An independent investigation into the death of B

Carried out on behalf of NHS England

ANNE RICHARDSON CONSULTING LTD

EXPERIENCE, KNOWLEDGE AND EXPERTISE IN MANAGING RISK

NHS Midlands and East

Independent review of an investigation (in line with guidance in HSG (94)27) into a mental ill-health related homicide

Confidential

East of England Collaborative Procurement Hub

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Project reference:	**2013007NC**
SIRI reference:	**301**
Initials of service user:	**A**
Incident type:	**Homicide**
Date of Incident:	**20 February 2011**

Report prepared by:	**Anne Richardson (Anne Richardson Consulting Ltd)**
Investigators:	**Dr Hugh Griffiths MB BS FRCPsych, Mr Lawrence Moulin BA, MSc, MBA, C Psychol, Ms Anne Richardson BSc MPhil FBPsS**

Date of report:	**9 September 2014**

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1. EXECUTIVE SUMMARY

1.1. BACKGROUND

This is the report of the investigation commissioned by East of England to review the circumstances of the tragic death of B on 20 February 2011. A, her husband was found guilty of manslaughter with diminished responsibility due to severe mental ill health. He had previously had contact with mental health services in Suffolk. This report represents an examination of the facts of the case and it provides an assessment of the learning and the changes that have taken place since.

1.2. DETAILS OF THE INVESTIGATION PROCESS

The investigation was structured and used tools and techniques informed by the principles of Root Cause Analysis. Information was collected from NHS and social services records; from policies and protocols concerning care delivery in use at the time as well as currently; and opinion and testimony was sought during 12 personal interviews with staff and members of A and B's family.

1.3. FINDINGS

A had been known to mental health services for only three weeks before the tragic incident which resulted in the death of B at his hand on 20 February 2011.

Information helpfully provided by members of A's family, and from health and social care records, shows that the almost 22 year relationship between A and B was complex. A and B both had physical and mental health difficulties and B was very dependent upon her husband who also acted as her carer.

Records also suggest that A had, in fact, been depressed for some time before the 20 February 2011. The notes certainly make it clear that he was profoundly depressed at the time that the incident occurred and there are reasons to believe that he may not have disclosed how ill he was beforehand.

However, the investigation team also uncovered facts that were not discerned at the time when the incident occurred: namely, that B, the victim, had also been a patient of the Trust (albeit some time before) and she was known to social services. Furthermore, A appears to have been a victim of domestic abuse by her at home. These findings lead the investigation team to make some specific recommendations regarding the importance of obtaining family testimony wherever possible at all stages of care, treatment and investigation.

1.4. CONCLUSION

The investigation team appointed to undertake this `Stage 3' independent review believes, on the basis of a systematic investigation of the evidence, that this tragic incident was neither predictable nor preventable. There is no question that A was profoundly depressed at the time that the incident occurred and there are good reasons to believe that he did not disclose how ill he was, making it very difficult for those who interviewed him beforehand to obtain as full a picture as it was possible to establish afterwards. It is also true that, although A's family had a sense of the difficulties that the couple experienced, neither they, nor the staff who saw A only briefly, could have predicted what was to follow.

The team also reviewed progress with recommendations made in the `Stage 2 report' completed shortly after the incident occurred and we conclude that these have largely been met. It is clear that a significant level of re-organisation has taken place in the Trust since the time that report was written. For example, a merger has taken place; new management systems are in place, and policies and procedures (e.g. for initial assessments) have changed. Most notable amongst the changes as they pertain to this case are those relating to the re-design of the Crisis and Assessment Team, and the development and expansion of the Psychiatric Liaison Team. By these means, access to services for people in crisis have been strengthened.

However, this review has also established facts about the case that were not uncovered at the time that the Stage 2 review was undertaken. For example, B, the victim, had also been a patient of the Trust (albeit some time before) and she was well known to local social services and to the police. Furthermore, A, his wife's carer, appears to have been a victim at least of bullying and probably also of occasional violence by B at home.

More is now known about the mental and physical impact of caring for someone with difficulties like those experienced by B, and more is known about the risks associated with what is commonly termed `domestic violence'. For example, the 1999 National Carers' Strategy (which was subsequently reinforced in 'Our Health, Our Care, Our Say' in 2006; refreshed in 2008 for social care, and for the NHS in 2010) set out rights for carers to have an assessment of their needs.

Five recommendations are therefore made to further strengthen services within the Trust concerning these and other areas.

Recommendation 1: Co-location
The Trust should further consider the opportunities and limitations of co-location across the patch for health and social care staff as a means to facilitate communication and information-sharing. Whilst co-location is not always possible or practical, the impact upon communication may be significant and extra care may be needed to develop solutions where co-location is impractical.

Recommendation 2: Carers
The investigation team recommends that attention is given as part of staff training and reflective practice to the association between mental ill health and caring for someone with significant mental and/or physical problems. New guidance on the value of an assessment of carers' needs should be included as part of this.

Recommendation 3: Domestic violence and abuse
It will be important for the Trust to include as a routine part of staff training and/or reflective practice a focus on the association between domestic violence and risk of homicide. This should help to ensure that policy on the conduct of initial interviews and risk assessment keeps pace with the evidence.

Recommendation 4: Family testimony
The investigation team recommends that awareness is raised about the importance of family testimony. At local level for clinicians, this could be achieved via training for staff which includes representation from users, carers and family members as appropriate and/or a focus on reflective practice. We would also suggest that national and local commissioners of investigations (Stage 3 and Stage 2 respectively) strengthen their governance and quality assurance mechanisms for independent investigations to ensure that information from carers and families is always sought.

Recommendation 5: Support for staff
The investigation team believes that support for staff could be improved if, as a matter of course, a senior manager attended in person when a serious incident (SI) occurs. In addition, there may be value in developing a staff support policy to bring together all the guidance currently available on the intranet into one place. Responsibility to maintain and update this and ensure that support is tailored to individual needs to be clearly defined and assigned.

2. REPORT OF THE INDEPENDENT REVIEW

2.1. INTRODUCTION

This independent review was commissioned by East of England in accordance with Health Service Guidance (HSG (94) 27) in December 2013, 34 months after a homicide on Sunday 20 February 2011 by a patient (A) who had contact with mental health services at Suffolk Mental Health Partnership NHS Trust (SMHPT).

Note: SMHPT merged with Norfolk and Waveney Mental Health Foundation Trust on 01/01/12 to form Norfolk and Suffolk NHS Foundation Trust.

This report represents a `Stage 3' examination of the facts of the case and it provides an assessment of the learning and the changes that have taken place since. Like the authors of the Stage 2 report, we would like to express our deepest sympathies to all the people affected by the tragic events that took place on the weekend of 18 - 20 February 2011.

2.2. ACKNOWLEDGEMENTS

We would like to thank A and his family, and the health and social care staff who gave time to talk with the team about the circumstances that led up to the death of B, and how the matter was handled afterwards. It can be distressing for those involved to re-visit these events and we greatly appreciate their candour.

The importance of a rigorous investigation following any untoward incident is very clear. NHS guidance, the families of those affected, and NHS and social care staff all concur: processes must be in place to monitor, investigate and learn lessons from adverse events in order to reduce the risk of similar events occurring in the future.

Our aim in conducting this independent review for NHS England was to support the local NHS and its partners in social care services to make use of findings and recommendations made in the `Stage 2' report which was published in July 2011 to continuously improve local mental health services.

Our `Stage 3' report acknowledges that changes in the service since 2011 have occurred and it concludes that recommendations made following the first investigation into this tragic event have largely been implemented. However, we also outline some learning points which were not directly addressed in that first report. We hope that these will help to improve local patient care and public safety in the future.

2.3. TERMS OF REFERENCE

Terms of Reference (TOR) for this independent investigation were agreed following a meeting between representatives of the local NHS (the Trust team and NHS England) and the principle investigators on 14 March 2014.

The TOR set out the investigatory team's responsibility to:

- review the Trust's internal investigation and assess the adequacy of its findings, conclusions, recommendations and action plan;
- review the report's chronology of events leading up to the homicide;
- review the appropriateness of the treatment delivered to A, highlighting areas of good practice and areas of concern, including any implications for future risk, specifically in relation to diagnostics;
- review progress in implementing the action plan in the light of changes and developments in Suffolk and Norfolk & Waveney since the time of the incident, ensuring a specific focus on inter-agency and cross-border working and learning from best practice;
- review the adequacy of current risk assessments and risk management, including specifically the risk of the service users harming themselves or others and review any related issues for safeguarding children and vulnerable adults;
- involve the families of both the victim and the perpetrator as fully as possible;
- review and assess current compliance with local policies, national guidance and relevant statutory obligations;
- provide a written report to NHS England and make a presentation, if agreed, to the Trust Board, including any appropriate measurable and sustainable recommendations;
- draft appropriate communications in consultation with the Trust;
- provide routine monthly and bi-monthly update reports to the Head of Independent Investigations NHS Midlands and East;
- ensure day-to-day communication and coordination with the Trust;
- liaise with East Suffolk CCG regarding primary care;
- and assist NHS England in undertaking a brief post investigation evaluation.

2.4. THE INVESTIGATION TEAM

The investigation team consisted of the following people:

Anne Richardson, BSc MPhil FBPsS, is a former Head of Mental Health Policy at the Department of Health and a clinical psychologist by background. She has experience of leadership in mental health policy and policy on mental ill health and offending both at the Department of Health and for the Cabinet Office. She also has experience of teaching and training, having formerly worked with the team to develop the DClinPsy programme at University College London, and she worked as regional tutor at UCL and at UEL. Anne has a significant level of experience in managing independent investigations into serious incidents in health and social care at Trust as well as national level. For example, she administered the national investigation commissioned by Secretary of State, chaired by Sir Jonathan Michael, into the deaths of six people with a learning disability (`Healthcare for All', 2008).

Mr. Lawrence Moulin, BSc MSc MBA, is a former clinical psychologist with over thirty years' experience working within the NHS and at the Department of Health in mental health and learning disabilities. Lawrence Moulin has worked as a clinician, as a service manager, and strategically at SHA level. His most recent post in the NHS was as the West Midlands Strategic Health Authority Lead for mental health and learning disabilities, with oversight of safety and service performance across the whole area. Prior to this he worked as a commissioner of services for people with mental health problems or with a learning disability. In addition he has worked on the delivery of national policy with the National Institute for Mental Health in England and in the Department of Health.

Dr Hugh Griffiths MB BS FRCPsych, has a national profile in mental health and over thirty years experience as a consultant psychiatrist in the North-East of England. He has held roles as NHS Trust Medical Director, Medical Director of the Northern Centre for Mental Health and gained extensive experience conducting inquiries into untoward incidents in mental health services. He was Director of Policy and Knowledge Management for the NHS Clinical Governance Support Team for 2 years until 2004 and then became Deputy National Clinical Director for Mental Health (England) at the Department of Health. From 2010 until 2013 he was National Clinical Director for Mental Health during which time he led the development of the Government's Mental Health Strategy ("No Health Without Mental Health", HM Government February 2011) and was instrumental in its subsequent Implementation Framework.

Ms Carol King is a Prince 2 Registered Practitioner with experience in project management, data analysis, finance, budgeting and business operational support both within the NHS and in the private sector. This includes, for example, work to coordinate the establishment of School Boards for the National School of Healthcare Science and national recruitment. Carol provided a point of liaison for all those involved in the present investigation.

2.5. METHODOLOGY

The team used an approach based upon Root Cause Analysis to examine the facts of this case and identify ways in which care might have been altered or improved and to identify risks, best practice, and opportunities to improve patient safety. In short, the aim was to establish whether there were improvements at the individual, team and/or organisational level to help the system to learn.

12 personal interviews lay at the heart of the investigation (see Annex 3.1). Interviewees (witnesses) were selected on the basis that they had previously contributed to the investigation undertaken at the time (the `Stage 2' investigation) and/or had close connections with the events of that day.

The team also examined NHS medical records, the statements made by witnesses for the investigation completed at Stage 2 (July 2011) and other health and social care records to establish a full account of the care received by A in the months and years prior to the death of his wife (B). The team also looked at evidence relating to the care provided for B, the victim.

Records and notes examined during the course of this investigation included:

- ePEX records containing notes of all clinical contacts with A;
- section 136 Assessment Records;
- records of assessment, care planning and risk assessment;
- primary care medical records for A;
- current and previous Trust policy documents (care planning, risk assessment, etc);
- archived notes from Suffolk Trust concerning care provided to B;
- evidence concerning B from Carefirst 6 system (Suffolk County Council's electronic care record database);
- the Root Cause Analysis prepared within 7 days of the incident
- and the `Stage 2' report of the internal investigation completed 1 July 2011.

A had not been interviewed by the investigators at Stage 2. Although, our team decided that it would be appropriate to see him on this occasion, the clinical notes suggested that he remained hazy about the events of that day and, as A's family were concerned about how distressing the interview might be for him, it was decided to see him only when a clear picture of all the other evidence had emerged.

In this way, the team hoped to be able to focus on looking beyond the event (which has already been the subject of formal Court proceedings) to the learning that has taken place in the Trust, and any further necessary recommendations.

Salmon Principles[1] were adapted for this non-judicial investigation. This meant that all initial interviews with witnesses were taped and confidential written accounts of the conversations were sent to witnesses for their correction and approval.

At the point when the investigation team were formulating their views and had prepared an initial draft of their report, key witnesses including members of A's family were invited back to meet the team, discuss matters of fact as recorded in the draft, and consider whether the draft recommendations were sound.

In this way, the investigation team could be as confident as possible that the facts set out in the report were accurate, and that the conclusions and recommendations clear. Staff of the Trust were also given an opportunity to feed back corrections on matters of fact.

2.6. BACKGROUND TO THE CASE

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

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

A summary of the longer term background to this tragic incident is helpful in that it provides a picture of the relationship between A and B at the time of the incident, and it sets the treatment he received in context.

A met B in 1989 and they married a year later in 1990. Both of them were working at that time, she as a cleaner and he in the building trade. A year after that, in 1991, work overload problems for B appear to have led to her having panic attacks and she began to depend more upon her husband for support. His absence, according to notes by the therapist she saw, mirrored a previous occasion with B's first husband who left her. It seemed that she would feel overwhelmed if she was without A and she frequently telephoned him or turned up at his workplace.

In 1993, B's parents died within 6 months of one another and A left his job to look after her. In 1994 they moved to Needham Market where they resided for five

[1] **The Salmon Principles** are six requirements set out under the Tribunals and inquiries Act 1921 designed to ensure fair and appropriate procedures are used in the conduct of investigations. Although the current investigation is not judicial (solicitors were not involved) the investigators ensured that all those known to have any involvement in the case were invited to participate; they were informed of the circumstances of their testimony, about the interviewers and the purpose; and they were offered the opportunity to have someone accompany them. All interviews were tape recorded and witnesses were invited to correct the written account that was prepared afterwards.

years. Then B developed back problems and, in 1999, they moved to a ground floor council flat in Ipswich.

Whilst the early days of their relationship appear to have been described in positive terms (and A's family confirms that they were very attached to each other) it seems that there were a number of difficulties later on. Immediately prior to the incident, in the early part of January, members of the family received a number of telephone calls from A which led them to think he was worried and unhappy and they had a sense that his health and wellbeing were deteriorating.

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

A was his wife's carer and, although the social services notes do not explicitly detail the physical support that he provided in relation to her mobility problems, there are explicit references (August 2005) to B not feeling able to be left alone (apparently due to her phobic anxiety). The notes also record a crisis in her mental health on 22 July 2009, when Suffolk Social Care Services were contacted by the Police after they were called to her home address because she was said to be feeling suicidal and threatening to harm herself or A with a nail file.

There was also some evidence of physical violence by B towards A. On the 18 February 2011, for example, just two days before her death, members of A's family visited A to find him being hit by B following an argument about whether he was going to bathe. However, for his part at interview, A was reluctant to describe his wife's behaviour in terms other than that she was often unaware of what she was doing.

The picture of a difficult relationship between A and B is reinforced by information provided by the Mental Health Social Care Lead for Adult Community Services in Suffolk. Information from Council records shows that B had been in contact with social services for over ten years (July 1999 - September 2010). There are also old notes from the Trust as she was seen routinely at St Clements Hospital psychiatric outpatients between 1992 and 2005. However, as she had been discharged from St Clements outpatients in 2005, such information as was available about her past would not have been accessible to the team working in either A&E or the crisis team using the ePEX system.

In summary, it appeared that B was psychologically dependent on her husband and they were rarely apart. This is an impression that is reinforced in primary care notes as well as notes made by social care staff and staff of the Trust over approximately the same period (1992-2005). The information provided by members of A's family, coupled with accounts in the care records, and

information from A's GP also suggest that he had been depressed for some time before the tragic incident which occurred on 20 February 2011. The GP had, for example, prescribed an antidepressant although the notes apparently suggest that he only took this intermittently. It is thought that A had lost a lot of weight, and that he was preoccupied with discomfort from physical symptoms relating to irritable bowel syndrome. He had thoughts about his own death, and feared cancer as had apparently been the cause of a friend's death not long before.

The notes certainly make it clear that immediately after the incident A was suffering from a severe psychotic depressive illness. Details about this, and the care that was provided at the time, are provided in the report of the investigation completed by the interim Director of Nursing (July 2011). The investigation team has checked and verified this information, and it has been used to supplement the more detailed chronology of events which appears in Section 2.6 below.

2.7. INCIDENT CHRONOLOGY

TIMELINE/CHRONOLOGY OF EVENTS		
Date	**Event**	**Comment**
1989	A (age 37) meets B (age 39). A was formerly married with two children and a step-daughter. He then separated from his first wife in 1982. B was previously married with two children, both with learning disabilities, who were subsequently taken into care. Another relationship she made after this was abusive and her partner also left her.	
1990	A and B marry	
1991	B reports problems at work and has panic attacks. GP prescribes Stelazine, Diazepam and Procyclidine. A's friend from work dies from bowel cancer. A himself has a range of physical difficulties	
1992	B is referred to psychiatric services at St Clements for a range of symptoms (panic attacks, agoraphobia, OCD, `tantrums and outbursts') and she is seen in outpatients routinely until 2005.	
1993	B's parents die within 6 months of each other. Reports suggest an increasing level of dependence upon A who leaves his job in the building trade to become her carer.	
1994	A and B move to Needham Market. B is now in receipt of disability benefits and A is her sole carer.	
1999	B's back problems, asthma, diabetes and other emotional difficulties worsen. Notes held on the Carefirst 6 system (Suffolk County Council's electronic care record database) show that she made contact with social services. The couple move to a ground floor council flat in Ipswich. As a consequence of the physical restrictions imposed by her health conditions, B experienced difficulties in using the toilet and bathing facilities, as well as using appliances in	

	the kitchen. For the next 11 years, B is recorded as being in regular contact with social services. She attended infrequently in relation to requests for specialist modifications in the home to address the restriction imposed by her various health complaints. She reported suffering with arthritis, back problems, asthma, diabetes, high blood pressure, anxiety, panic attacks and depression. An application for a higher level of Disability Living Allowance (DLA) was made but was not supported. A is diagnosed with Irritable Bowel Syndrome and complains of back pain. Notes record frequent visits to his GP. He was prescribed Citalopram 20mg (an anti-depressant) but notes suggest that he took it only erratically.	
2001	B was referred for Cognitive Behavioural Therapy (NHS referral from secondary care) but owing to difficulties attending, or attending without A, this was discontinued.	
06/2002	An advice worker asks for help to get B a higher level of DLA which would mean acknowledgement of receipt of at least some support at home each day, but it is not clear from the NHS notes whether this was supported.	
09/2005	A letter to the GP from the psychiatric outpatients' team at St Clements discharges B back to the care of the GP. It describes how, whilst upset lately because of the death of her pet rat, there was little that psychiatric services could offer to her. It describes how she was being supported by A and his mother, herself an ex-psychiatric nurse, who was visiting fortnightly.	
2008	A's incontinence and anal fissure recurs.	
01/2011	A began to telephone his son and daughter-in-law regularly, but terminated the calls as soon as B could be heard approaching. Family members report that A had lost a significant amount of weight and was troubled by a range of physical symptoms.	
31/01/2011	At 07:00 one of A's family received a text from him to say `I will always love you, but I can't go on, take care of B, I've gone to heaven.' The police were called. Notes report her to have said that A thought B was poisoning him (hence his stomach problems). A's son also subsequently supplied information to indicate that A had withdrawn £200, bought socks and pants at a supermarket, and planned to go to a B&B - so it is not entirely clear what A's intentions were. The policewoman who went to the house to see B reported that she and A had argued and that he had been depressed because it was the anniversary of the death of his friend. A was also reportedly concerned that he would die from bowel cancer. In	See comments 2.8.1 and 2.8.2

	the afternoon, Police found A in Clacton, Essex and took him to the local S136 suite. The necessary social circumstances report and AMHP (Approved Mental Health Professional) assessment were completed by a Suffolk employee, as the local team was busy. A's son was with him in the hospital. Then, B arrived by taxi. The family requested that they be interviewed individually, but they were seen together and it appears that A had indicated that he was content for this. The interviewer could not remember whether she gave them the crisis team number or if they already had it. Authors of the July 2011 independent investigation commented that it had taken some time for the notes of the assessment to appear in the NHS ePEX (electronic) notes.	
01/02/2011	The member of staff who had conducted the interview contacted the GP to check that he had followed up A, as planned, and he had.	This was good, thorough practice.
16/02/2011	A telephoned the crisis team to say he had felt low, but now was feeling better. Staff nurse X suggested he contact his GP which he agreed to do.	See comment 2.8.3
18/02/2011	Worried for his safety and disturbed by his frail appearance, members of A's family took him (after calling the crisis team and following their advice) to see his GP. A told the GP (in his daughter-in-law's presence) that he wanted to kill himself. The GP made an urgent referral to the crisis team describing how A's symptoms had deteriorated in the past 2-3 weeks, including anxiety about his bowels, and thoughts of suicide. He prescribed Citalopram. The family went home again. Members of A's family then left the couple alone for an hour, but continuing to feel concern for A's welfare, they returned to find B hitting him following an altercation. A's son therefore took him straight to A&E and his wife stayed with B to call the crisis team. When trying to explain that A as well as B needed help, she was told that it would be best to telephone the vulnerable adults team on Monday. She was also told that the crisis team would visit A in A&E. She asked them to ensure that A and B were interviewed separately because B was raising objections to her husband receiving treatment as an inpatient because she was fearful about being alone, and fearful about losing carer's benefits. In A&E, A received treatment for an impacted bowel (a procedure which B continually interrupted once she arrived on site). As the single member of the psychiatric liaison service who would have seen A if he had arrived earlier, was off duty, a member of staff	See comment 2.8.4 See comments 2.8.3, 2.8.4 and 2.8.5 See comments 2.8.6 and 2.8..7

	from the crisis team visited instead. Having received the message about seeing A alone, she completed her assessment and offered admission which A refused. Although the member of the crisis team was aware of the events of 31 January (one reason she offered an admission) the notes are clear that she considered there was insufficient evidence to warrant use of compulsory detention under the Mental Health Act. It was therefore agreed that the family would go home and that the crisis team would visit soon. A's son was not invited to participate in this interview and was therefore unable to supply detailed information about the couple's relationship. However, the crisis team representative spoke afterwards to those family members who were present. Although at interview with the investigation team A's son was not certain whether his father had been seen without B being present, the member of staff confirmed that he had and A was also able to confirm this.	
19/02/2011	The case was discussed at the crisis team handover meeting on Saturday and the member of staff wrote back to the GP to say that they (the crisis team) would try to visit on Sunday.	This was thorough and effective practice.
20/02/2011	A's daughter-in-law telephoned the crisis team, fearful that B might try to sabotage the crisis team's visit by ensuring that they were out. In fact, when two representatives from the crisis team visited as agreed, A wasn't there. His son telephoned the team again to check whether, despite this, they would still provide support, which they reassured him that they would. However, when a representative from the crisis team went back for a second time, the police were already there, the house was cordoned off, and it was clear that there had been an incident. It appeared that A and B had gone for a very early drive to the lakes (it was still dark), something they periodically did, and A had allegedly pushed B into the water. He had then taken an overdose of her Stelazine. By 21:30 that evening, A was picked up by the police and taken to Ipswich Hospital. At interview he was still hazy about the events of that day although he was aware that he had had thoughts of suicide.	This was thorough and effective practice.
21/02/2011	Having been contacted by the police, the consultant psychiatrist located A on the short stay acute admissions ward where he was receiving treatment for the effects of his overdose. The consultant and the `modern matron' completed a clinical assessment, judging A to be suffering from a profound level of depression with psychotic symptoms. He was	This was thorough and effective practice.

	subsequently detained under Section 2 of the Mental Health Act.	
28/02/2011	A's symptoms worsened initially, but by May of 2011 he was improving. His plea of manslaughter on the grounds of diminished responsibility (severe psychotic depression) was accepted.	
03 - 04/2011	A's court appearance is adjourned to 5th April. His family were not able to participate or provide evidence, although a friend of B's was able to provide a statement. The process proved frustrating for A's family.	
07/2011	The Stage 2 report is completed into the circumstances of B's death and the treatment and care provided for A. Six recommendations are made and the report is distributed. Support is offered/provided for the staff involved.	See comment 2.8.8

2.8. ISSUES IDENTIFIED DURING THE INVESTIGATION

The investigation team was initially concerned to establish whether the six recommendations made in July 2011 in the `Stage 2' report had been met. The recommendations from that report are reproduced below.

RECOMMENDATIONS MADE IN 2011 BY THE `STAGE 2' INVESTIGATION

1. `Mental Health Act (MHA) assessments by Approved Mental Health Professionals (AMHP) should not be undertaken 'out of county' to avoid delays for the client.

2. It then follows that clients from, 'out of county' presenting in Suffolk should be seen and assessed promptly by Suffolk AMHPs.

3. Refer to Social Services Lead for AMHPs for inclusion in policy and briefing to AMHPs.

4. The AMHP service gave contact details of the CRHTT alongside the recommendation that he [A] contact his GP for support. No referral to CRHTT was made or intended. A was not clear that he was not to be referred to the CRHTT. Communications systems/information sharing between the AMHP service and CRHTT should be considered. Co-location of services has proved to be successful and should be considered as a Trust-wide model.

5. CRHTTs struggle nationally with the question of staffing levels to ensure that they remain effective in the face of peaks and troughs of activity. The out of hours service is currently being reviewed Trust-wide and the review should take into account a consideration of CRHTT staffing levels during 'out of hours'.

6. A structure of working which allows and supports joint assessments by workers from time to time will promote peer review, good practice and enable staff to be confident about the quality of their work.'

2.8.1. Out of area assessments

(Stage 2 recommendations 1, 2 and 3 above)

The assessment of A completed on Monday 31st January 2011 in the S.136 suite appears to have been thorough although it was unusual at the time for the assessment to have been completed by an AMHP (an adult mental health professional employed by the local authority social services department) from A's home area rather than by someone in the vicinity.

This matter was addressed in the `Stage 2' report and was the subject of two recommendations. The investigation team believes that there is now much greater clarity concerning policy for AMHPs to see patients `out of area.' On the whole, they do not do this unless the needs of the individual patient dictate that a different arrangement should obtain. The investigation team has seen a copy of the policy communication which sets this out, written by the Mental Health Social Care Lead, and was able to confirm through interviews that the policy is being implemented. The investigation therefore concludes that these three Stage 2 recommendations have been implemented.

2.8.2. Joint working and co-location

There are now much more effective arrangements in place to ensure that communications, notes and reports from the AMHP, and vice versa, are sent quickly and entered, where appropriate, into the NHS electronic (ePEX) files.

The arrangements appear to be working well. Several witnesses also commented positively upon the new arrangements for co-location within Suffolk for AMHPs and community team members. The investigation team is therefore pleased to report that this component of recommendation 4 of the Stage 2 report has been implemented. However, the team notes that co-location does not extend across the whole of the service and believes that it would be helpful for the Trust to explore this further (see Recommendation 1 below).

2.8.3. Access to the crisis team and crisis team staffing levels

There is some uncertainty regarding the way that A (and his son and daughter-in-law) on Monday 31 January 2011 obtained the crisis team telephone number. Some witnesses thought it normal to give out the number; others that this would be unusual. Some thought it had been given to the family by the member of staff they saw, but she herself isn't sure whether the family already had it.

Whilst it seems that there was some confusion at the time, there was no substantial evidence to suggest that staff in the crisis team responded inappropriately when A telephoned them on the 16 February just over two weeks after his S136 assessment. Although, it is likely (with the benefit of hindsight) that A's telephone call on this

day, just a short time before the tragic incident which resulted in the death of B, was, in fact, a signal that all was not well, it would have been routine practice to refer back to the GP without sound evidence of the need to respond any other way. This is still the case today: members of the public who now need a new, first time contact with services should still be referred by a professional. The investigation team believes that this is clinically appropriate practice given local circumstances.

However, the investigation team has also learnt that referrals for support in a crisis may now be made by a much wider range of professionals to a new (single point of) Access and Assessment – a team which has urgent and non-urgent arms. This means that whilst there was some uncertainty at the time regarding who could refer, and how, there is now much greater clarity and there is wider access. The investigation team is therefore able to report that recommendation 4 of the `Stage 2' investigation has been largely implemented.

2.8.4. The Crisis Team response

(Recommendations 5 and 6 in the `Stage 2' report)

The crisis team made a judgement on 16 Feb 2011 when A called; that referral back to the GP was the most appropriate course of action. The investigation team believes that there is no reason to doubt that this was an appropriate thing to do, given the information that was available. The crisis team also responded very quickly and appropriately as soon as the GP's referral letter arrived on 18 February and it became clear that A was in A&E.

The information about the importance of seeing A alone was passed on, and responded to, and there are no substantial reasons to doubt the quality of the assessment that was then undertaken by a member of the Crisis Team. It was reasonably thorough, well documented, and risks were appropriately assessed. However, it was undertaken by a lone worker who stepped in when the sole member of the psychiatric liaison service was off duty.

The investigation team is pleased to report that appropriate modifications to team structures and policy have now been made. For example, a significant level of re-organisation has taken place in the Trust since 2011. Two Trusts have merged; new management systems are in place, and policies and procedures (e.g. for initial assessments) have changed. Most notable amongst the changes as they relate to this case are those relating to the re-design of the Crisis and Assessment Team, and the development and expansion of the Psychiatric Liaison Team. By these means, access to services for people in crisis have been strengthened very significantly and although it is clear that the staff are still under pressure to meet demand for services, waiting times are not currently a source of concern.

However, there are other issues which it is important to highlight:

2.8.5. The quality of risk assessment

The investigation team believes that a reasonably thorough and well-documented assessment was undertaken on the 18 February 2011. It appears that the interviewer responded to information about the need to see A alone and she saw him separately as well as with B. Furthermore, she offered A an admission to hospital, although he refused. As it seems that there was insufficient evidence available at the time to warrant use of the Mental Health Act there was no alternative but to let him go home.

Nowadays, there is a well-staffed multi-disciplinary psychiatric liaison team in place to ensure that assessments are undertaken quickly and always by two people. Indeed, the policy for all new assessments to be seen by two people extends to the whole of the crisis service and the arrangement appears to be working well. This should also make it easier for family members (and other informants) to be interviewed to ensure the fullest information possible is obtained. Furthermore, policies and documentation on risk appear appropriate.

2.8.6. The impact upon carers

Supporting someone with mental and/or physical health problems has an impact and this has been well documented in recent years. Awareness of the risk to the mental health of carers has risen significantly. For example, the 1999 National Carers' Strategy (which was subsequently reinforced in 'Our Health, Our Care, Our Say' in 2006; refreshed in 2008 for social care, and for the NHS in 2010) set out rights for carers to have an assessment of their needs.

With hindsight it is clear that A was significantly burdened by the caring responsibilities he shouldered. With hindsight, it is also clear that having been detained on a Section 136 of the Mental Health Act barely two weeks previously, A was very vulnerable when he presented to A&E on Friday 18 February. It also seems highly likely that A hid how unwell he really was. However, given the information available at the time, there appeared to be insufficient evidence to warrant application for detention under the Mental Health Act, the member of crisis team staff had little option but to respect his wish to be sent home.

However, the risks to A as a carer were not addressed in any of the clinical notes or in the Stage 2 report. Indeed, no-one who saw A around the time of this tragic incident appears to have been aware that he was a carer of someone quite challenging who had been in contact with mental health services. This is because neither A nor B had current files (see Recommendation 2) and because little attention was directed towards obtaining information from members of A's family (see below).

2.8.7. The importance of obtaining information from families

Hindsight is always clear. We now know that B had expressed reservations about A receiving treatment as an inpatient owing to the threats she perceived that she would lose support and that they would lose financial benefits. We know now that B was reluctant to be left alone, and that A may have been a victim of bullying and abusive behavior at home. The team has also obtained testimony to the effect that A was unwilling or unable to disclose information about his mental state or his wife's behaviour in her presence. At the same time, and whilst he obviously cared for her, he was gradually becoming more seriously depressed and unable to cope. Together this combination of factors proved catastrophic. However, without the testimony of all (or at least some of) the family, a complete picture could not be drawn. It has become clear that more information was available from the family which would have been useful to see, both at the time of A's presentation on 31 January as well as on Friday 18 February.

The investigation team considers that it is important for the future to consider strengthening awareness of the importance of listening to the views of family members. The investigation team understands that this can be difficult and is not always possible, especially in emergency situations. Patients sometimes want to exclude their families and/or they refuse to give permission for them to be involved; sometimes they may feel unable, or frightened or ashamed to speak out.

The implication is that, wherever possible, it is important to see members of a patient's family and to listen carefully to all the information they provide. It is certainly true that at various stages of A's contact with services, his family felt that their efforts to inform staff were not always heard. They tried to communicate the importance of conducting sole assessments, and explain how B's problems and relationship issues were affecting their father.

A's oldest son was reported in the Stage 2 report to feel that A was let down and other family members who spoke to us also share this view (see Recommendation 3).

2.8.8. Support for staff

It is not uncommon for staff involved in caring for someone with a mental illness to be badly affected in the circumstances of a sudden death. Staff generally share a compassionate and caring attitude towards their patients and they may feel significantly traumatised. In our view, a senior manager should always be present when an incident is first registered to ensure that any affected members of staff are able to cope.

Like families, staff have needs for information and support, and whilst Mental Health and other NHS employers share responsibility to provide this, evidence suggests that it is not always done effectively.

De-briefing procedures, for example, which are commonly employed, are not always appropriate for everyone and, for some staff; the emotion of a homicide can last for months or even years, regardless of the support that is offered. In this case, the Trust offered and provided support including group de-briefing, written advice on the Trust intranet, as well as individual counseling and psychological therapy.

The investigation team believes the Trust behaved appropriately. However, there would be value in reviewing the systems in place to ensure that they do meet individual needs which can vary widely (see Recommendation 5).

2.9. RECOMMENDATIONS

The following recommendations are made with the aim of strengthening further the care, treatment and support provided by the Trust for people who need mental health services.

2.9.1. Recommendation 1: Co-location

The Trust should further consider the opportunities and limitations of co-location across the patch for health and social care staff as a means to facilitate communication and information-sharing. Whilst co-location is not always possible or practical, the impact upon communication may be significant and extra care may be needed to develop solutions where co-location is impractical.

2.9.2. Recommendation 2: Carers

The investigation team recommends that attention is given as part of staff training and reflective practice to the association between mental ill health and caring for someone with significant mental and/or physical problems. New guidance on the value of an assessment of carers' needs should be included as part of this.

2.9.3. Recommendation 3: Domestic violence and abuse

It will be important for the Trust to include as a routine part of staff training and/or reflective practice a focus on the association between domestic violence and risk of homicide. This should help to ensure that policy on the conduct of initial interviews and risk assessment keeps pace with the evidence.

2.9.4. Recommendation 4: Family testimony

The investigation team recommends that awareness is raised about the importance of family testimony. At local level for clinicians, this could be achieved via training for staff which includes representation from users, carers and family members as appropriate and/or a focus on reflective practice. We would also suggest that national and local commissioners of investigations (Stage 3 and Stage 2 respectively) strengthen their governance and quality assurance mechanisms for independent investigations to ensure that information from carers and families is always sought.

2.9.5. Recommendation 5: Support for staff

The investigation team believes that support for staff could be improved if, as a matter of course, a senior manager attended in person when a serious incident (SI) occurs. In addition, there may be value in developing a staff support policy to bring together all the guidance currently available on the intranet into one place. Responsibility to maintain and update this and ensure that support is tailored to individual needs to be clearly defined and assigned.

2.10. CONCLUSION

The investigation team appointed to undertake this `Stage 3' independent review believes, on the basis of a systematic investigation of the evidence, that this tragic incident was neither predictable nor preventable. There is no question that A was profoundly depressed at the time that the incident occurred and there are reasons to believe that he did not disclose how ill he was, making it very difficult for those who interviewed him beforehand to obtain as full a picture as it was possible to establish subsequently. It is also true that, although A's family had a sense of the difficulties that the couple experienced, neither they, nor the staff who saw A relatively briefly, could have predicted what was to follow.

The team also reviewed progress with recommendations made in the `Stage 2 report' (completed shortly after the incident occurred) and we conclude that these have largely been met. It is clear that a significant level of re-organisation has taken place in the Trust since the time that report was written. For example, a merger has taken place; new management systems are in place, and policies and procedures have changed. Most notable amongst the changes as they relate to this case are those relating to the re-design of the Crisis and Assessment Team, and the development and expansion of the Psychiatric Liaison Team. By these means, access to services for people in crisis have been strengthened significantly.

However, this review has also established facts about the case that were not uncovered at the time that the Stage 2 review was undertaken. For example, B, the victim, had also been a patient of the Trust (albeit some time before) and she was well known to local social services and to the police.

Furthermore, A appears to have been a victim of bullying and occasional violence by B at home. More is now known about the mental and physical impact of caring for someone with difficulties like those experienced by B, and we know more about the risks associated with what is commonly termed `domestic violence. Five recommendations are therefore made to further strengthen services within the Trust concerning these and other areas.

3. APPENDICES

3.1. WITNESSES INTERVIEWED

- Operational Team Manager (AMHP)
- CRHTT Manager
- CRHTT Nurse
- Social worker (AMHP)
- Consultant Psychiatrist with overall responsibility for the crisis and assessment team, crisis beds, and elements of community and inpatient provision
- Psychiatric Liaison Team nurse
- Modern Matron for AMH
- Son and daughter in law of A
- A's step daughter
- A
- A's MH nurse
- A's GP at time of incident

3.2. ACTION PLAN

Approved by Executive Team on 13 August 2014

Recommendations	Agreed response / additional action(s)
Recommendation 1: Co-location The Trust should further consider the opportunities and limitations of co-location across the patch for health and social care staff as a means to facilitate communication and information-sharing. Whilst co-location is not always possible or practical, the impact upon communication may be significant and extra care may be needed to develop solutions where co-location is impractical	AGREED. Co-location is in line with the Trust's clinically-informed Estates Strategy and in Suffolk this is part of the Integrated Delivery Team model. Across Norfolk and Suffolk the Trust continues to explore co-location opportunities, not only with mental health services but also the wider health and social care network as part of our commitment to integration. In Mid-Suffolk the Trust has purchased a building in Stowmarket which will allow a number of separate teams to move into one base later in 2014. Lead Director: Leigh Howlett (Commercial Director)
Recommendation 2: Carers The investigation team recommends that attention is given as part of staff training and reflective practice to the association between mental ill health and caring for someone with significant mental and/or physical problems. New guidance on the value of an assessment of carers' needs should be included as part of this.	AGREED. On 24th April 2014 The Trust's Board of Directors approved a proposal to adopt the Triangle of Care for mental health. The key elements of this are: 1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter. 2) Staff are 'carer aware' and trained in carer engagement strategies. 3) Policy and practice protocols re confidentiality and sharing information are in place. 4) Defined post(s) responsible for carers are in place. 5) A carer introduction to the service is available, with a relevant range of information across the acute care pathway. 6) A range of carer support services is available. Progress of services in implementing the Triangle of Care will be reported to the Board of Directors every six months. Lead Director: Jane Sayer (Director of Nursing, Quality and Patient Safety).

Recommendation 3: **Domestic violence and abuse** It will be important for the Trust to include as a routine part of staff training and/or reflective practice a focus on the association between domestic violence and risk of homicide. This should help to ensure that policy on the conduct of initial interviews and risk assessment keeps pace with the evidence.	AGREED. Following the publication of NICE guidance (February 2014) the Trust carried out a benchmarking exercise and identified that the need for further training in order to meet this standard, *"Frontline staff in all services should be trained to recognise the indicators of domestic violence and abuse and ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner."* The Trust now has DV basic awareness at induction, and introduced statutory mandatory level as a day's course. This will be evaluated in the light of the Domestic Homicide Reviews we have had in line with the Community Safety Partnership action plan. Work is also underway to create a standard for staff to ask about DV as part of assessments. Lead Director: Jane Sayer (Director of Nursing, Quality and Patient Safety).
Recommendation 4: **Family testimony** The investigation team recommends that awareness is raised about the importance of family testimony. At local level for clinicians, this could be achieved via training for staff which includes representation from users, carers and family members as appropriate and/or a focus on reflective practice. We would also suggest that national and local commissioners of investigations (Stage 3 and Stage 2 respectively) strengthen their governance and quality assurance mechanisms for independent investigations to ensure that information from carers and families is always sought.	AGREED. The importance of this has been recognized by the Board which receives testimony from service users and family carers at its private sessions in order to inform board thinking. The Trust's Recovery College includes a course on 'telling your story' which provides people with the skills to use their experiences constructively to inform recovery and service improvement. The Medical Director will write before 31.08.14 to lead clinicians to emphasise the importance of listening to families. Lead Director: Hadrian Ball (Medical Director)

Recommendation 5: Support for staff The investigation team believes that support for staff could be improved if, as a matter of course, a senior manager attended in person when a serious incident (SI) occurs. In addition, there may be value in developing a staff support policy to bring together all the guidance currently available on the intranet into one place. Responsibility to maintain and update this and ensure that support is tailored to individual needs to be clearly defined and assigned.	AGREED. It is standard practice for at least one senior manager to meet with staff after an SI to provide immediate support, a formal debrief and to assess ongoing support needs. The Trust has a dedicated section on the Intranet called, “Staff Well-being” which includes information for staff on how to access support. This includes • 24 hour confidential counselling and support service • Free access to the Trust's online individual wellbeing support zone for staff and their families • Staff Physiotherapy Service • Wellbeing and Resilience Workshops for staff and managers • Support to make healthy lifestyle changes • Locality/Service based employee forums and local based initiatives • Discounts at Local Gyms and for local heath activities Lead Director: Jane Marshall-Robb (Director of OD and Workforce).