



IMPROVEMENT THROUGH INVESTIGATION

**Independent investigation into the care and treatment of
Mr A**

A report for
NHS England, North Region

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1 Introduction

NHS England, North Region commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr A.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation may not identify root causes or find aspects of the provision of healthcare that directly caused an incident, but it will often find things that could have been done better.

1.1 Background to the independent investigation

On 1 May 2013, Mr A, aged 79 years, stabbed and killed his wife. He then committed suicide. At the time of the incident, Mr A was in receipt of older persons' specialist mental health services provided by Northumberland, Tyne and Wear NHS Foundation Trust. He had been under its care since March 2013.

1.2 Overview of the trust

Northumberland, Tyne and Wear NHS Foundation Trust (the trust) is a large mental health and disability trust that provides services to people living in Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside, Sunderland and North Easington.

2 Terms of reference

The terms of reference for the independent investigation, set by NHS England, North, in consultation Northumberland, Tyne and Wear NHS Foundation Trust are as set out below.

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of the offence.
- Review the appropriateness of the treatment of the service user in light of any identified health and social care needs, identifying areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the effectiveness of the service user's care plan, including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if the incident was either predictable or preventable.
- Provide a written report to the investigation team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a post-investigation evaluation.

3 Approach to the independent investigation

NHS England, North Regional Team, commissioned a type C independent investigation. This type of investigation does not seek to reinvestigate a case from the beginning. The independent investigation team builds upon any investigative work that has already been carried out by the trust.

The Safer Sunderland Partnership Board convened a Domestic Homicide Review (DHR) panel and made the decision that a review should be carried out, since there were lessons to be learnt from the case in respect of Mr A's mental health history and services provided. A DHR report into the death of Mrs A was published in March 2014.

The investigation team consisted of Chris Brougham, director of Verita, Gemma Caprio, senior consultant, and Dr Peter Jeffrey, consultant psychiatrist. Dr Jeffrey provided expert advice and undertook a review of Mr A's clinical records. Barry Morris, partner, provided peer review for the report. From now on the investigation team will be referred to as 'we'. Our biographies are at Appendix A.

We reviewed documentary evidence. This included:

- national guidance;
- trust policies and procedures;
- Mr A's clinical records; and
- the trust internal investigation report.

The family of Mr A gave us permission to review his medical records. We met with Ms C, Mr A's daughter-in-law at the start of our investigation to explain about the investigation and to establish if she had any concerns about the care and treatment provided to Mr A. We contacted her again at the end of the investigation to share with her what we found in our investigation. We also sent Ms C a copy of the report for her comments prior to publication. We have included her comments within the report.

We held a telephone interview with the lead investigator of the trust serious incident investigation.

We based our findings on analysis of the evidence we received. Our recommendations are intended to improve services.

Our report includes a chronology which describes Mr A's care and treatment in detail from March 2013 to May 2013 and examines the key issues arising from it. These are listed on page 20.

4 Executive summary and recommendations

NHS England, North Regional Team commissioned Verita, a consultancy specialising in public sector investigations, review and inquiries, to carry out an independent investigation into the care and treatment of Mr A.

The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are provided in section 2 of this report.

The purpose of an independent investigation is to discover what led to the adverse event, and to audit the standard of care provided to the individual. While the independent investigation might not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it might find things that could have been done better.

4.1 The incident

On 1 May 2013, Mr A, aged 79 years, stabbed and killed his wife. He then committed suicide. At the time of the incident, Mr A was in receipt of specialist mental health services provided by Northumberland, Tyne and Wear NHS Foundation Trust. He had been under its care since March 2013.

4.2 Overview of care and treatment

Records show that Mr A had a history of episodes of depression in 1987 and 1990 which were managed by his GP. He was prescribed antidepressant medication which he continued to take over several years.

In December 2012 Mr A was diagnosed with a bladder tumour and had surgery. Mr A underwent an aortic aneurysm repair on 22 January 2013. A course of radiotherapy was planned to take place between 7 March and 3 April 2013.

On 6 March 2013, Mr A attempted suicide by connecting a hosepipe from his car exhaust into the interior of the car and then sitting in the car in the garage with the engine running and the windows closed. His daughter-in-law, Ms C, found him and took him to the emergency department later the same day. A suicide note had been left.

Mr A was assessed by a duty doctor using the Beck depression inventory¹. The results showed that Mr A was a high suicide risk. The doctor referred him to the mental health Initial Response Team (IRT).

¹ The Beck Inventory is a series of questions developed to measure the severity of the intent of a suicide attempt through the identification of a cumulative numerical value.

Two nurses from the IRT carried out a core mental health crisis assessment, which included completion of a FACE¹ risk assessment. Mr A described being particularly stressed about his physical health and expressed concern about starting radiotherapy the following day.

Following the consultation Mr A engaged with community mental health services and was under the care of the community team until the index offence in May 2013. Throughout his care in the community, Mr A was managed by the same community psychiatric nurses (CPNs) and consultant psychiatrist.

4.3 Overall conclusions about care and treatment

Mr A engaged with mental health services and was predominantly managed by his care coordinator with input from the consultant psychiatrist.

4.3.1 Diagnosis

We have considered the formulation of diagnosis and subsequent management of Mr A. Mr A's records from 6 and 7 March 2013 are consistent with a presumptive diagnosis of depression in the context of serious and acute physical health problems triggering a suicide attempt. This was appropriate at this stage. Note was also made of Mr A's "demon thoughts". Appropriate arrangements were made for a consultant psychiatrist assessment on 11 March.

Consultant psychiatrist 1 concluded that Mr A's "demon thoughts" were likely to be intrusive thoughts rather than either auditory hallucinations, indicating a psychotic episode, or a primary feature of depressive illness. This was a reasoned clinical judgement. The differential diagnosis was that of intrusive thoughts versus stress induced psychosis versus an underlying depression.

Mr A was closely monitored over the following six weeks. Mr A's "demon thoughts" fluctuated in intensity and became more intense by 29 April.

There is no record that any attempt was made to review consultant psychiatrist 1's earlier 11 March preliminary diagnosis. In our opinion, with the benefit of hindsight consultant psychiatrist 1 could have given more weight to the possibility of the diagnosis of depression.

The trust have responded that Consultant psychiatrist 1 felt that Mr A's notes do not suggest that he had any thoughts of harming his wife from 14 March 2013 to 24 April 2013. As these thoughts were not evident for several weeks Consultant psychiatrist 1 concluded that the intrusive thoughts were not an indicator of underlying severe depression and his diagnosis was reasonable.

¹FACE (Functional Analysis of Care Environment) is a mental health assessment tool endorsed by the Department of Health as a validated tool of good practice in assessing clinical risk. (Department of health: National risk management programme, 2007)

4.3.2 Care Programme Approach

The Care Programme Approach (CPA) is the process that mental health services use to coordinate the care of people with mental health problems. The concept was introduced in 1991, and in 1999 *Effective care coordination in mental health services – modernising the care programme approach* set out the arrangements for all adults of working age under the care of secondary mental health services.

Mr A was subject to an enhanced CPA. He was assessed, allocated a care coordinator and had a care plan. Mr A's care plan was not formally updated after 6 March 2013. However, progress notes were recorded on RiO¹ on all subsequent visits to Mr A. The notes make reference to relevant care issues, such as medication supply or compliance.

The trust internal investigation noted these findings and made recommendations. The trust has provided evidence that improvements have been made.

4.3.3 Risk assessment and risk management

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice.

On 6 March an initial management plan for Mr A was devised, recorded and implemented with immediate effect. This plan was appropriate and involved daily close monitoring and support.

We found staff failed to comply with trust recording procedures. They did not formally repeat risk assessments using FACE schedules or formally update Mr A's care plan. We concluded these omissions were appropriately criticised in the trust internal investigation.

We found evidence that immediate risk, particularly of suicide, was reviewed at most contacts made with Mr A between 7 March and 30 April. In addition, on the one occasion that Mr A was seen by consultant psychiatrist 1 on 11 March, the clinical notes were comprehensive indicating that a reliable clinical assessment of risk was made.

Although Mr A's care plan was not formally updated after 6 March 2013, progress notes made on all subsequent visits by trust staff to Mr A prior to his death, regularly make reference to relevant care management issues, such as medication supply or compliance.

4.3.4 Nature and quality of clinical monitoring – access to additional skills

An implicit part of Mr A's treatment plan was monitoring for changes in his mental state or behaviour that might have significant impact on risk and his treatment needs.

¹ RiO is an electronic patient record system.

On 29 April 2013, when Mr A's intrusive thoughts became worse, plans were made for him to be reviewed again by a psychiatrist. We concluded this was good practice.

Mr A was not seen by consultant psychiatrist 1 before his death two days later.

4.3.5 Services offered to Mr A

When Mr A was first assessed on 6 March 2013, inpatient psychiatric admission was considered by trust staff. The agreed plan was management at home with daily mental health service input. This was an appropriate management plan/service response for Mr A at that time.

The lack of formal repeated risk assessments using FACE schedules, and the absence of an updated care plan were appropriately criticised in the trust internal investigation. However, there is evidence that immediate risk was systematically reviewed by clinical staff at each visit.

4.3.6 Carer's assessment and family involvement

We concluded the trust failed to offer or provide a carer's assessment for Mrs A, or any other key family supporters such as Ms C, Mr A's daughter-in-law. Mrs A and Ms C were not offered any services by the trust.

We also concluded there is no indication that a structured approach to assessments and reviews involving individuals and their spouses or carers was standard trust practice.

4.3.7 Exploration of marital disharmony

An unusual feature in this case was early flagging of marital disharmony and its resurfacing on many home visits undertaken over succeeding weeks. Both Mr A and his daughter-in-law Ms C alerted staff about the marital disharmony.

We found clinicians did not take a systematic history about Mr and Mrs A's marital disharmony. Therefore staff were not aware of key environmental and emotional factors that could have impacted on both of them. The clinicians did not have an effective or appropriate management plan to support either Mr A or his wife.

In addition, we concluded staff were unable to make a reliable assessment of the potential risk to the psychological wellbeing of either Mr A or Mrs A.

The background to these omissions is explored in the Domestic Homicide Review (DHR). We endorse their criticisms and conclusions. Serious weakness in the training of staff to recognise domestic abuse was seen as a contributory factor by the DHR author.

4.3.8 Interagency working and communication

Consultant psychiatrist 1 wrote a comprehensive letter to Mr A's GP summarising his assessment, which easily met the necessary professional standards for such a communication.

There is no evidence that any further written communication was made by the trust to the GP. Mr A's initial care plan, prepared on 6 March 2013, was not copied to the GP. There was no communication with the GP when Mr A's mental state worsened at the end of April 2013.

These omissions are serious, particularly since staff knew that Mr A had a serious physical health condition (cancer of the bladder), with complications such as urinary infections, and was likely to have ongoing contact with his GP.

Also, staff made no attempt to seek further information about two key issues highlighted in the initial GP referral letter. These were Mr A's history of depressive illness and marital disharmony. Information about both these issues was relevant to Mr A's diagnosis, management and treatment. This represents a significant missed opportunity by staff.

The DHR found that City Hospitals Sunderland NHS Foundation Trust (CHS) staff possessed relevant information about Mr A's marital disharmony, and that observations had also been made about his mental state on some occasions. This information may have assisted staff if they had made appropriate enquiry.

Mr A remained under the outpatient supervision of CHS for his medical conditions after trust staff became involved. CHS management of Mr A may well have been helped by trust information about his evolving mental condition, including suicide risk. The failure of trust staff to liaise with CHS services was an important omission.

Staff knew that Mr A was attending the Northern Centre for Cancer Care five days a week from 7 March to early April. Although Cancer Care staff may not have had much useful information about Mr A's mental state, it would have been sensible for trust staff to inform them about Mr A's suicide attempt and risk management, as part of his overall risk management. Trust staff did not do so. It would have been necessary to seek Mr A's consent for disclosure. We concluded these omissions were appropriately criticised in the trust internal investigation.

4.4 The trust investigation

The trust investigation was conducted in line with trust policy. The report was comprehensive and addressed the terms of reference. It contained a detailed chronology, relevant benchmarks, analysis of key events, findings and recommendations. It identified areas of concern and omissions. We found the conclusions of the trust investigation were sound and we endorse them.

The trust's internal investigation made 26 findings and 13 recommendations covering the following themes:

- assessment and management of risk;
- treatment and care; and
- record-keeping and communication.

4.5 Predictability and preventability

4.5.1 Predictability

We found Mr A spoke about thoughts of harming his wife, but had no plans to do so. Staff had no information from Mr A or his wife or daughter-in-law about any previous incident when he had caused her physical harm. When examined on 29 and 30 April, Mr A was cooperative with staff and was not obviously psychotic.

Based on this evidence, we concluded the incident on 1 May 2013 when Mr A killed his wife was not predictable.

4.5.2 Preventability

We concluded there is no evidence to suggest that any specific alternative course of action by the trust could have prevented the incident, given that Mr A had no plans to harm his wife when seen on 29 and 30 April 2013. Mr A could not be detained as he did not meet the criteria of the Mental Health Act (MHA).

We found no evidence to indicate that staff had the knowledge, opportunity or means to prevent the homicide from taking place.

4.6 Recommendations

The trust should ensure that staff make contemporaneous records about interventions including MDT meetings. This issue should be included in the trust's Quality Monitoring Tool and audited every six months

The clinicians should ensure they comply with the information sharing requirements of the trust *Care coordination policy*.

5 Chronology of care and treatment

Records show that Mr A had a history of depressive episodes in 1987 and 1990, which were managed by his GP. He was prescribed antidepressant medication, which he continued to take over several years.

In December 2012 Mr A was diagnosed with a bladder tumour and had surgery. This indicated that he had invasive bladder cancer. He was also diagnosed with an aortic aneurysm.

Mr A underwent an aortic aneurysm repair on 22 January 2013.

Mr A was seen by doctors at an outpatient clinic at Sunderland Royal Hospital to discuss the treatment of his bladder cancer. The doctors confirmed that radical radiotherapy would be the best form of treatment. His course of treatment was planned to take place between 7 March and 3 April 2013.

On 6 March 2013, Mr A attempted suicide by connecting a hosepipe from his car exhaust into the interior of the car and then sitting in the car in the garage with the engine running and the windows closed. Mr A was alone at the time; his wife had gone shopping. His daughter-in-law, Ms C, found him and took him to the Emergency Department at Sunderland Royal Hospital later the same day.

Mr A was assessed by a duty doctor at Sunderland Royal Hospital who noted that Mr A was known to have bladder carcinoma (with planned radiotherapy) and that he had a recent endovascular repair of an aortic aneurysm. He recorded that Mr A had been alone at home when his wife had gone shopping, and that he had impulsively wanted to end his life because he did not want to be a burden to anyone. The doctor recorded that Mr A was glad to be alive, and the doctor did not identify any previous history of overdose or active involvement with mental health services. Mr A had no clinical complaints, such as headache, nausea, breathlessness, chest pain or any other physical symptoms. The doctor noted that Mr A was anxious: his speech was normal, but he avoided any eye contact. The doctor described Mr A's mood as "subjectively low but objectively reactive during consultation". There was no evidence of thought disorder, psychosis or behavioural abnormality.

The duty doctor assessed Mr A using the Beck depression inventory. The results showed that Mr A was a high risk of suicide, so the doctor referred him to the mental health IRT.

Two nurses from the IRT carried out a core mental health crisis assessment, which included completion of a FACE risk assessment. Mr A's wife and daughter-in-law were present when this assessment took place. Mr A confirmed he was happy for them to be present, and declined the opportunity to be seen alone. Mr A described being particularly stressed about his physical health and being convinced he was dying, saying he had had haematuria (blood in urine) for the preceding two weeks. Mr A expressed concern about starting radiotherapy the following day, and felt guilty that other people had to provide transport for him so that he could get to the hospital.

Mr A told nursing staff that he had felt like killing himself the night before, but had not acted on his thoughts. When his wife had gone out he told staff that he felt overwhelmed with stress, which is when he decided to attach the pipe to the car exhaust. His daughter-in-law, Ms C, then came around unexpectedly and found him. He told the nurses that he had no thoughts of harming himself, and that he wanted help to cope with his stress, anxiety and the bad thoughts in his head. The assessment record shows that Mr A's wife and daughter-in-law told the nurses that he had experienced poor sleep pattern, poor appetite and weight loss over recent weeks, and that he was irritable. They also informed the nurses that he no longer wanted any of his treatment, and had started withdrawing to his bedroom.

The mental state examination recorded that Mr A was casually dressed and well kempt. He was pleasant, polite and amenable to engage with appropriate rapport. He maintained good eye contact throughout the assessment; his speech was described as normal in rate, volume and tone. His thoughts were noted as being constantly negative about his own mortality with reference to his friends/neighbours also all being ill or dying.

The FACE risk assessment indicated that Mr A had a significant risk of suicide, but there was no indication that Mr A intended to harm anyone else.

Mr A denied any further thoughts, plans or intent to commit suicide, and said that he was willing to attend his radiotherapy appointment on 7 March. He also agreed to engage with mental health services so that they could help him cope with his low mood, stress and anxiety. The nurses advised that, because of Mr A's age, he would be referred to the Older People's Services. He would be seen on a daily basis to monitor his risk, commencing the following day after his radiotherapy appointment.

The nurses identified that Mr A would require health education and management for his stress and anxiety, and that a further medical mental health review might be necessary. Mr A was placed on enhanced care co-ordination due to the significant stress and worries he experienced in relation to his physical health.

The family of Mr A have commented that they raised their concerns during this assessment that Mr A was scared of hurting his wife and requested Mr A was admitted to hospital. This was not noted in Mr A's records.

On 7 March 2013 members of the Mental Health Initial Response Multi-Disciplinary Team (MDT) meeting reviewed Mr A's care and treatment. Although Mr A had been referred to the Older People's Services, the teams agreed that a short period of joint working would be beneficial, so some joint visits were arranged.

A visit took place on 8 March 2013, the day after Mr A's first radiology treatment. Records show that Mr A was very pleasant, and that his wife was at home throughout the period of the visit, but only attended half the session with Mr A.

The nurses assessed Mr A and felt that the decision to harm himself did not appear to be altogether impulsive. In talking with Mr A, they felt there had been a gradual decline in his mental health and depressive features had come to a peak the day before the incident. Mr A said his behaviour had been out of character, that he had

been feeling a lot better, and having slept well he was keen to put the event behind him. Mr A's wife, who was present at that point, said she felt he was considerably improved from the days leading up to the incident. There then followed a lengthy discussion about Mr A's attitude towards his physical illness, and about Mr A not wanting people to help him.

The nurses also carried out a mental state assessment and recorded their observations. They noted that Mr A displayed full insight and capacity throughout the session. There was no evidence of psychosis or major mental illness, although his wife did mention that he had previously referred to "demon thoughts" in his head. This was explored further and the nurses felt that these were "intrusive thoughts" relating to anxiety and distress. Mr A said these thoughts had now gone, but acknowledged that they had been present in the few days before the incident. The nurses felt that Mr A may have been expressing some mild to moderate depressive symptoms, exacerbated by his emotional feelings of guilt and concern relating to his physical health.

During the visit, Mrs A described her own physical difficulties about getting in and out of the bath and getting up and down stairs. The nurses provided her with the contact telephone number for the physical disability service at social services. They explained the procedure and suggested she contact them to request an assessment for support with her own mobility.

The nurses decided that Mr A should continue to be visited daily, so they arranged for a psychiatric nurse from the Older People's team to start the daily visits on the following day.

The following day, 9 March, the IRT discussed Mr A, as they did all their clients, at their daily MDT meeting. They confirmed that a CPN from the Older People's team would visit him that day. They advised observation for increased triggers, and reaffirmed these as being expressions of guilt and feelings of being overwhelmed. The IRT utilised a local risk rating scale based on red, amber and green (RAG rating) to provide an indication of their assessment of risk based on patients' presentation at that time. Mr A was categorised as red, although the team noted that they felt his risks were contained.

The Older People's team noted during their visit on 9 March that Mr A was very stressed and experiencing "command hallucinations". Mr A elaborated by saying he experienced hallucinations relating to "pushing her" but no thoughts about killing anyone and did not think he would harm his wife Mrs A. The records note Mr A was in control of these hallucinations. However, Mr A was noted to be extremely concerned that these thoughts may get worse and that he may harm somebody or expose himself.

Mr A was discussed by the IRT on 10 March at its daily meeting. During a visit that day, it was reported that Mr A continued to experience "command hallucinations", but felt he was in control of them. The team concluded that Mr A's risk was controlled at present.

On 11 March the IRT agreed the Older People's team would take full responsibility for the care of Mr A. A medical assessment was conducted by consultant psychiatrist 1 accompanied by a CPN (CPN 1). Mr A described "the demon in his head". Consultant psychiatrist 1 questioned him further about this, and noted that Mr A appeared to be describing intrusive thoughts and that he did not seem to hear voices. Consultant psychiatrist 1 could not rule out the possibility that Mr A was experiencing auditory hallucinations, but noted that the intrusive thoughts were likely to be related to stress. His diagnosis was Mr A had intrusive thoughts rather than stress-induced psychosis.

Consultant psychiatrist 1 prescribed seven days' supply of 5 mg of olanzapine (an antipsychotic). Consultant psychiatrist 1 also recorded that he offered Mr A admission to hospital, but that the patient declined because he felt that it would interfere with his radiology appointments. Consultant psychiatrist 1 recorded that Mr A's risk of harm to others was low to moderate, and that his risk of suicide was low to moderate.

On 12 March, Mr A's daughter-in-law, Ms C, contacted CPN 1 to discuss the marital disharmony between Mr A and Mrs A. Ms C raised concerns that Mr A was not receiving his medication from his wife. Subsequently, Ms C agreed with Mr A that she would keep his medication and provide it to him daily.

CPN 1 visited Mr A later that day and noted that he was settled. A geriatric depression scale assessment indicated Mr A's mood to be normal. Mr A reported that he was having strange thoughts, but did not experience any suicidal thoughts. Mr A requested that his wife Mrs A was not informed that his daughter-in-law Ms C was keeping his medication.

On 13 March, CPN 1 visited Mr A with a community support worker (CSW 1). CPN 1 noted that Ms C was continuing to keep Mr A's medication and provide it to him daily. During a discussion about Mr A's physical health, Mrs A confirmed that she had not contacted Mr A's GP for a repeat prescription for his medication. The plan was to continue daily visits, and that CSW 1 would visit the following day.

CPN 1 discussed Mr A with consultant psychiatrist 1 later that day. They agreed to continue to monitor Mr A and to update his GP on a regular basis. Consultant psychiatrist 1 wrote to Mr A's GP on 13 March. There were no further updates sent to Mr A's GP.

During the visit by CSW 1 on 14 March, Mr A explained that he and his wife had not spoken for ten years before his diagnosis of cancer.

CPN 1 and CSW 1 visited Mr A on Friday 15 March and noted tension between Mr A and Mrs A and that Mr A was anxious about his impending radiotherapy treatment. Mr A confirmed he would like telephone calls over the weekend instead of house visits, and agreed that if he had any concerns he would contact services.

In spite of Mr A's expressed preference for phone calls rather than visits at the weekend, CPN 2 visited Mr A at his home on Saturday 16 March, and noted that Mr A was feeling well and that his mood appeared good. Mr A was not experiencing

thoughts about suicide, self-harm or harming others. It was confirmed that another home visit would take place the following day.

CPN 2 visited Mr A again on 17 March, and noted tension between Mr A and his wife. Mr A felt he was a burden to his family, but was not experiencing any thoughts of suicide, self-harm or harming others. No signs of anxiety or psychosis were recorded. Daily visits were to continue.

The visit on 18 March noted that Mr A was positive and no risks were identified.

On 19 March Ms C, contacted CPN 1 because Mr A had finished his supply of medication. CPN 1 requested a prescription from Consultant psychiatrist 1 and this was provided to Mr A later that day during the daily home visit.

Further home visits continued between 19 and 21 March. Mr A was noted to be positive. On 21 March CPN1 discussed Mr A with consultant psychiatrist 1. They agreed to reduce visits to twice per week.

During a home visit on 22 March, Mr A was noted to be well and it was agreed with him to reduce visits to twice a week. Contact numbers were provided to Mr A if he needed additional support.

CSW 1 visited Mr A on 25 March. Mr A reported that the tension between him and his wife was detrimental to his mood. Mr A denied any thoughts of suicide, self-harm or harming others. Mr A discussed stopping his olanzapine, but when Mrs A entered the room, Mr A stopped talking about his medication. CSW 1 agreed to discuss the medication with CPN 1 and arranged an appointment to see Mr A on 8 April, after her annual leave.

During the visit on 27 March, Mr A told CPN 1 that he had stopped taking his olanzapine during the previous week. Mr A had not been experiencing any intrusive thoughts. CPN 1 noted a tense atmosphere when Mrs A entered the room. CPN 1 arranged a further visit for 2 April, and confirmed that Mr A would contact services if he required additional support.

Ms C contacted CPN 1 later that day. She was concerned that Mr A had not been taking his olanzapine. CPN 1 recorded that Ms C had not noted any deterioration of Mr A's mood. Mr A was managing well, and Ms C would contact services if he required further support.

The notes of the next visit on 2 April say Mr A had no suicidal thoughts. Mrs A was present during the visit, and spoke to CPN 1 about problems with her knees. When Mrs A left the room, Mr A told CPN 1 that Mrs A was concerned only with her own health issues. Mr A confirmed that he was no longer taking olanzapine.

On 3 April, CPN 1 discussed Mr A's presentation with consultant psychiatrist 1. No intrusive thoughts were noted, and they therefore agreed to reduce the number of visits to weekly, and Mr A was scheduled to be discussed at the MDT meeting two weeks later.

CPN 1 visited Mr A on 5 April. Mr A had finished his radiotherapy sessions and was positive about the future. His risk of suicide and harm to others was recorded as low. Mr A was informed the visits would be reduced to one per week.

The following week, CSW 1 visited Mr A on 12 April. Mr A's mood remained positive; he was aware that CPN 1 would be discussing his discharge from services with Consultant psychiatrist 1.

On 15 April, CPN 1 received a phone call from Ms C, who reported that Mr A was unhappy that Mrs A was not talking to him, and the atmosphere was bad. Mr A stated Mrs A is regularly present during visits and he therefore cannot talk to CPN 1 or CSW 1. Ms C had offered Mr A the opportunity to be seen at her home but he declined this.

CPN 1 visited Mr A the following day, 16 April. Mrs A remained in the kitchen during this visit. Mr A reported that the atmosphere had improved, and he had been out shopping with Mrs A. There was no evidence of intrusive thoughts and his mood was good. CPN 1 agreed to discuss discharge from services with consultant psychiatrist 1.

On 24 April CSW 1 was greeted by Mrs A in the garden before she entered the house. Mrs A confirmed she had been arguing with Mr A as he had been preoccupied with his health. Mr A was positive, but felt anxious about the side-effects of his radiotherapy treatment. Mr A requested medication for his anxiety and discussed with CSW 1 that medication would not remove the difficulties in his relationship with Mrs A. CSW 1 recommended distraction and they discussed Mr A going out, visiting friends and helping the family. Mr A denied any intrusive thoughts, but requested contact numbers for further support.

CPN 1 visited on 29 April and spoke to Mr A alone. Mr A described voices in his head which he described as his own thoughts trying to take over. Mrs A entered the room and told CPN 1 that Mr A had been having thoughts telling him to hurt her but she should not worry as he would never do so. CPN 1 noted that Mr A had accused Mrs A of having an affair with a man across the road and a bin man. Mr A was noted to be hesitant in his speech, and appeared anxious and frightened when talking about his thoughts, but denied thoughts of harm to himself or others. CPN 1 confirmed that Mr and Mrs A had contact numbers for crisis services, and that CPN 2 would discuss the current situation with consultant psychiatrist 1 the following day. CPN 1 discussed the situation with CPN 2.

On 30 April CPN 2 discussed Mr A's presentation with Consultant psychiatrist 1 and confirmed that CSW 1 was due to visit that morning. They agreed the visit would include a review of Mr A's mood, including thoughts of harming others or himself, and check if he had kept any of his medication. This discussion was not recorded in the health records and was obtained from police statements.

CSW 1 visited Mr A during the morning of 30 April and noted that Mr A was a little anxious, had trouble breathing, had warmth in his ear, and could hear his own heart beating. Mr A denied that these could be symptoms of anxiety. He was advised to contact his GP or go to the walk-in centre if he was concerned about his symptoms.

Mr A asked Mrs A if she would go to the GP with him. Mrs A refused and stated she was due to speak to her GP that afternoon as she was stressed with Mr A. Mrs A was tearful during the visit, and stated that Mr A had accused her of having affairs and stealing money. Mr A initially denied this behaviour, and then said that he had only been joking.

CSW 1 clarified that Mr A was not taking olanzapine because he thought it was a sleeping tablet. Mr A confirmed he was experiencing thoughts which he found difficult to describe. When asked directly if Mr A was experiencing thoughts to harm himself or others, Mr A did not give a definite answer, he only stated that he would not act on any thoughts.

CSW 1 informed Mr A that she would discuss his current presentation with Consultant psychiatrist 1 that afternoon. Mr A left the house at the same time to attend the walk-in centre.

CSW 1 discussed the visit with CPN 2, and indicated that Mr A was anxious, but she was not concerned about his mood since Mr A had requested medication for his anxiety. CPN 2 relayed this information to consultant psychiatrist 1, who agreed to review Mr A the following day.

On 1 May CPN 2 attempted to contact Mr A several times by telephone. There was no reply and the mailbox on his phone was full, so she was unable to leave a message. CPN 2 updated consultant psychiatrist 1, who also attempted to contact Mr A to arrange a visit that afternoon. Consultant psychiatrist 1 was also unable to contact Mr A, and obtained a mobile number from his records. This number belonged to Ms C, Mr A's daughter-in-law. Ms C advised Mr A was probably out, and consultant psychiatrist 1 agreed that he would visit the following day at 9:30 am. Ms C advised consultant psychiatrist 1 that Mr A was lower in mood but had not expressed any thoughts of harming himself or others.

Ms C then attempted to contact Mr and Mrs A. As the call was diverted to answer phone, Ms C decided to drive to their house.

The police contacted the trust that afternoon to advise that Mr and Mrs A had been found dead at their home address.

6 Issues arising

In the following sections of the report we analyse and comment on the issues we have identified during our investigation into the care and treatment of Mr A.

The themes are:

- formulation of diagnosis and subsequent management;
- Care Programme Approach;
- risk assessment and risk management;
- carer's assessment and family involvement;
- inter-agency working and communication;
- the trust internal investigation and report;
- progress made on implementing the trust's action plan; and
- whether the incident was predictable or preventable.

7 Formulation of diagnosis and subsequent management

In this section we consider Mr A's diagnosis and whether it was appropriately formulated and evidenced by those responsible for his care.

Formulating an accurate diagnosis is important because it largely determines the type of care and treatment that is required. In psychiatry, diagnosis is based mainly on clinical grounds by interpreting an individual presentation (history and examination). A diagnostic formulation, bringing together all relevant information, is valuable in mental health, not least because it shapes the care and treatment provided to that particular individual. Factors such as physical health, emotional development and social environment, which may impact on mental health presentation and treatment, are incorporated in a good formulation.

With acute mental health presentations, a triage process identifying the risks and symptoms is undertaken, and a provisional diagnostic opinion reached. Initial treatment is usually devised with the primary aims of risk reduction and relief of distress. A more sophisticated diagnosis usually follows with the involvement of a psychiatrist.

Mr A's records from 6 and 7 March are consistent with a presumptive diagnosis of depression in the context of serious and acute physical health problems triggering the suicide attempt. This was consistent with the documentary evidence available at the time. This presumptive diagnosis was appropriate at this stage. Mr A's records make reference to Mr A's "demon thoughts", which could indicate psychosis. On 9 March Mr A was noted to be experiencing command hallucinations, and he was concerned that the thoughts might get worse and that he might harm someone or expose himself. Appropriate arrangements were made for a consultant psychiatrist assessment to be completed on 11 March.

Consultant psychiatrist 1 undertook a thorough examination and gave careful consideration to Mr A's "demon thoughts", which, he concluded, were more likely to be intrusive thoughts than either auditory hallucinations indicating a psychotic episode or a primary feature of depressive illness. Consultant psychiatrist 1 prescribed seven days' supply of olanzapine. This was a reasoned clinical judgement. His differential diagnosis also included a stress-induced psychotic episode as well as depressive illness. This was appropriate.

Over the following six weeks, while Mr A was monitored closely by the clinical team, his depression improved but on occasions he was noted to be anxious. Late in March, Mr A discontinued taking olanzapine.

Mr A's "demon thoughts" fluctuated in intensity. They appeared to resolve from 14 March to 24 April. They became more intense by 29 April when he also revealed, for the first time, that he had thoughts about his wife having an affair with a neighbour and a bin man. As a consequence, it was agreed that his diagnosis should be reviewed by consultant psychiatrist 1. This was an appropriate action. Mr A was not seen by consultant psychiatrist 1 before his death two days later.

In our opinion, with the benefit of hindsight, consultant psychiatrist 1 could have given more weight to the possibility of a diagnosis of depression. He could have given more consideration to Mr A's lengthy history of depressive illness, as mentioned in the initial GP referral letter.

The trust have responded that Consultant psychiatrist 1 felt that Mr A's notes do not suggest that he had any thoughts of harming his wife from 14 March 2013 to 24 April 2013. As these thoughts were not evident for several weeks Consultant psychiatrist 1 concluded that the intrusive thoughts were not an indicator of underlying severe depression and his diagnosis was reasonable.

Mr A portrayed himself as an evil person and expressed thoughts of debasing himself by taking his clothes off in public. On 29 April he revealed for the first time his thoughts about his wife's infidelity. In our opinion these symptoms, taken together, are better explained as part of an underlying severe depressive illness than simply as "intrusive thoughts".

Mr A faced the challenge of a life-threatening medical condition in the weeks prior to his mental health presentation. There had been two recent hospital admissions for major surgery. He was about to embark on a radical course of treatment for bladder cancer the day after his suicide attempt. All trust staff involved with Mr A's care were aware of the seriousness of his physical health issues, and of its timing in relation to his mental health presentation. However, there is no indication in his records that trust staff gave weight, in reflecting on his diagnosis, to the fact that a major depressive illness, particularly in an older person, can be triggered by the stress of a serious medical condition.

The trust *Record Keeping Policy* dated October 2012 sets out the framework for which all staff are responsible for managing records.

Paragraph 5.6.1 states:

"Records are valuable because of the information they contain and that information is only usable if it is correctly and legibly recorded in the first place; are contemporaneous, kept up to date, and is easily accessible when needed".

Paragraph 5.6.2 states:

"To ensure quality and continuity of operational services all records must be accurate and up to date."

One unusual feature was noted on Mr A's notes on RiO. Entries relating to the MDT reviews on 7 and 8 March 2013 were not recorded and validated on RiO within 3 working days as specified by the trust record keeping policy. The trust internal investigation makes reference to the timeliness of data entry.

7.1 Findings

Mr A was appropriately referred to a consultant psychiatrist for review. The diagnosis and the prescribed olazapine were appropriate given Mr A's presentation.

All staff involved in Mr A's care were aware of his serious health issues and its timing in relation to his mental health presentation. Although depressive illness was included in Mr A's differential diagnosis by consultant psychiatrist 1 on 11 March, in our opinion, with the benefit of hindsight, further consideration of the fact that depressive illness can be triggered by the stress of a serious medical condition may have been appropriate.

The trust have responded that Consultant psychiatrist 1 felt that Mr A's notes do not suggest that he had any thoughts of harming his wife from 14 March 2013 to 24 April 2013. As these thoughts were not evident for several weeks Consultant psychiatrist 1 concluded that the intrusive thoughts were not an indicator of underlying severe depression and his diagnosis was reasonable.

In addition, there is no record that any attempt was made before Mr A's death on 1 May to review consultant psychiatrist 1's earlier 11 March preliminary diagnosis.

The trust record keeping policy states that records must be accurate and up to date. Minutes of MDT meetings were not recorded and validated on RiO within 3 working days as specified by the trust record keeping policy. This is an important omission, since timely record keeping is imperative to enable treating staff to have full overview of the patient's condition.

7.2 Recommendation

The trust should ensure that staff make contemporaneous records about interventions including MDT meetings. This issue should be included in the trust's Quality Monitoring Tool and audited every six months.

8 The Care Programme Approach

In this section we examine the Care Programme Approach (CPA) process to determine whether Mr A was cared for in line with national and trust policies.

CPA is the process that mental health services use to coordinate the care of people with mental health problems. The concept was introduced in 1991, and in 1999 *Effective care coordination in mental health services – modernising the care programme approach* set out the arrangements for all adults of working age under the care of secondary mental health services.

The Department of Health published *Refocusing the Care Programme Approach* in March 2008. This document updates the guidance and highlights the need to focus on delivering person-centred mental health care. It also confirmed that crisis contingency and risk management are integral parts of assessment and care planning.

Trust policy dated November 2010 states that where a service user has more complex needs and characteristics, enhanced care coordination incorporating the requirements of CPA is the framework used to deliver continuous care. People who receive enhanced CPA could experience some of the issues listed below:

- Severe mental disorder with high degree of clinical complexity.
- Current or potential risks, including suicide, self-harm, harm to others, relapse history, self neglect, non-concordance, vulnerable adult, adult/child protection.
- Current or significant history of severe distress/instability or disengagement.
- Non-physical co-morbidity e.g., substance/alcohol misuses, learning disability.
- Multiple service provision from different agencies.
- Currently/recently detained under the MHA, or referred to crisis/home treatment team.
- Significant reliance on carer/s, or has own caring responsibilities.
- Disadvantage or difficulty as a result of:
 - parenting responsibilities;
 - physical health problems/disability;
 - unsettled accommodation;
 - employment issues;
 - significant impairment of function when mentally ill; and
 - ethnicity, sexuality or gender issues.

The trust *Care Coordination/Care Programme Approach Practice Guidance Note* Issue 2 dated October 2012 includes key elements of national policy.

The trust practice note also states:

Paragraph 1.15

“Where an initial assessment is indicative that the service user has enhanced needs (CPA) the assessor will ensure that the initial assessment is developed into a comprehensive assessment of health and social care needs completing the Care Coordination assessment document and recorded in the electronic

care record using the core assessment screens which meets the requirements of CPA. They will also update the initial risk assessment the outcome being recorded as a minimum using the appropriate FACE risk profile. The comprehensive assessment and risk outcomes and formulation will be used to agree the appropriate professional to be the care coordinator.”

Paragraph 5.1

“The care coordinator, through discussion and negotiation with the service user and others, will ensure that a comprehensive formal written care plan is developed, agreed and recorded on the electronic care record (RiO) on the care co-ordination care plan screen.”

Paragraph 5.3

“The care plan will identify the service user’s needs, the resources and actions by individual members of the care team, including the service user and carer and any Lasting Power of Attorney (LPA) (as appropriate) to meet those needs.”

Paragraph 9.1

“For all service users their Care Plan must be subject to ongoing monitoring and review but should be reviewed formally in line with the risk management plan and planned review dates. Frequency of the reviews should be determined by the needs of the service user.”

Trust policy states that service users with enhanced needs can expect:

- to have a care coordinator;
- to have access to health and social care services through one systematic assessment of their health and social care needs;
- that the care coordinator, through discussion and negotiation with them and others, will ensure that a comprehensive, formal written care plan is developed and agreed taking into consideration any advance statement or advance decision to refuse treatment;
- their care plan to be clear and easy to understand and include outcomes that they have determined;
- that any disagreement they have with any part of the care plan will be recorded on that care plan;
- to know who their care coordinator is and what role that person will play in their treatment and care;
- to have the role of their carers recognised, and actively supported;
- to have information on how risks will be assessed and managed;
- to have clear crisis arrangements agreed in their care plan;
- to know who is doing what and when, to have this clearly stated in their care plan, including their comments, and be offered a copy;
- to be offered copies of letters as outlined in the trust’s policy – ‘Sharing letters with service users’;
- to have the care plan reviewed regularly and changed if necessary with their active involvement, including being informed of their right to request a care coordination review at any time;

- to have access 24 hours a day and seven days per week to information and services; and
- to have access to information in a way they can understand in an accessible format appropriate to their needs, including information about their condition and/or treatment, the risks of the treatment and information about available alternatives.

8.1 Findings

Mr A met the criteria so was subject to an enhanced CPA. He was assessed, allocated a care coordinator and had a care plan in line with trust policy. Mr A's care plan was not formally updated after 6 March 2013. However, progress notes were recorded on RiO on all subsequent visits to Mr A. The notes make reference to relevant care issues, such as medication supply or compliance.

The trust internal investigation recognised these findings and made recommendations. The trust had provided evidence that improvements have been made and therefore we make no recommendations here. The trust has ensured that staff are encouraged to identify risk as part of their mandatory training. All staff have now received additional training in care coordination and clinical risk update. The trust provided us with their 2014 Quality Monitoring Tool audit results as evidence.

9 Risk assessment and risk management

In this section we examine the risk management process to determine whether national and local policies and procedures were followed. We find out whether Mr A was risk-assessed in light of his suicide attempt and risk of harm to others.

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice.

The trust's *Clinical Risk Strategy Practice Guidance Note*, which is not dated, states in paragraph 2.2.3:

“Risk should be formulated alongside other problems associated with a service user or patient’s mental disorder”.

The trust *Care Coordination/Care Programme Approach Practice Guidance Note Adult Services – Planned and Urgent Care, Forensic Mental Health and Specified Specialist Services* dated October 2012 states:

Paragraph 6.1

“Risk assessment is a dynamic and ongoing process in the provision of care and treatment to all service users. It is a multi-disciplinary responsibility and the outcome of risk assessment should be formally documented using the approved FACE risk profile as a minimum.”

Paragraph 6.6

“Risk management plans are an integral part of the Care Plan and will be developed when the level of risk is significant, serious or serious and imminent (FACE risk profile ratings scale 2, 3, or 4).”

The trust internal investigation contains a detailed analysis of risk assessments and plans recorded during Mr A’s care by the trust. The analysis is consistent with Mr A’s clinical records, and its conclusions are appropriate. A full risk assessment of Mr A to an appropriate standard was undertaken on 6 March 2013, when Mr A was first seen after a suicide attempt. It included a well-documented history and clinical examination, and was accompanied by a well-completed Department of Health/trust-approved FACE risk assessment and management proforma with an associated care plan.

On 6 March an initial management plan for Mr A was devised, recorded and implemented with immediate effect. It was communicated in writing to relevant clinical teams the following morning. This plan was appropriate and dealt with immediate risk as well as with monitoring and review requirements. In particular, the plan involved daily close monitoring and support as an alternative to inpatient admission. This was appropriate in the circumstances.

In the weeks that followed, staff failed to comply with trust recording policy. They did not formally repeat risk assessments using FACE schedules or formally update Mr A’s care plan. We concluded these omissions were appropriately criticised in the trust internal investigation.

However, there is evidence that immediate risk, particularly of suicide, was systematically reviewed at every contact made with Mr A between 7 March and 30 April. In addition, on the one occasion that Mr A was seen by consultant psychiatrist 1 on 11 March, the clinical notes were to a comprehensive indicating that a reliable clinical assessment of risk was made.

Although Mr A's care plan was not formally updated after 6 March 2013, progress notes made on all subsequent visits to Mr A prior to his death regularly make reference to relevant care management issues, such as medication supply or compliance.

Following examination of Mr A on 11 March, consultant psychiatrist 1 prescribed olanzapine and a short-acting anxiolytic. Given the nature of Mr A's acute symptoms and his differential diagnosis, these medications were appropriate and necessary. An antidepressant was not prescribed. Consultant psychiatrist 1 did not consider depressive illness to be Mr A's primary diagnosis. Some experienced psychiatrists may also have been reluctant to initiate antidepressant medication at this point, but others would have recommended their use in a similar clinical situation. Consultant psychiatrist 1 therefore made an acceptable clinical judgement.

9.1 Findings

It was appropriate to reduce visit frequency towards the end of March 2013 when Mr A was more stable and still attending radiotherapy treatment daily. On 29 April, when Mr A appeared to be relapsing and was more troubled by thoughts about harming his wife, it was appropriate to increase contact frequency to daily.

9.2 Nature and quality of clinical monitoring – access to additional skills

Because of Mr A's significant suicide risk, his treatment plan involved close monitoring of this risk by the clinicians visiting him at home. There is reliable evidence that all trust staff who visited him, over the following seven weeks, both qualified and non-qualified, complied with this requirement.

An implicit part of Mr A's treatment plan was monitoring for changes in his mental state or behaviour that might have significant impact on risk and his treatment needs. In this context, when Mr A complained of "demon thoughts", a prompt request was made for psychiatric review to consultant psychiatrist 1, acknowledging the value of a consultant's skill in mental state assessment and diagnosis. This was appropriate. On 29 April 2013, when Mr A's intrusive thoughts became worse, plans were made for him to be reviewed again by a psychiatrist. This was good practice. Mr A was not seen by consultant psychiatrist 1 before his death two days later.

9.3 Services offered to Mr A

When Mr A was first assessed on 6 March 2013, inpatient psychiatric admission was appropriately considered by trust staff. Their assessment of the pros and cons of admission or community management included awareness of his radiotherapy

treatment starting the following day and knowledge that a daughter-in-law was closely involved and that his family were planning to take him for daily treatment. They knew he lived with Mrs A. Alternatives to admission were discussed with him. The option of management at home with daily mental health service input for further treatment and monitoring was explained to him, and he agreed with this plan. In light of his responsiveness and engagement on 6 March with trust staff, this was an appropriate management plan/service response for Mr A at that time.

The issue of exactly which service team took responsibility for Mr A and for how long was one primarily of trust resources and organisation. The service offered to Mr A was not compromised by the internal organisational issue. Commendable effort was made to ensure continuity of professional contact with joint visits to mitigate the possibly adverse effects of transfer.

A positive feature of the services provided to both Mr A and his family was how to make out of hours contact. Telephone numbers were provided. This important message was repeatedly conveyed. It was entirely appropriate. The trust's investigation report noted that Mr A's daughter-in-law, Ms C, obtained CPN 1's work telephone number. On the day of the incident, Ms C made numerous attempts to contact CPN 1 using the work telephone number to establish the visiting time of Consultant psychiatrist 1. As CPN 1 was on annual leave, these messages were unanswered. The trust has made improvements to ensure that staff provide patients and their carers/family members with the team contact number and crisis team number for out of hours. The trust's new principal community pathways ensure that each patient receives a single point of access number.

The trust's investigation recognised the issues, and the trust has since implemented improvements. The trust updated its *Clinical risk strategy and practice guidance note* in April 2015. We therefore have no recommendations.

The family of Mr A has disputed that any contact numbers were provided to either Mr A or Mrs A. The only contact number available to Ms C was the personal mobile number of CPN 1.

10 Carer's assessment and family involvement

In this section we examine whether Mr A's family were appropriately involved in his care and treatment and if any family members were identified as carers by the trust, and, if so, whether or not a carer's assessment was carried out.

The trust *Care Coordination (Incorporating Care Programme Approach (CPA) Policy* dated November 2010 states:

Paragraph 13.1

"The Care Coordinator is responsible for ensuring all carers who provide 'substantial care on a regular basis' are offered an assessment of their needs; (The Carer and Disabled Children's Act 2000). Where applicable their own care plan will be developed. This can be at the time of the service user's initial assessment, review or any other appropriate point. The assessment may be carried out by the Care Coordinator, a care development worker or support worker or another member of staff involved in the development of the service user's care plan."

The trust internal review criticised the failure to offer or provide a carer's assessment for Mr A's wife, or to offer any more focused assistance. This criticism is endorsed. Mrs A was not in effect offered any services by the trust. Mr A's daughter-in-law, Ms C, made telephone contact with trust staff on more than one occasion and was properly viewed as another key family supporter for Mr A. However, beyond encouraging her to phone them with concerns, the trust does not appear to have explicitly examined or discussed her needs, nor to have determined what her skills were and how she might assist Mr A in partnership with the trust.

The family of Mr A have raised concerns about the lack of support from the trust for the family. They feel that they should have been supported by the trust and included in the care and treatment provided to Mr A. Ms C's contact number was provided on Mr A's records.

10.1 Exploration of marital disharmony

An unusual feature in this case was early flagging of marital disharmony in the GP's referral letter of 6 March 2013, and its resurfacing on many home visits undertaken over succeeding weeks. Quite apart from the "demon thoughts" about harming his wife, which frequently featured in Mr A's mental state, both Mr A and his daughter-in-law Ms C told staff about the marital disharmony. There were instances observed by staff of Mrs A minimising Mr A's symptoms in contrast to her own.

More by chance than for any other reason, Mr A and his wife were sometimes seen separately and sometimes observed together. On his own, Mr A stressed that he did not want his wife involved with his treatment.

At no point did clinicians take a systematic history about their marital disharmony from Mr A or Mrs A or from their daughter-in-law. As a result, staff were not sufficiently aware, throughout the period, of key environmental and emotional factors

that could impact on both Mr A and his wife. As a consequence, staff did not have an effective or appropriate management plan to support either Mr A or his wife on this issue.

In addition, staff were unable to make a reliable assessment of the potential risk to the psychological wellbeing of either Mr A or Mrs A, nor of the risk of self-control being lost – by either party – with a violent outcome. In the context of Mr A's explicit statements about harming his wife, the failure to make such an assessment is remarkable.

The background to these omissions is explored in the Domestic Homicide Review (DHR). Their criticisms and conclusions are endorsed. The DHR further noted that trust staff had not had specific training in relation to domestic abuse, and recommended promotion of the AVA (Against Violence and Abuse) Complicated Matters toolkit and training with all staff.

At a more basic level, there is no indication that a structured approach to assessments and reviews involving individuals and their spouses or carers was standard trust practice.

Good mental health assessment practice should include a preliminary enquiry about whether a patient has a relative/carer/friend who is familiar with them or responsible for aspects of his or her care. If so, an attempt should be made, with the consent of the patient to obtain information from that person. Contact may be face-to-face or by telephone, with timing determined by the clinical circumstances.

10.2 Findings

The trust did not consider the needs of Mr A's carer or family members. This was identified in the trust investigation report and the Sunderland Partnership DHR.

Clinicians should consider the needs of carers. The trust should ensure that its staff work in partnership with carers and family members to address their needs and assess risks. The trust has introduced a "Getting to Know You" process across this service team. We therefore make no recommendations.

11 Interagency working and communication

In this section we examine the communication of the trust with other agencies providing care for Mr A.

The trust's *Care Coordination policy (2010)*, advises:

“...the service user can only benefit from well co-ordinated assessment and planning if there are clear lines of communication between professionals and agencies.”

11.1 GP

Consultant psychiatrist 1 wrote a comprehensive letter to Mr A's GP summarising his assessment, which included a discussion about diagnosis, immediate treatment, risk and arrangements for monitoring including home based treatment with daily reviews. It easily met the necessary professional standards for such a communication.

However, there is no evidence that any further written communication was made by the trust to the GP. In addition, Mr A's initial care plan, prepared on 6 March 2013, was not copied to the GP. There was no communication with the GP when Mr A's mental state worsened at the end of April 2013.

These omissions are serious, particularly since staff knew that Mr A had a serious physical health condition (cancer of the bladder), with complications such as urinary infections, and was likely to have ongoing contact with his GP.

Also, no attempt was made by staff to seek further information about two key issues highlighted in the initial GP referral letter. These were Mr A's history of depressive illness and marital disharmony. Information about both these matters was relevant to Mr A's diagnosis, management and treatment. This represents a significant missed communication opportunity by staff.

11.2 City Hospitals Sunderland NHS Foundation Trust (CHS) and Northern Centre for Cancer operated by Newcastle upon Tyne NHS Foundation Trust

Between October 2012 and Mr A's suicide attempt on 6 March 2013, Mr A had surgery for two life-threatening medical conditions and an assessment for an intensive course of radiotherapy, due to commence on 7 March 2013. This basic information was known to trust staff at their first contact with him.

The initial assessment acknowledged the psychological impact of these medical conditions on Mr A's mental state and presentation. It is surprising, therefore, that no subsequent attempt was made by staff to liaise or seek information either from CHS staff who knew him as an outpatient, or from the radiotherapy team at the Northern Centre for Cancer Care, who were seeing him daily from 7 March onwards.

The DHR found that CHS staff possessed relevant information about Mr A's marital disharmony and observations were also made about his mental state on some occasions. This information may have assisted staff if they had made appropriate enquiry.

Mr A remained under the outpatient supervision of CHS for his medical conditions. CHS management of Mr A may well have been helped by trust information about his evolving mental condition, including suicide risk. The failure of staff to liaise with CHS services was an omission.

Staff knew that Mr A was attending the Northern Centre for Cancer Care five days a week from 7 March to early April. Although Cancer Care staff may not have had much useful information about Mr A's mental state, it would have been sensible for trust staff to inform them about Mr A's suicide attempt and risk management, not least as part of his overall risk management. Trust staff did not do so. Clearly it would have been necessary to seek Mr A's consent for disclosure, but the failure to consider or take such action is criticised.

The family of Mr A felt there was a lack of communication between the agencies involved in Mr A's care. The marital disharmony was communicated on every occasion with Mr A's consultant at CHS. The family have asked why this information was not shared between the agencies.

11.3 Finding

Staff did not liaise with other care providers to explore fully Mr A's health conditions. The trust internal report recognised the lack of communication with Mr A's GP, and recommended that the trust should review this process in its action plan. We recommend that the trust improve its multi-agency working relationships with other care providers. Clinicians should ensure that they liaise with other care providers to obtain a complete history of patient issues.

11.4 Recommendation

The clinicians should ensure they comply with the information sharing requirements of the trust Care Coordination policy.

12 Trust internal investigation and report

The terms of reference for this independent investigation include assessing the quality of the internal investigation and reviewing the trust's progress in implementing the action plan.

In this section we examine the national guidance and the trust's incident policy to determine whether the investigation into the care and treatment of Mr A met the requirements set out in these policies.

12.1 National guidance

The National Patient Safety Agency (NPSA) good practice guidance *Independent investigation of serious patient incidents in mental health services* (2008) outlines three steps in the independent investigation process, two of which are the responsibility of the trust. These are to undertake an initial service management review within 72 hours of the incident being reported, and to complete an internal investigation using root cause analysis (RCA).

The NPSA produced *Root cause analysis investigation tools – Three levels of RCA guidance* (2008). It lists three levels of RCA and states that a level 2 (comprehensive investigation) should be:

“Commonly conducted for actual or potential ‘severe harm or death’ outcomes from incidents, claims, complaints or concerns”.

It also states that the investigation should use:

“Appropriate analytical tools (e.g. tabular timeline, contributory factors framework, change analysis, barrier analysis)”,

and that it is:

“Normally conducted by a multidisciplinary team, or involves experts/expert opinion/independent advice or specialist investigator(s). Conducted by staff not involved in the incident, locality or directorate in which it occurred”.

The trust has a number of policies that concern incident investigation and review. These include *Guidelines for conducting an internal review (with an external assessor) of an adverse/untoward clinical event* (2012) and *A guidance note on the investigation of incidents* (2012).

12.2 Detection of the incident

The police contacted the trust on 1 May 2013 to advise that two people had been found dead at Mr A's address and had been identified as Mr A and his wife.

Ms C told us she also contacted Consultant Psychiatrist 1's secretary on 1 May 2013 to advise Consultant Psychiatrist 1 of the incident.

12.3 The trust internal investigation

On 30 July 2013, the trust commissioned a serious incident investigation into the care of Mr A. The investigation team consisted of:

- an independent investigator (report author);
- a consultant psychiatrist (clinical advisor); and
- a clinical nurse manager (clinical advisor).

The independent investigator was appointed by the trust and the consultant psychiatrist and clinical nurse manager are employed by the trust; however, they did not work in the services being covered by the investigation.

The terms of reference for the investigation included: a review of Mr A's care and treatment and supervision in relation to the implementation of the multi-disciplinary CPA; the adequacy of risk assessments, record-keeping and communication between all interested parties; and whether Mr A's care was in line with statutory obligations and relevant guidance.

The internal investigation panel reviewed Mr A's clinical notes, trust policies and procedures and met with Mr A's son and daughter-in-law, who assisted in developing the investigation terms of reference.

The panel also led an After Action Review (AAR) which took place on 14 August 2013. An AAR is a trust discussion following the event to help the service team review the incident to identify lessons. This review was attended by seven members of staff. Mr A's GP and members of the IRT provided their apologies. The report author told us that the AAR involved a group discussion. Individual interviews were also held with staff.

The investigation report contained a detailed chronology and explored a number of areas, including assessment and management of risk, treatment, care and implementation of the care plan, record-keeping and communication. The final report was completed in December 2013.

We asked the lead author if he encountered any difficulties during the course of the investigation. He told us there were areas of concern regarding the trust systems and process: for example, the care co-ordinator provided the family with her personal mobile number. This resulted in the family being unable to contact the service while the care co-ordinator was on annual leave. Additionally, the lead investigator noted the high workload pressures on clinical staff.

The trust systems and processes regarding record-keeping were also highlighted. The record-keeping discrepancy was due to the manner in which they were writing the notes, which was not in line with the trust process. The trust investigation author noted the trust was very supportive and engaging during the investigation process.

12.4 Analysis

We found the trust internal investigation was conducted in line with trust policy, though not within the identified time scale. The AAR was completed after the 10 working day deadline specified in the trust *Incident policy practice guidance note* dated October 2012.

The trust internal investigation report was comprehensive and addressed the terms of reference. The report authors provided a detailed chronology, relevant benchmarks and analysis of key events.

It made 26 findings. Its conclusions are presented thematically. These include the following.

- Policy and guidance pertaining to standards of care for Mr A:
 - Northumberland and Tyne and Wear NHS Foundation Trust has relevant policies and guidance in place;
 - teams providing care had high level of training compliance; and
 - practice standards not always consistent with policy standards.
- Treatment and care;
 - provision of care to Mr A at enhanced CPA level was appropriate;
 - initial assessment and crisis/contingency care plan by IRT appropriate;
 - weakness in care coordination and compliance with CPA recording policies;
 - no care plans in place, although regular contact, engagement and monitoring;
 - breakdown and delay in medication supply;
 - Mrs A not offered carer's assessment;
 - number of lost opportunities to explore marital disharmony and threats; and
 - no indication that MHA admission to hospital needed.
- Risk assessment and management:
 - decision for review of Mr A by support worker rather than qualified staff member criticised (end April 2013), when he was relapsing;
 - failure to review and update FACE risk assessment/management plan by Older Adults Team criticised, plus poor compliance with care coordinator/CPA policy;
 - use of parallel risk management tool (RAG) by crisis service criticised – not consistent with trust policy on use of FACE; and
 - home-based treatment programme considered appropriate.
- Record-keeping and communication:
 - urgent attempt to contact service by family member failed – criticism of personal mobile as primary source of contact for practitioner;

- delays in recording information by Older Adult Team clinicians; and
- allocation of clinical workload via individual practitioner e-mails criticised.

The internal investigation made 13 recommendations covering these themes (Assessment and Management of Risk; Treatment and Care; Record-keeping and Communication). The conclusions of the trust investigation were sound and we endorse them.

12.4.1 Finding

The trust internal investigation fulfilled the terms of reference, was comprehensive and in line with trust policy.

12.5 Domestic homicide review

The Safer Sunderland Partnership Board convened a Domestic Homicide Review panel and it made the decision that a review should be carried out, since there might be lessons to be learnt from the case in respect of Mr A's mental health history and services provided. The DHR was commissioned in line with the expectations of *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011*. This guidance is issued as statutory guidance under section 9(3) of the *Domestic Violence, Crime and Adults Act 2004*. The case met the criteria set out in paragraph 3.8 of the guidance due to Mr A's act of violence towards his wife.

The DHR report into the death of Mrs A was published in March 2014. It's primary focus was on whether Mrs A was regarded by those services in contact with her or her husband as a potential victim of abuse or violence, rather than on the appropriateness of Mr A's treatment and care. Its findings build on those of the trust investigation. We endorse its conclusions and recommendations in so far as they apply to the trust. We do not seek to repeat the full details of this report, but it is useful to note the DHR's conclusion that "at no stage was Mrs A considered as a potential victim of abuse or violence, and as a result remained outside of all subsequent assessments and decision-making. This is despite the fact that a number of potential indicators of domestic abuse and associated risk were present".

With respect to the trust's contacts with Mr A and his wife, the DHR noted that "any thoughts expressed by Mr A or concerns raised by Mrs A in relation to his thoughts towards her, were seen as a presentation of his mental health" and "there was a lack of depth to the exploration of risk to others and the structured FACE risk assessment was not used as necessary". The DHR further noted that trust staff had not had specific training in relation to domestic abuse, and recommended promotion of the AVA (Against Violence and Abuse) Complicated toolkit and training with all staff.

The DHR identified missed opportunities to ascertain Mrs A's views, and recommended that the trust "ensure that policy and procedures embed the need for carers' and family members' perspectives regarding risk to be explicitly sought".

The DHR found limited information-sharing within and across agencies. It noted that trust staff did not attempt to share information with other agencies involved with the care and treatment of Mr A following his serious suicide attempt. A weakness in internal communication was also found.

13 Progress on implementing action plan

In this section we look at the trust's progress in implementing the action plan developed in response to the internal investigation report.

The report identified three areas for improvement:

- treatment and care;
- risk assessment and risk management; and
- record-keeping and communication.

The action plan contains 13 recommendations. We set these out below under the relevant headings.

We reviewed the documents submitted by the trust as evidence of completion and/or progress with the plan.

13.1 Treatment and care

The trust investigation made three recommendations:

- The trust CPA lead officer will ensure the allocation and subsequent transition of Care Coordinators responsibilities from crisis to other services will be made explicit within the Care Coordination policy;
- The Group management team should ensure a workload analysis study of the older adults team is undertaken. This should include consideration of the degree and appropriateness of delegation to unqualified support workers. This ties into current work being undertaken around Principal Community Pathways examining staffing levels, skills mix, capacity and should be linked into this; and
- The service manager should review the progress of re-prescribing medication along side the monitoring of medication compliance within the older adults team to ensure proactive action that ensures continuity of treatment.

The care of patients was found to default to the crisis team manager as care coordinator. There were found to be concerns from staff about high workloads.

13.2 Analysis

“The trust CPA lead officer will ensure the allocation, and subsequent transition of care coordinator responsibilities from crisis to other services will be made explicit within the care co-ordination policy”.

In August 2014 the trust care coordination development lead e-mailed staff to confirm that the Crisis Resolution Home Treatment Teams (CRHTs) are using flow charts to demonstrate the process. The South Tyneside action plan following care co-ordination audit completed in June 2014 results have been provided to us as evidence.

Minutes of the South Tyneside Older People's meeting held on 5 November 2014 highlighted outstanding issues relating to care co-ordination and how these are being monitored:

"The group management team should ensure a workload analysis study of older adults team is undertaken. This should include consideration of the degree and appropriateness of delegation of activity to unqualified support workers. This ties into current staffing levels, skill mix, capacity and should be linked into this. A report should be available within three months and the outcome discussed and assured with local commissioners".

In January 2015 the Principal Community Pathways (PCP) in Sunderland and South Tyneside became operational. The introduction of the PCP in Sunderland and South Tyneside is regularly reported to a PCP board attended by commissioners.

This action was completed in January 2015, one month after the scheduled implementation date:

"The service manager should review the process of re-prescribing and resupplying medication alongside the monitoring of medication compliance within the Older Adults' Team to ensure proactive action that ensures continuity of treatment."

The trust asked CPNs, consultants and medical secretaries how they support medication treatments when a prescription is due to expire, and established that different methods are used depending on individual preference.

At the team meeting on 5 November 2013, clinicians were reminded that they must ask to see the patient's medication at each visit to ensure compliance. This is the standard for this team; however, there is also a backup system with all prescriptions kept centrally, so that the team manager has oversight of the current position if a member of staff is on annual leave or sick leave.

13.3 Risk assessment and risk management

The trust investigation made three recommendations:

- All patients on an enhanced level of CPA, within the Older Adults Service should have an up to date formal written care plan that provides a framework for the patient, carers (as appropriate) and all clinicians, their individual risk assess, reviewed and updated in accordance with the standards set out in the trust policy/practice guidance note relating to risk assessment;
- The trust is already looking at adjusting current risk training re suicidality and the wider harm reduction agenda. Learning from the case will be used to inform the development of this programme of training; and
- The service manager will ensure the RAG tool used by the Crisis Service will be formally evaluated in the context of its relationship with other risk tools.

Subject to the outcome of the review the tool will be integrated into the trust risk policy/practice guidance note (or rejected).

13.4 Analysis

“All patients on an enhanced level of CPA, within the Older Adults’ Service, should have an up-to-date formal written care plan that provides a framework for the patient, carers (as appropriate) and all clinicians, their individual risk assessed, reviewed and updated in accordance with the standards set out in the trust policy/practice guidance note relating to risk assessment.”

Staff are encouraged to identify risk, and this is part of the trust’s mandatory training policy. A need has been identified for staff to receive further training in the way they raise issues. All staff received additional training in care coordination/clinical risk.

This action was achieved within the scheduled deadline, with the training programme completed in November 2014, eight months after the deadline of March 2014.

“The trust is already looking at adjusting current risk training re suicidality and the wider harm reduction agenda. Learning from the case will be used to inform the development of this programme of training.”

The internal investigation found a lack of depth to the exploration of the risk to others. In response to this, the trust has updated the clinical risk strategy. This strategy sets out the trust’s requirements relating to mental health staff working with service users and carers and other service providers to assess and manage risk. Subsequently, the strategy has been integrated into a number of trust policies and practice guidance notes. These set standards and requirements for risk assessment and management service user pathways. The *Clinical risk strategy practice guidance note* was updated to incorporate the changes to the clinical risk strategy. The trust challenging behaviour group is developing additional practice guidance notes regarding clinical risk formulation for service user-specific group/diagnosis. This will be supported by specific training for relevant staff. This is an ongoing programme.

This action was completed in March 2015, one month prior to the scheduled deadline of April 2015.

“The service manager will ensure the RAG tool used by the crisis team will be formally evaluated in the context of its relationship with other risk tools. Subject to the outcome of the review the tool will be integrated into the trust’s risk policy/PNGs (or rejected).”

The trust evaluated the RAG tool and determined it was not be used as part of the MDT pro-forma. On 31 January 2014, the crisis team nurse consultant circulated an e-mail to all crisis team staff confirming the change, and the change was documented in team meetings. Staff continue to use the traffic light system on crisis team boards as a visual aid to assist the home treatment function of the service.

The FACE risk tool continues to be the main mechanism by which staff assess and update their understanding of clinical risk. The new MDT pro-forma has been circulated and adopted by each CRHT as well as the most recent RAG guidance for new starters or students with effect from 3 February 2014.

This action was completed in January 2014 as scheduled.

13.4 Record-keeping and communication

The trust investigation made three recommendations in relation to record keeping and communication:

- Care coordination lead to pick up with the RiO team and consider how best to take forward;
- The service manager should ensure an assurance measure will be operational that confirms clinical work that has been allocated through electronic communication has been received and will be acted upon;
- Patient Safety Committee to consider this issue and agree the best system for ensuring that when a member of staff is not available due to absence, callers are directed to an appropriate contact number for their call to be answered to enable them to either leave a message or have their query dealt with.

13.4.1 Analysis

“Care co-ordination lead to pick up with the RiO team and consider how best to take forward.”

The care co-ordination lead clarified that a patient record can be closed on RiO through informing the senior information officer. The senior information officer will close referrals, CPA episodes etc., and will also register the date of death and ensure that all records are closed.

Information regarding accessing patient records after death was circulated via a “Spotlight on Safety” message in the chief executive’s bulletin of 11 February 2014.

“The service manager should ensure an assurance measure will be operational that confirms clinical work that has been allocated through electronic communication has been received and will be acted upon.”

Previously within Older Person’s Community Mental Health Team (CMHT) specifically in relation to planned out of hours or weekend home visits, the allocated clinician would discuss visits directly with the IRT worker. When weekend visits are required there are four CPNs who cover the weekend. The patient or patients who required a visit would be identified and their names recorded on the crisis board. All four CPNs and appropriate team leads would be e-mailed the visit details. In the event of sick leave, the alternative CPN would ensure the patient is seen. If both CPNs were unavailable on the same day, the Crisis Team and the Adult Home Treatment team would support the visit.

A computer file was established that could be accessed by all clinicians covering IRT duty. All patient visits were placed into the file with comments in relation to the visit, e.g. safety concerns. However, a review of this system highlighted concerns and therefore a new process has been established whereby the e-mail process has been strengthened by ensuring the team manager and clinical lead receive all e-mails. For weekend visits, crisis team staff must contact the IRT duty worker by telephone.

Any messages from patients at weekends or after hours are emailed to clinicians and the team leads. Clinicians have been reminded of this in their team meeting. A copy of the minutes from the South Tyneside Old Persons' CMHT meeting on 5 November 2013 has been provided as evidence.

Information regarding communication between individuals and teams about patients, staff using RiO as a message board and of the need to speak directly to the person concerned was featured in a "Spotlight on Safety" message in the trust bulletin on 6 August 2014.

A similar message was featured in the bulletin on 21 January 2014, in which staff were reminded of the importance of communicating important information face-to-face and not to reply on e-mail or RiO.

"Patient Safety Committee to consider this issue and agree the best system for ensuring that when a member of staff is not available due to absence, callers are directed to an appropriate contact number for their call to be answered to enable them to either leave a message or have a query dealt with.

"The Crisis Service/Older Adults' Team should receive refresher training in the area of information sharing utilising this case as a basis for reflective learning."

A local plan for the team has been put in place which incorporates the requirement that patients and relatives are not given individual clinicians' mobile numbers and are provided with the team contact number in working hours and the crisis team number out of working hours. If a patient contacts the department, clinicians will be e-mailed. Clinicians are required to respond to the message at the earliest opportunity. Any urgent messages are passed to the duty worker to speak to the patient or relative; subsequently, the appropriate clinician should be contacted and the treating team e-mailed to confirm the details of the conversation.

A buddy system is in operation to be used in instances of sick leave or annual leave. CPNs use this buddy system by requesting a colleague to oversee their caseload. In the case of annual leave, an appropriate handover must happen. The buddy CPN's name must be on the booking-out board for the administration team to clearly identify who is covering the caseload. When medical staff are on annual leave or sick leave, the medical secretaries will e-mail the CMHT with details of the appropriate medical cover. Where possible, the covering medical staff's availability is included to ensure clinicians are aware of the availability for prescriptions and medical advice.

The trust patient safety committee agreed this local action plan on 7 November 2014. It has been confirmed that under new PCP developments, patients will be given a single point of access number to contact the service on.

13.5 Additional recommendations

The trust investigation made three additional recommendations:

- Within two months the group management team should review the service risk register (including the time since the item was placed on the register), the mitigating actions relating to completion of RiO governance standards and identify what further actions (in the context of the other recommendations identified in the report) are required to ensure the required standards are achieved;
- The 'Getting to Know You' process is currently being rolled out across the team. Service manager to provide assurance that progress is being made in this area: and
- Service manager to review processes to ensure staff are complying with the copying letters to patients policy.

13.6 Analysis

"Within two months the group management team should review the service risk register (including the time since the item was placed on the register), the mitigating actions relating to completion of RiO governance standards and identify what further actions (in the context of the other recommendations identified in this report) are required to ensure the required standards are achieved."

The senior nurse planned care confirmed the risk is always examined with staff during regular clinical caseload supervision. This is incorporated in the trust *Clinical supervision and peer review policy NTW (C) 31*.

"The 'getting to know you' process is currently being rolled out across the team. Service manager to provide assurance that progress is being made in this area."

The community clinical manager confirmed the getting-to-know-you questionnaires are being offered and completed for all carers of newly referred patients to the team, including those referred who have been recently discharged from inpatient services. Carers' packs are also being distributed. The "Getting To Know You" details are recorded onto RiO by clinicians.

"Service manager to review processes to ensure staff are complying with the copying letter to patients policy."

Administrative staff send letters and record this information on the patient record; these are copied into viewed images. This current standard way of working ensures

that patients' views are sought about receiving letters and sharing information with relatives.

13.7 Finding

An action plan was developed to take forward the recommendations. The trust has provided evidence of completion of the action plan.

14 Predictability and preventability

In this section we examine whether the incident could have been predicted or prevented.

14.1 Predictability

We assess predictability based on the following principle:

The homicide would have been predictable if there was evidence from Mr A's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

Mr A spoke about thoughts of harming his wife, but at no point disclosed plans to do so. His thoughts on this issue were repeatedly explored, and at no point did he reveal that he had plans to kill her. He was asked by staff on both 29 and 30 April (the day prior to the incident) about plans to harm his wife and he denied them. Staff had no information from Mr A or his wife or daughter-in-law of any previous incident when he had caused her physical harm.

When examined on 29 and 30 April, Mr A was not obviously psychotic. He was cooperative with staff. He agreed to being visited again the following day. At the end of the home visit on 30 April 2013, Mr A left the house to attend the GP surgery.

Based on this evidence, the incident on 1 May 2013 when Mr A killed his wife was not predictable.

14.2 Preventability

We assess preventability based on the following principle:

The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so.

Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

Although there were serious weaknesses by the trust and to some extent other services in their lack of rigour in exploring the potential risk to Mrs A, there is no evidence to suggest that any specific alternative course of action by the trust could have prevented the incident, given that Mr A denied plans or making any immediate threat to kill his wife when seen on 29 and 30 April 2013. Mr A could not be detained, because he did not meet the criteria of the MHA.

We found no evidence to indicate that staff had the knowledge, opportunity or means to prevent the homicide from taking place.

Team biographies

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its highest-profile investigations and reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations and individual management reviews. As head of training, Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people.

Dr Peter Jefferys

Peter is an experienced consultant psychiatrist specialising in old age and a former trust medical director. He is a non-executive director for Norfolk and Suffolk NHS Foundation Trust. He has investigated unexpected mental health deaths for health authorities, the Mental Health Act Commission and the Care Quality Commission, and conducted extensive suicide audits. A former advisor to the Parliamentary and Health Services Ombudsman, he chairs the Medical Practitioners Tribunal Service and the General Medical Council Fitness to Practice Panels and serves on mental health review tribunals.

Gemma Caprio

Gemma is a senior consultant at Verita and is based in the Leeds office. Gemma has gained extensive investigative and governance experience within the NHS, having worked in primary care, at an acute trust and at the North West Strategic Health Authority, supporting the transition from the North West Strategic Health Authority to NHS England and the commissioning and publication of mental health homicide investigations.

Throughout her career Gemma has supported organisations and delivered projects specialising in patient safety and clinical quality.

Recently Gemma assisted the NHS England (North) chief nurse co-ordinating the regional response to the Morecambe Bay independent investigation into maternity services.