Chronology

This chronology has been constructed utilising the chronological information from all the IMRs submitted to the panel

Date	Source of Information	Family Contact - Adult	Comments
November 1994	GP		First signs of ADULT B illness were present. ADULT B presented with symptoms of [redacted] was commenced on [redacted]. The follow up from the GP did not happen and there some concern expressed by GP partners about ADULT B behaviour as ADULT B had significant side effects. ADULT B was then referred to a consultant psychiatrist 1 and the medication was discontinued. ADULT B had become slightly [redacted], and was considered to have either a [redacted] or [redacted]. ADULT B was drinking excessively consuming a bottle of wine every two days
January 1995			When reviewed, ADULT B was described as having reduced her alcohol intake and appeared improved, ADULT B was feeling more settled, thinking rationally about various stresses and was no longer attributing them all to her husband. ADULT B continued to request marital therapy and noted she would have liked her husband to be more supportive in their relationship. ADULT B was noted to have had some counselling. ADULT B was described as not getting on with this consultant and was referred to another consultant psychiatrist.
24 January 1995	GP		The GP notes record on 24/01/95 ADULT B was anxious and had gone to a solicitor to make her friend her next of kin under the Mental Health Act, rather than her husband and to see whether she could make sure consultant psychiatrist 1 never treated her again.
January/ February 1995	Consultant Psychiatrist 2		ADULT B saw consultant psychiatrist 2. There had been a reoccurrence of [redacted] symptoms attributed to domestic stress. ADULT B son was diagnosed with autism. There was an exacerbation of pre-existing marital problems. ADULT B reported wider problems within family, particularly with regard to her sister. ADULT B is noted to have talked about worrying her [crime related - redacted] (this was established as factual information). There were classic symptoms of [redacted] present and heavy drinking of

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			wine
November 1996	Consultant Psychiatrist 2		Consultant psychiatrist 2 wrote to ADULT B GP with an update. ADULT B seen eight times since last update letter. It is noted there was no evidence of [redacted]. It was concluded ADULT B problems were a consequence of [redacted] and a stressful lifestyle.
December 1996	GP		At a GP consultation it is noted ADULT B stopped seeing consultant psychiatrist 2 as she was feeling better. Consultant psychiatrist 2 gives his opinion there is no evidence of [redacted], and believes ADULT B had [redacted] syndrome rather than a [redacted] episode. This may have been a more acceptable diagnosis for ADULT B who expressed concern what a [redacted] diagnosis might mean for her career.
2000	GP		At a GP consultation, ADULT B discusses relationship problems and work difficulties. ADULT B was referred to the practice counsellor. In July 2000 ADULT B is referred to consultant psychiatrist 3, who makes one assessment and refers ADULT B to RELATE. ADULT B had period of time off work, returning in August 2000.
January 2009	GP		ADULT B consulted her GP about psychiatric problems. ADULT B was referred to consultant psychiatrist 4 at CFT [redacted] Unit; the outcome to this is unclear.
December 2010			By December 2010 ADULT B had a number of chronic illnesses, including [redacted], [redacted], [redacted], [redacted] and [redacted]. At this time ADULT B had a [redacted] which was normal. ADULT B was unhappy with the outcome and was worried she had [redacted] and ADULT B requested a second opinion
February 2011	Emergency Department		ADULT B was seen in the Emergency Department (ED) there were concerns about a [redacted]; ADULT B had some difficulty with her [redacted], a [redacted], [redacted].
March 2011	Stroke Clinic		ADULT B was followed up in the [redacted] clinic as her symptoms lasted over seven days. ADULT B had other concerns about her health, [redacted] and concerns about the stress of work necessitating time off work; this led to ADULT B decision to retire from GP practice in September 2011. The loss

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			of ADULT B career and role may have been a precipitating event in ADULT B developing a [redacted]. ADULT B has identified she did not cope well following retirement and found it hard to fill her time.
May 2011	Police		Adult B retires from general practice
April 2012	GP		ADULT B had a GP consultation. ADULT B was noted to have a reoccurrence of [redacted]; [redacted], [redacted], [redacted], [redacted]. ADULT B was commenced on [redacted].
16 May 2012	Emergency Department		ADULT B was seen with ADULT A at the ED by [redacted] after taking an overdose of [redacted]. After this assessment ADULT B returned home with the support of ADULT A
26 July 2012	Consultant psychiatrist		Consultant psychiatrist 5 in private practice received call from ADULT A 'out of the blue' at 19:00hrs. He *said "I'm desperate I think she is acutely [redacted]"*. ADULT B was willing to see consultant psychiatrist 5. When asked why ADULT A had not contacted the NHS mental health service he said ADULT B was opposed to this; she had two previous encounters, and fell out with both psychiatrists. ADULT B believes she was unhappy about only one psychiatrist. Medication was prescribed and given that night. ADULT A described to consultant psychiatrist 5 he did not want ADULT B referred to NHS because his wife would be so angry with him. Consultant psychiatrist 5 understood this as ADULT A being concerned about damaging his relationship with his wife. In interview ADULT B was guarded. Consultant psychiatrist 5 stated to both ADULT B and ADULT A if she was not going into hospital it had to be a condition of care that ADULT B was never left alone.
30 July 2012	Consultant psychiatrist		Consultant psychiatrist 5 made the GP aware of the consultation with ADULT B. Consultant psychiatrist 5 was clear in her diagnosis and detailed the extent and type of ADULT B [redacted] and crucially that she had been acting on these [redacted]. In her letter consultant psychiatrist 5 commented on ADULT B having [redacted] believing she was bankrupt and the house was going to be repossessed. As a result she packed her clothes into bin bags and put them in the car and later the garage. ADULT B dismissed the cleaner and gardener saying there was no money to pay

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			them. ADULT B turned off the hot water to save money and she refused to sign a 'Deed of Gift' for their son to put down a deposit on a home. ADULT B was shopping in cheaper supermarkets and saying there was no food in the house when in fact there was. ADULT B expressed the view her husband was going to leave her. Her evidence for this was toothpaste and toothbrush in his car. ADULT A stated he was going to the dentist. ADULT B also believed she had been poisoned with carbon monoxide from faulty central heating system in her home. ADULT B is described as being deliberately guarded as she was concerned she might be sectioned and admitted to hospital. ADULT B had stopped [redacted] and [redacted], ADULT B was not driving due to poor concentration; she was agitated and picking at her skin. The letter concluded ADULT B was [redacted] with [redacted], in perpetual state of [redacted], with classic symptoms of [redacted] present. Consultant psychiatrist 5 advised if ADULT B is unwilling to cooperate and take medication consideration needs to be given for hospital admission.
9 August 2012	Consultant psychiatrist		In the evening ADULT A rang consultant psychiatrist 5 saying ADULT B won't leave the car. ADULT B was saying she was not safe to go in the house, she had refused medication, and consultant psychiatrist 5 advised as ADULT B was outside in car to make a phone call to police, and they would consider Section 136 of Mental Health Act (MHA) 1983(07). Later that evening ADULT B was detained on a Section 136. The clinical notes record whilst ADULT B and her sister in law were walking, the sister in law tried to drag ADULT B back from cliff edge and ADULT B tried to jump out of the car. At 23:14 there was a MHA assessment and ADULT B was admitted to [redacted] Ward at [redacted] Hospital under section 2 of MHA 1983(07). Admitting medical staff note ADULT B husband is supportive but possibly due to her illness there is friction in the relationship. ADULT A reports ADULT B spitting medication down the toilet. Consultant psychiatrist 5 spoke to ADULT A later that night and the following morning, establishing ADULT B was safe in hospital. On the Monday consultant psychiatrist 5 faxed all reports through to the CMHT consultant psychiatrist for the [redacted] CMHT.

Date	Source of Information	Family Contact - Adult	Comments
9 August 2012	Police	Adult A calls requesting police assistance. Adult B has tried to commit suicide at location [redacted]. Sister in law has got her into car and on journey home Adult B has tried to climb out of car. She is now outside their home refusing to go inside. Adult A has spoken to her psychiatrist who has advised police be called.	Adult B detained by police under section 136 MHA 1985 and taken to [redacted] for assessment. Admitted to [redacted] Ward
09 August 2012 - 11 September 2012"	[redacted]		ADULT B remains on the ward under Section 2. ADULT B was treated with [redacted] medication and [redacted] medication. The presentation described by consultant psychiatrist 5 is in marked distinction to the comments made by medical staff while on the ward when admitted, where a view was expressed "*[redacted]."* ADULT B was guarded in what she would disclose and the notes comment ADULT B as "unwilling to discuss/disclose how she is feeling
August 2012	[redacted]		The ward request a care coordinator from the [redacted] and one is allocated on 23/08/12.
02/09/2012	[redacted]		A disclosure was made to ward staff about ADULT A during one to one time requested by ADULT B. ADULT B spoke about recently finding out her husband had opened a savings account in his name only and she was concerned her name was not on it. ADULT B was asked about her relationship with her husband as on admission she felt her husband was having an affair. ADULT B stated they had been together a long time and her husband was coming up for retirement and she was worried what will happen then.
4 September 2012	[redacted]		The [redacted] attended the ward round to meet ADULT B and her husband. Documentation records a diagnosis of depression with [redacted] symptoms. On this date Section 2 is rescinded.

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September 2012	HTT		ADULT B was on leave from the ward and supported by HTT. Leave was agreed on 11/09/12, during this period ADULT B finds being at home difficult.
13 September 2012	HTT		ADULT B is visited and is described as not doing well at home by herself, HTT planned with the ward for ADULT B to spend time on ward during day and home at night when her husband was present.
17 September 2012			ADULT B is brought back to ward by husband – ADULT B got up during night and took herself to [redacted] in order to jump off the cliff. ADULT B is clear she did not want to come back to ward, but acknowledged she had suicidal ideation at time of going to [redacted].
October 2012			ADULT B is assessed as having [redacted] with [redacted] improving and leave continued with HTT follow up.
10 October 2012	HTT		HTT made a home visit. ADULT B was observed to pick at both her arms and lips throughout the visit. ADULT B acknowledged an awareness of doing this and reflected the frequency of her picking varies according to her stress levels, but she spoke in vague and ambiguous terms about why this may have increased since returning home. The content of ADULT B speech is noted as lacking any meaningful or specific content, with ADULT B being easily led by questioning and there being a high risk of her simply agreeing with and reflecting back the questions being asked. ADULT B described on going thoughts and fears about her husband leaving her and a preoccupation with legal proceedings she is undertaking against her former GP practice. ADULT B stated her approach to this was causing friction between herself and her husband. HTT staff questioned if ADULT B was masking symptoms and or making efforts to present as well as possible.
6 November 2012			At ward round, ADULT B discharge is agreed. ADULT B has been an inpatient since 10/8/12. ADULT B diagnosis was given as depression with [redacted] and [redacted], [redacted] with [redacted] symptoms. The CPA level is agreed as requiring enhanced (although this was called CPA). ADULT B has an allocated care coordinator and was given her contact number. ADULT B is advised not to drive and to inform DVLA regarding her admission. Risk of noncompliance with prescribed medication was noted

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			with an increased risk of relapse of her illness - this is assessed as moderate risk. ADULT B was advised not to drive until she had been cleared fit to do so by DVLA. ADULT B agreed to inform them and await their decision as to the date when she might start driving again. Follow up arrangements are agreed as: • CPN to see ADULT B on Monday 12/11/12 • Social inclusion worker will then visit ADULT B on 14/11/12 • Initial support plan – HTT continue to provide support for brief period prior to discharge back to CMHT
8 November 2012	HTT		After discharge from the ward ADULT B was seen by HTT at home on 08/11/2012. During this visit ADULT A telephoned while HTT present. ADULT B likes to speak to her husband a couple of times a day for reassurance; ADULT B told HTT ADULT A is getting fed up with it every day. ADULT B was complaining about hair loss, she was advised this is an initial side effect of her medication which usually wore off. Handover to [redacted] was planned for this day, the care coordinator planned to visit on Monday 12 November 2012 and the social inclusion worker on Wednesday13 November 2012. ADULT B was given the out of hours service telephone number to call if she felt she needed extra support.
9 November 2012			ADULT B is detained by police on Section 136 of MHA 83(07). ADULT B was found sitting at [redacted] in the rain. ADULT B talked about being upset by reading letters from her [family- redacted], feeling guilty for not giving her support when her [family – redacted] had an accident. ADULT B had thoughts about jumping off cliff, mostly prompted by worries her husband was going to speak to a solicitor seeking divorce. ADULT B did not act on thoughts of self-harm due to religious beliefs. Assessing staff noted there was no evidence of [redacted] thoughts, ADULT B wanted to go home and was accepting of HTT support. The assessing staff spoke with ADULT A, who was surprised at the events as he felt ADULT B was improving and the previous day had been good, they were planning their holiday. The assessment concluded ADULT B was not detainable under Mental Health legislation so ADULT B should go home with support from ADULT A who agreed to collect ADULT B and take her home. The plan was for HTT to

Date	Source of Information	Family Contact - Adult	Comments
			support ADULT B with home visits the next day.
9 November 2012	Police	Adult A reports Adult B as a missing person. Adult A states Adult B is depressed and has recently been released from [redacted]. He last saw her at 08:30 and returned from work at 17:00 to find her and her car gone.	Immediately assessed as high risk missing person. Adult B found in her vehicle at [redacted]. She was detained under s.136 and taken to [redacted]. She was assessed but not detained and returned home.
10 November 2012	HTT	Community nurse has called on Adult B at location B by appointment and is getting no reply. She is concerned as Adult B has severe [redacted] having recently been released from hospital. She can see discarded medicine boxes through window.	HTT make the home visit as agreed after the previous day's events. ADULT A joined them at the end of the visit. ADULT B appeared anxious and perplexed, frequently scratching/picking at her skin, troubled and uncomfortable. ADULT B identified yesterday was challenging, and admitted to searching though her husband's files to find evidence he was planning to leave her. HTT staff felt ADULT B mood was difficult to assess, ADULT B describes experiencing overwhelming emotions she is unable to control, prompting her to drive to [redacted], although was able to reign in self-harm thoughts, and called her husband. ADULT B felt her husband was likely to grow tired of her, that he is fitter, more attractive and has aged better than her. Risk was assessed and ADULT B denied on-going thoughts on [redacted] or [redacted]. ADULT B stated she had become distressed by finding items in husband's files she felt demonstrated he had not been honest with her. ADULT A stated he was concerned despite on-going encouragement to call services ADULT B was resistant to do so. ADULT A was also concerned ADULT B had voiced concern about issues which were resolved, namely asking if he would be staying at home last night, making reference to clothes being moved, concerns police may be looking into their finances. ADULT B continued to present with high level of unpredictable impulsive suicidal acts. The agreed plan of care is for the HTT to visit the next day, a joint visit was planned for the Monday with the care coordinator, and the social inclusion worker to visit on Wednesday, HTT and ADULT B to develop prompts for distraction activity and seeking support at times of increased distress.

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11 November 2012	HTT		When HTT visit the next day, 11 November 2012, ADULT B remained troubled. ADULT B voiced concerns her husband was planning to leave her. ADULT B was encouraged to consider the reassurance her husband offered previous day. ADULT B felt it was good to hear, making reference to it being offered in front of staff. ADULT B stated her husband is more critical of her lack of function when they were alone. HTT staff tried to explore this further. ADULT B stated she could understand why professionals have previously considered her 1 suspicious, paranoid or over anxious and she wished to make it clear her fears were not a figment of her imagination and her husband's behaviour, the emotional distance and their relationship has altered.
12 November 2012			The care coordinator made a home visit. ADULT B did not answer the door. When checking round the property there was no sign of ADULT B. A pile of empty medicine boxes on the bed were visible. Police were called for welfare check. ADULT B was not in the property. Attempts were made to contact her husband. ADULT A phoned the care coordinator to report ADULT B was on cliffs at [redacted], and the police were informed. Police detained her using Section 136 MHA 1983(07), ADULT B was found standing next to the cliffs.
12 November 2012			A Mental Health Act Assessment (MHAA) was undertaken after the Section 136 detention. ADULT B stated she had a small row with her husband over car keys and was worried about; finance, concerns about tax, worried her husband was having an affair and planned to leave her. ADULT B spoke about finding a card to her son from a previous girlfriend in her husband's file and mentioned vaguely she may have misinterpreted the situation at the time. Assessing staff spoke with ADULT A who stated he was supportive of ADULT B returning home but voiced he was not as keen as last time. ADULT A agreed to support the assessing team's decision as he did not think ADULT B being in hospital was beneficial and it made her anxiety worse, so agreed HTT support at home was appropriate. ADULT A also stated ADULT B was monitoring his movements 24hrs a day and he was finding this restrictive. ADULT A could not say whether ADULT B was

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			concordant with medication. The outcome of assessment concluded she was not [redacted], but had [redacted], overvalued ideas with regard to her husband, and detention in hospital under MHA was not required because risks were reduced at that time as her husband was happy to have her back home and provide support.
12 November 2012	Police		Police force entry and Adult B not present. Established that Adult B had spoken to staff at Adult A's surgery an hour earlier. Police spoke to Adult B on her mobile. She stated she was walking on [redacted]. Adult B found at [redacted], detained under s.136 MHA and taken to [redacted]. [redacted] later contacted and declined due to patient confidentiality to discuss what had happened with Adult B.
14 November 2012	Social Inclusion Worker		ADULT B next had a visit on 14.11.12 from the social inclusion worker. ADULT B and the worker looked at various activities. Thursday and Friday were identified as the most difficult days as her husband was on call and away for long days.
16 November 2012			ADULT B requested no HTT visits over the weekend as she would be at home with her husband.
20 November 2012	HTT/Care Co-ordinator		HTT and the care coordinator make a joint visit for review. ADULT B reported some improvement and had less fixed ideas. Initially ADULT A was present due to ADULT B asking him to stay but he was ready to go out on his bike ride. ADULT B became quite anxious about this but rationalised this by stating he may have an accident and she worries. ADULT A reported some overall improvement but stated he does have to reassure her he is going to come home and not leave her, he felt this was not such a fixed belief as previously. This was discussed with ADULT B who agreed she does get anxious when he goes out but she does feel more reassured he will return. They had been making plans for Christmas and were hoping to go away in the New Year on a skiing holiday. ADULT B reported making plans for the future made her feel more positive about the future and more

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			secure in her relationship. HTT plan to visit on 22.11.12, as their last visit and the care coordinator would visit on Monday 26.11.12.
22 November 2012	HTT		At the next planned visit HTT found ADULT B continued to hold anxieties about her husband leaving and she recognised this was putting strain on the relationship. ADULT B described what she believed were real triggers, including ADULT A setting up a separate bank account solely for himself. ADULT A explanation was for tax reasons but ADULT B expressed little confidence this was true. At this visit ADULT B was concerned about [redacted]. HTT staff talked about RELATE to address the issue of trust between them. ADULT B agreed they have used RELATE in the past helpfully; but at this time didn't deem it suitable. ADULT B spoke about her faith and not undertaking these activities. HTT booked a future OPA with consultant psychiatrist to enable ADULT B to discuss [redacted] and driving issues. HTT liaised with the care coordinator on Monday 26.11.12.
26 November 2012	Care Co-ordinator		A home visit by the care coordinator took place. ADULT B was keen to drive again, keen to start activities, and felt ADULT A was getting short tempered with her for not taking on the tasks she normally does, i.e. the shopping. ADULT B reported the fears about her husband leaving were still present, and their relationship was a little strained, not helped by the physical difficulties she described in responding to his advances which she believed were caused by the medication. ADULT B was keen to know when medication would be reduced although aware this needed to be carefully balanced against the risk of self-harm. ADULT B was asked to call HTT that night to ensure she was comfortable with the process in the hope this would make her more likely to use them if needed. ADULT B discussed looking forward to her skiing holiday, admitted it was with a good friend who is very glamorous, which brought its own fears. At 20:08 ADULT B called HTT and sounded well and positive.
27 November 2012	HTT and Care Co-ordinator		HTT had a discussion with the care coordinator, and a decision to close and discharge from HTT was made.
30 November	Social		ADULT B had a home visit from the social inclusion worker. ADULT B was

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2012	Inclusion Worker		concerned about not driving and this is limiting her ability to do activities.
4 December 2012	Care Co-ordinator		Care coordinator saw ADULT B with the consultant psychiatrist. ADULT B described feeling; a lot better, energy good, concentration 'not too bad', denied thoughts of self-harm. ADULT B is described as lacking in insight into past and why others would be worried. ADULT B had on-going worries re her pension, settlement of financial arrangements at previous practice and whether her husband might leave her. The notes comment the impression formed is that these are part of her depressive illness and seem like anxiety related ruminations. No [redacted] symptoms or [redacted] symptoms noted. The plan of care was to reduce [redacted] to 150mgs daily, continue other medication with on-going support from care coordinator and social inclusion. ADULT B was to use www.moodscope.com to monitor whether changes in her medication were affecting her mood for better or worse. The plan was to gradually reduce medications over time cautiously. ADULT B was considered fit to drive, she was asked to let DVLA know she was in hospital. ADULT B was asked to consider psychotherapy.
11 December 2012 to 15 February 2013			ADULT B had four visits from the social inclusion worker. Over the Christmas period ADULT B did not want to pursue activities but had plans to go to the gym, and do pilates at the village hall. ADULT B's sons were visiting at Christmas and ADULT B had plans to go away with her husband around early January 2013. ADULT B had an appointment to see her GP on 13/12/12 and after this she was requested to send the necessary documents to the DVLA informing them of the situation with the request to be allowed to drive. In the contact with social inclusion worker on 23.01.13 it was noted ADULT B has not started work on occupying her days as she was experiencing anxiety from her recent holiday and had anxiety about a planned holiday where ADULT B and her husband will be on separate holidays. Diversion techniques were discussed and a plan to visit a group of her choice was discussed to try to establish a focus, make new social friends, to help her with her confidence and her recurring thoughts around her relationship with her husband. At the appointment on 01/02/13 it was noted ADULT B had made some progress. ADULT B had contacted two

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			groups; the women's institute and another women's group for a social aspect of her recovery. ADULT B had also participated in a learning poker group, and had thoughts about becoming a magistrate which ADULT B had been considering on and off for a while. ADULT B thought working for citizen's advice bureau would be too much. On the visit on 12/02/13 ADULT B had engaged in pre-arranged activities with women's group and the women's institute, ADULT B had also looked in to citizen's advice bureau voluntary work and agreed to follow this up herself. At this point ADULT B continued voicing anxiety about a planned holiday where she and husband will be parted. Between 11/12/12 and 14/02/13 the care coordinator cancelled two appointments, 17/011/13 and 31/01/13.
14 February 2013			When the care coordinator next visited on 14/02/13 ADULT B had made some changes to her appearance, her hair had been coloured and she was pleased with results. ADULT B was noted as remaining pre-occupied with her marital relationship and was especially focused on the planned separate holidays. ADULT B was concerned ADULT A would meet someone else and she could not imagine life without him. ADULT B was clear helping her establish her own structure to her week and becoming engaged in activities that slightly challenged her, activities she found rewarding would improve her self-esteem and so hopefully relieve some of her anxieties regarding her marriage. ADULT B had agreed to attend a training course to become a volunteer with the citizen's advice bureau. ADULT B was more confident she would not lose her driving licence and was keen to engage in activities that needed her to drive to the venue i.e. dance class. ADULT B was aware her mood generally improved in the spring and was keen to spend time on their boat with ADULT A when the weather was better.
15 February 2013	Consultant psychiatrist		ADULT B was seen by the [redacted] consultant psychiatrist at the [redacted]. Current medication was recorded [redacted] 150mg daily, [redacted] 300mgs nocte, [redacted] 300mgs bd. ADULT B diagnosis was recorded as [redacted] and [redacted] (resolved) but anxious rumination continued. ADULT B was noted to have progressed well. ADULT B was noted as continuing to have anxieties around her marriage and financial affairs, however these were less marked than previously. ADULT B was planning a

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			week skiing holiday with a friend and her husband was going with another friend separately. ADULT B was concerned her hair was falling out and felt this was partly a result of medication side effects. The plan of care was agreed as: • Reduce [redacted] to 200mgs daily, other medication to stay the same. • On-going support from social inclusion and her CPN.
7 March 2013	Care Co-ordinator		ADULT B was next seen by the care coordinator on 07/03/13. ADULT B reported her holiday went well, she talked about having second thoughts about work with citizen's advice bureau, ADULT B was attending the poker class, the women's institute and the Women Register. ADULT B was also thinking about attending church again. ADULT B noted she had a knee injury from skiing. Their son's wedding was planned for October, and ADULT B was hoping to see her other son, but noted their relationship was still fraught. ADULT B reported there has been no increase in anxiety since reduction of medication. The care coordinator planned to see ADULT B on 10/4/13. At this point the care plan is monthly contact with care coordinator, in-between contact with the social inclusion worker for activity planning / support, monitoring of medication and mood by care coordinator and ADULT B. In a crisis situation ADULT B was to make contact with services. Telephone numbers were given to her from HTT.
7 March 2013	Social Inclusion Worker		ADULT B also had a visit from the social inclusion worker. ADULT B discussed she felt able to look into groups in her surrounding area as well as other locations, ADULT B also felt able to attend these groups. ADULT B described feeling more optimistic now winter and the holiday were over. ADULT B did not feel there was a role for the social inclusion worker or the rehab outreach team and was agreeable to discharge. The care coordinator cancelled the next planned appointment on 10/04/13 at 14:00hrs and records on [redacted] in error a referral transfer.
15 May 2013	Care Co-ordinator		The next contact with the care coordinator was at a home visit on 15/05/13. At this visit ADULT B updates on her knee injury. ADULT B was enjoying the poker class, women's institute group and was considering volunteering at an infants school to help children learn to read. ADULT B

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			was concerned about being able to go sailing two evenings a week with her husband and worried about the younger son. ADULT B appeared more relaxed, but there was evidence of her biting her lips. ADULT B had reduced [redacted] to one a day, stopping the morning dose in last 2 weeks without any ill effects. ADULT B has spent a few days away with husband in [redacted], was doing gardening and had made contact with her 1 sister which she was pleased about. The care coordinator next planned to see ADULT B on 13/6/13 at 09:30hrs, and reminded ADULT B she could contact the care coordinator before then if needed.
July 2013	GP		ADULT B had a GP consultation to review her medication. ADULT B reported she had stopped [redacted], which her CPN (care coordinator) was aware of and ADULT B was keen to reduce [redacted]. ADULT B informed the GP she was seeing her CPN that afternoon. ADULT B felt it was a good time to try a lower dose. ADULT B reported she had reduced [redacted] to 100mgs for some time now.
28 August 2012			ADULT B phones the CMHT to re-schedule an appointment as she is going to a wedding in Greece, and the next appointment arranged for 18/09/13. This appointment is cancelled by administration staff due to sickness absence and a message left for ADULT B that she can schedule another appointment upon the care coordinator's return or she can phone in if in need or services in the interim.
7 October 2013	Police	Adult A reports Adult B missing. He had spoken to her on phone at 1200 when she was at home. He has returned from work at 2100 and she is not there and her car has gone. Describes her depression and that she has previous been missing and found at location [redacted].	Adult B recorded as high risk missing person. Adult B found in her vehicle at [redacted]. She was driven back to her home and handed to the care of Adult A.
9 October			ADULT A telephones the service to request an urgent appointment, ADULT

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2013			B had gone missing and was found by police at [redacted], ADULT A was requesting an urgent review with the [redacted]T consultant psychiatrist. ADULT B is seen by the consultant psychiatrist and the care coordinator alone and then with her husband. The events leading up to this was their son's wedding on [redated]. The lead up to the wedding appears to have been stressful. On the day of the wedding ADULT B was very anxious, and ruminating about their financial situation. ADULT B was worried her son had spent too much money on the wedding, that they may be in financial difficulty and may need to ask ADULT B and ADULT A for money. ADULT B was also concerned ADULT A may leave her; these worries were described as having been much better in recent months but had worsened. The consultant psychiatrist questions whether this coincides with ADULT B gradually reducing her medication. The plan of care is: • An increase in [redacted] to 150mgs M/R daily, • ADULT B not to ask for any changes in this and for any changes to be discussed with the consultant first, if ADULT B makes any changes this will be against medical advice • Continue with [redacted] 100mgs M/R daily • Care coordinator to support ADULT B to get involved at a local school i.e. children reading – a therapeutic tool for ADULT B • ADULT B provided with details for 'The Site' and ADULT B encouraged to take up psychological therapy with the recommendation of a period of at least one years 'talking therapy'.
17 October 2013	Care Co-ordinator		Care coordinator visited ADULT B at home. At this visit ADULT B appeared distracted; her arms were noted to be sore from picking. ADULT B described her concentration was difficult and she remained worried about money, her tax return, the amount of money spent on the wedding and fear her husband will leave her. ADULT B denied [redacted] – the care coordinator documented her impression of this response as not being accurate. They discussed planning gentle routines, the care coordinator documented she was not confident ADULT B had ability to do this. The importance of taking medication was reiterated to ADULT B. ADULT B was

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			strongly encouraged to contact a therapist of her choice for psychological intervention, and another appointment was made for 24/10/13. ADULT B risk assessment was updated by the care coordinator. It is documented in the 'summary and further information' box on the assessment *"ADULT B has experienced a return of the anxiety and fears, her presentation is currently low but does not appear to warrant considering greater input at this time than weekly visits, plan to review this regularly"*. Later the same day police detain ADULT B using Section 136 of MHA 1983(07). ADULT B was found at [redacted] sitting on the edge of the cliff, police described ADULT B as appearing upset and emotional. ADULT B stated she went to [redacted] with a plan but changed her mind. A MHAA was undertaken, ADULT A was contacted. His view was ADULT B was as poorly as she has been in the past, he was concerned about the risk of suicide and believed ADULT B will make active attempts to slip away from family again, this was a worry. ADULT B was offered and accepted voluntary admission to hospital. There was no bed available at [redacted] hospital therefore ADULT B was admitted to [redacted] ward at [redacted] Hospital, with a plan to transfer ADULT B when a bed became available.
17 October 2013			Police attend and find Adult B walking a short distance away. She describes thoughts of killing herself and that jumping from [redacted] would be a quick way of doing so. Detained under s.136MHA and taken to [redacted] where she assessed and admitted. It is recorded on 28/10/13 that MH was later transferred to [redacted] ward at [redacted] Hospital although she was expected to be returning to [redacted].
21 October 2013	[redacted] Hospital		ADULT B requested medical staff to allow her to go home. ADULT B was seen by a junior doctor. ADULT B stated she felt better today and she did not want to stay in hospital, although was still feeling low and anxious, she wanted to go home to sort out financial issues. Medical staff explained to ADULT B she had only been on the ward a few days and there was no great improvement, that three days was not enough to properly assess her.

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			ADULT B understood this and decided to stay in hospital to be seen by the consultant psychiatrist. During her time on the ward ADULT B medication was increased, ADULT B had one to one time, she attended ward activities. While on the ward ADULT B expressed concerns to staff, she had concerns about finances, her husband leaving her, concerns about her vulnerability if he leaves her and concerns about being sectioned. ADULT B reported her husband is willing for her to come home, ADULT B struggles with the concept of how she will know she is 'better', ADULT B fears it is inevitable her husband will leave her and she will have no home and no income.
4 November 2013	Consultant psychiatrist		ADULT B is reviewed by the consultant psychiatrist who feels it may be appropriate for ADULT B to go on leave with HTT support. There is a plan for HTT to assess, give their view. There are mixed views, ward staff feel ADULT B is not well enough for leave when HTT seek their view on 4 November 2013, although when assessed by HTT on the same day the view from HTT is ADULT B should have some unescorted ground leave over the next few days and be reviewed again by the consultant psychiatrist prior to going on leave with husband and HTT support.
6 November 2013	Consultant psychiatrist		ADULT B is reviewed by the consultant psychiatrist. It is noted anxiety, ruminations and delusions remain but ADULT B is less distressed by them. ADULT B is assessed as able to go home on leave at the weekend when her husband was around and HTT daily support, with a plan to see ADULT B at the next ward round on Tuesday 12th November 13. The consultant psychiatrist commenced a trial of haloperidol 1mg to augment other medication. HTT were requested to review ADULT B fitness to drive, ADULT B to be encouraged to get active with plans such as helping out in primary school, ADULT B agreed to phone ward if she felt unsafe.
8 November 2013			ADULT B remained on the ward until 8 November 2013 when she went on home leave with her husband at the weekend with support from HTT.
9 November 2013	HTT		HTT visit ADULT B at home, ADULT B was anxious and her mood appeared low. ADULT B had anxious thoughts about money, worries about housekeeping, ADULT B denied thoughts of suicide, but responded to risk questions evasively. Risk to self was considered high. A plan was made for

Date	Source of Information	Family Contact - Adult	Comments
			HTT to monitor home leave, encourage ADULT B with activity planning, meal planning, and to visit daily.
10 November 2013	HTT		HTT qualified staff make home visit. ADULT B continues to voice anxieties about ADULT A leaving her. ADULT A remained concerned about ADULT B driving. ADULT B requested an afternoon visit the next day to allow her some time alone in the morning.
11 November 2013	HTT		HTT staff make a telephone call to ADULT B to arrange the home visit. ADULT B expressed concerns she was worried about ADULT A leaving her. During the home visit ADULT B expressed again anxieties about whether ADULT A would come home that night and whether staff thought ADULT A had stayed with a 'lady friend' while she was in hospital. ADULT B is described as unable to accept any reassurance and ADULT B reported ADULT A was unable to reassure her either. ADULT B felt she was not ready to attend activities at the moment, ADULT B had a list of tasks to do left by her husband. HTT staff assess risk as, ADULT B remaining at risk of impulsive actions of self-harm.
12 November 2013	[redacted] Hospital		ADULT B and ADULT A attend a review by the junior doctor on Bay ward. The CMHT consultant psychiatrist was on leave, another consultant psychiatrist was available to provide support if needed HTT staff were present at this meeting. ADULT B is described as anxious and guarded, she had a fear she would be sectioned, she was described as having fixed beliefs that money was an issue when it was not, ADULT B was worried about her son's wedding and the cost. At this review ADULT B stated she wanted to drive again, her husband was worried about her driving to [redacted] to commit suicide – he expressed a view that there are never any signs. The review discussed there are other ways to die. ADULT B was noted as more anxious when her husband was working; she had thoughts of him leaving her, so much so she sat with her husband and watched his TV rather than read in the quiet as she did previously. The junior doctor recorded the risk as difficult to determine, ADULT B was vague about the topic, would not commit to answer on suicidal thoughts. Risk was discussed with ADULT B and husband. The junior doctor documented *"We cannot*

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			change risks substantially and ADULT B could find a way to die if she had the car or not – the impulsiveness will likely not change. Admission at this point will not likely make a difference". It was agreed to continue with home leave from the ward, with support from husband and daily contact from HTT, medication is to remain the same, social inclusion was already offered by HTT, husband to reconsider the risk of driving if ADULT B is fit enough.
13 November 2013	HTT		HTT qualified staff made a home visit. ADULT B presented as anxious with thoughts that ADULT A may leave her, she had concerns about finances. On leaving ADULT B showed HTT staff her husband's wardrobe, ADULT B stated there were several empty hangers, that shirts and other items of clothes had disappeared. It was discussed whether going out when HTT staff visit would be of benefit. ADULT B agreed to go for a coffee or for a walk at the next visit and to have further discussion about exploring other opportunities to increase social activity. The care plan was to continue with daily visits by HTT as agreed at ward review and to monitor ADULT B mental state and risk, HTT and ADULT B to identify further opportunities for social activity. HTT contacted the social inclusion team who agreed to bring forward their input. The HTT shift leader planed the next day's activity and allocated an STR worker to visit ADULT B with the purpose of taking ADULT B out on a social activity.
14 November 2013	HTT		HTT STR worker made a home visit in the morning. ADULT B presented as anxious, ADULT B agreed to go out for coffee, ADULT B was observed to be less anxious when out. On arrival back at the house ADULT B agitation was observed to increase. ADULT B showed HTT STR worker her husband's wardrobe, and his underpants and sock drawers. ADULT B believed a lot of underwear had gone and felt ADULT A intention was to leave her. As the STR worker went to leave ADULT B got into the car, and did not answer when asked if she was feeling safe. Following conversation lasting approximately 20 minutes ADULT B agreed to go back in the house and contact her husband and or one of her sister's in law. The HTT STR worker phoned into the office to tell the team ADULT B's anxieties had increased. Upon returning to the office later that afternoon/evening the HTT STR

Date	Source of Information	Family Contact - Adult	Comments
			worker documented her visits. There was a plan agreed for HTT to make telephone call and a home visit to ADULT B the next day. The purpose of this visit is to review/discuss if ADULT B needed to be back in hospital. The shift leader's rationale for this decision was at the time the information was given to the team/him, it was around evening time and it was expected ADULT A would be home from work and if he had any concerns about ADULT B he would contact the team.
15 November 2013			At approximately 07:30hrs ADULT B stabbed ADULT A once in the heart. ADULT A died of single stab wound. ADULT B inflicted stab wounds to her own chest requiring medical intervention. ADULT B called for an ambulance at approximately 07:30 stating "I've stabbed him, I've killed him". Police later notified [redacted] ADULT B had been arrested for murder.
15 November 2013	Police		Police attend location and find Adult A on bed with chest wound. Adult B is lying beside him and has a self inflicted chest wound. Adult B arrested for murder and taken to hospital regarding her injuries that are assessed to be damaged lung and bruised heart.
19 November 2013	Police		Adult B is discharged from hospital after MH assessment.
20 November 2013	Police		On 20 November 2013 Adult B is charged with the murder of Adult A.
6 June 2014	Police		Adult B pleads guilty to the manslaughter of Adult A. It was stated in court that Adult B had psychotic delusions and wrongly believed Adult A was having an affair. Adult B is sentenced to a hospital order and is currently in [redacted] Hospital [redacted].