entry. ○ Broke down the door to get in. ○ Found two bodies but unable to identify them until following morning. <p>On call manager informed.</p>
12.1.13 CATT	Care notes	<p>9.20: Telephone call from Police reiterating outcome of welfare check visit by Police. Adding that a male and a female body had been found but they had not yet been formally identified. Police officer also requested the following information:</p> <ul style="list-style-type: none"> • Written log of contacts • Last person to see T • Medication <p>Team Leader contacted appropriate managers and processed information request according to Data Protection requirements in HPFT.</p> <p>Permission given to provide Police with information requested and request executive.</p>
13.1.13	Care notes	<p>Telephone call to CATT from HPFT Patient Safety Manager advising that Coroner's Office had reported that it appeared that T hanged himself and his wife was strangled.</p>

Appendix C – Table of recommendations

Recommendation 1:

The outcome of primary care referrals should always be communicated back to the service user's GP, and the GP should be kept informed of plans of care and progress through mental health services.

Recommendation 2:

Adherence to the Observation policy with respect to recording of clinical information and formal reviews should be monitored

Recommendation 3:

An information sharing agreement with Hertfordshire Police should be established.

Recommendation 4:

Information based on third party disclosures should be noted as such, and risk assessments should clearly note whether information is evidenced or not.

Recommendation 5:

The Trust should develop a strategy to ensure the safeguarding policy incorporates domestic abuse, and that staff fully understand and implement the policy.

Appendix D – Documents accessed

Hertfordshire Partnership NHS Foundation Trust Policies:

Carer Practice Policy 2014

Carer's Assessment Practice Guide 2010

Care Records Management Policy 2015

Interim Operational Policy for Crisis Assessment and Treatment Teams 2011

Crisis Assessment and Treatment Teams Operational Policy 2013

Clinical Risk Assessment and Management for Individual Service Users 2012

Clinical Risk Assessment and Management Policy 2013

Care Coordination Policy 2012

Dual Diagnosis Procedure 2013

Lambourn Grove Operational Policy 2007

Learning from Adverse Events 2010

Learning from Incidents 2013

Specialist Mental Health Team for Older People Operational Policy 2010

Single Point of Access (SPA) Operational Policy 2013

Single Point of Access (SPA) Operational Policy 2014

Safeguarding Adults from Abuse Policy and Procedures 2012

Safe and Supportive Observations Policy 2012

Tackling Domestic Violence and Abuse DRAFT 2014

Transfer and Discharge Policy 2014

Other documents

West Herts SBU Quality and Risk Management meeting agenda

Integrated Governance structure

Presentation on care of T for CATT

Preventing Suicide training programme

Clinical Risk Assessment and Management training programme

CQC registration, Lambourn Grove

Team Leaders development session on learning from serious incidents

Thematic review of mental health homicides

Clinical Risk and Learning Lessons group membership and agenda

CAADA Review of Hertfordshire Countywide Domestic Abuse Framework and Provision of services 2014

Multi agency Risk Assessment Conference (MARAC) leaflet

MHSOP service user referral chart

Older People Community (OPC) & 24/7 Trust wide Organisation Chart 2012

Organisational Structure East and North Strategic Business Unit Management 2014

PARIS risk assessment forms

Practice Audit and Clinical Effectiveness team report on clinical risk assessment and management February 2015

Sample learning lessons notes and RCA briefings

Safeguarding Leads minutes November 2014

Hertfordshire Police 'closing report'

Post Mortem reports for T and M January 2013

Hertfordshire Police report dated 4 June 2015

Appendix E – Profile of the Trust

Hertfordshire Partnership University NHS Foundation Trust provides mental health and social care services in Hertfordshire; including Adults of Working Age, Older Adults, Children and Adolescents and Specialist Learning Disabilities services.

The Trust works in close partnership with Hertfordshire County Council and also with other NHS organisations to promote and support mental health in the community. The Trust also provides specialist learning disability services in Norfolk and North Essex.

Services:

Community Services including local teams for mental health

Acute and Rehabilitation Services including inpatient services and crisis teams

Specialist Services such as mental health services for older people, eating disorders, and our mother and baby unit

Learning Disability and Forensic Services

Lambourn Grove is the MHSOP inpatient unit in St Albans. At the time of writing the MHSOP was undergoing major service changes. The unit has been register with the CQC since 2010, and has not been inspected.

A CQC inspection under the new model took place on 27 April 2015, the report is not yet available.

Appendix F – Profile of the Investigation team

Carol Rooney, is Senior Investigations Manager at Niche. Carol is a Registered Mental Nurse (RMN) of 26 years who has worked in a variety of clinical, managerial and professional lead roles in the NHS and independent mental health sector. She also has experience leading on clinical risk management and violence reduction. Her most recent patient safety role in the independent sector was head of clinical risk management for a national mental health charity where she led on all aspects of patient safety improvement including the leadership and management of serious incident investigations and the learning of lessons, complaints and claims.

Dr Susan Benbow is Clinical Advisor for this investigation. Susan is an old age psychiatrist and systemic therapist. Her key skills are in knowledge and understanding of safeguarding, the ability to focus on individual vulnerable adults, and Older People's Mental Health. She was National Institute Mental Health England Fellow in the aftermath of the 'Rowan Report' and involved in the Department of Health response, including coordinating an audit of older people's mental health services to identify high risk services and arrange any necessary support.

Nick Moor provided quality assurance and oversight of the investigation. Nick is Director of Niche Patient Safety and responsible for all of our work in patient safety. Nick is a clinician by background, and he has a specific expertise in legal aspects of healthcare. Nick has undertaken and supervised, as lead director, numerous Patient Safety & Quality projects. These include many Independent Investigations following Homicides, Quality and Governance.