SAFER CORNWALL
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Safer Cornwall

Domestic Homicide Review Overview Report

Independent Chair and Author

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Foreword - Family tributes to Adult A

As part of the review, the chair met with members of Adult A's family. Throughout the process the panel sought to ensure that their voices were heard and that through them, Adult A was at the centre of our thinking. With this in mind, it was agreed that members of the family would have the opportunity to provide a written statement about Adult A as a foreword to the Overview Report. Their statement also sets out areas where the family disagree with some aspects of the reports findings. The family tributes are set out here in full and without editing by the panel or the author.

The report uses the terms Adult A to denote the victim in this case and Adult B to denote the perpetrator. The decision to adopt this approach was taken after discussion with family members and their advocate and was their request, rather than using initials or pseudonyms. It was taken to maintain confidentiality but also to be more personal to him rather than using random initials or other forms of anonymisation.

A tribute to Adult A from his family

This is written in the hope you will gain an understanding into the person who has been killed and what he meant to us as a family. He wasn't a statistic or sad incident.

Anyone who knew him will smile just to think about him. He told such terrible jokes, and often thought our reaction was better than the joke itself. Even if you didn't want to laugh you couldn't help it as his chuckling was infectious.

He adored his wife and did all he could to protect and care for her. Coping with her illness can't have been easy but he was always loyal and loving. She was everything to him. As for his sons, you wouldn't find a prouder Dad. He'd drive hundreds of miles so they could compete in sporting challenges. Then he'd grin and do his American 'Spike the Bull Dog' impression (from Tom and Jerry) saying 'That's my boy!' He was a keen sportsman himself and really enjoyed competing, whether it was black run skiing or sailing.

In a sympathy card a friend said she knew what he meant to us as a family. She had seen how our faces would light up when he came into the room. When he arrived the fun would start.

An open letter to the Home Office from the family of Adult A

The family of Adult A requested that an open letter to the Home Office be included in the Overview Report. It is produced here, unedited.

This commentary has been prepared by the elder son, daughter-in-law and six sisters of the victim of the crime which gave rise to this Domestic Homicide Review (DHR): Adult A. As his closest relatives we wish to offer some observations about the report – both its substance and the process involved in its preparation – and about the DHR process more generally. We hope that they will be found helpful: they are intended to be constructive.
We would like first to place on record the fact that, despite the shortcomings that we perceive in the process through which it was produced, we consider the final report to be a serious and honest effort to explore the issues raised by the case – in so far as they fall within the scope of a DHR. In our view it accurately identifies many of the key lessons to be learned from it. We are grateful to the author for inviting and paying attention to our comments on an earlier draft and for taking on board many of our suggested changes.

That said, we retain some important reservations about the overall process of review, of which this DHR report is the culmination. The nub of our criticism is that the approach to engaging us was throughout too reactive and insufficiently sensitive. In our view those carrying out not just the DHR itself but the contributing Internal Management Reviews (IMRs) should have sought from the outset to make early contact with family members and to agree with them the degree of involvement that they wished to have in the review processes. The aim at that stage should have been to establish trust and to engender confidence that any pertinent information and insights that we had to offer would be welcomed and taken into account.

This was not the sense that we got. In this respect things were not helped by the fact that in the first instance those conducting the Cornwall Foundation Trust (CFT) IMR seemed interested in dealing only with the "next of kin", rather than the family as a whole. Whatever practical advantages this approach may seemingly have offered, in reality it gave the rest of us the feeling that we were being excluded. What is more, it risked loading all the responsibility of keeping the wider family informed and engaged onto one of the two members closest to the victim and thus most severely affected by the crime – his elder son. The fact that CFT appear to have offered support to their own staff involved in the case without extending a similar offer to the family, including the victim's autistic younger son, served only to reinforce our impression that we were seen as not integral to the process.

Similarly the family were not given adequate opportunity to see and comment upon the IMRs at draft stage. As a result, the final versions contained some errors of fact which it was only possible to correct in the DHR report itself. Not only did this unnecessarily complicate and possibly delay the preparation of that report but it also perpetuated misunderstandings which could have been scotched much sooner.

As to the DHR itself, those conducting the review did not proactively contact us, explain the process and programme, or seek our input. Our request to meet, and ideally to sit on, the panel was not met. In the absence of any explanation, and despite the declared intentions of both the original and replacement chairs, we did not get the sense that our contribution was seen as an essential element of the exercise. The panel never actively solicited our knowledge and insights. Indeed it required great persistence on our part to secure the involvement that we did achieve.

It is true that from our standpoint part of the problem was that the DHR, and the IMRs previously, were in effect substituting for an open court criminal trial as a source of information about what actually happened immediately before and at the time of the homicide. Some of our relatively few outstanding criticisms of the report relate to the fact that, in the absence of evidence exposed and tested in court, the author – as he acknowledges - still relies heavily on the perpetrator's account of events. One observation not specifically relating to the DHR is therefore that even when there is an agreed plea, the victim's family and friends would still find it helpful for the court to establish formally the facts of the crime.

Although not strictly pertinent to the DHR, we would also like to note in passing that some of the failings observed in other public bodies, particularly an insensitivity to the feelings and expectations of a traumatised family, were at least equally characteristic of the conduct of the coroner's office. We are aware that a previous DHR in Cornwall has highlighted this lack of consideration for the bereaved and wish to underline the need for a change in attitude.

Turning to the substance of the report, there are a few points on which we retain some concerns:

(i) we question its stated reluctance to make judgments based on hindsight when, for the purposes of learning lessons, hindsight is surely exactly what is required:

(ii) we fear that some participants in the review had lurking in their minds an anxiety that too explicit a finding of fault could have damaging consequences for the individuals or organisations whose actions they were reviewing. We see apprehensions of this sort as potentially deeply corrosive of the effectiveness of the DHR process. Its exclusive purpose must be, and be seen to be, forward-looking: to do everything possible to ensure that future practice minimises the risk of a criminal and personal tragedy of the type which occurred;

(iii) We note and endorse the criticisms of the support provided for her at home, and especially of the lack of continuity amongst the staff involved. But the more fundamental questions concern whether she had been correctly diagnosed, whether in the light of past experience it was wise to rely on her taking her prescribed medication (or on her husband to ensure her doing so) and whether, at the time of her release from Bodmin Hospital, it was appropriate to allow her home;

(iv) the above matters bear directly on the crucial question of whether the homicide could realistically have been prevented – an issue on which we note that the report reaches a conclusion slightly different from that of the forensic psychiatrist commissioned to review the case;

(v) despite the report's useful recommendations in regard to record-keeping and access, we do not feel that it fully lays to rest our suspicion that the confidentiality attaching to medical records can inhibit the sharing of information vital to treating physicians in their handling of a case, especially when a patient seeks actively to conceal his or her clinical history; and

(vi) however strong panel members' other credentials, we have doubts about their authority to adjudicate in matters of clinical judgment. In this particular case the accuracy of Adult B's diagnosis was clearly a critical issue. From our perspective the report commissioned from an independent forensic psychiatrist was accordingly the single most valuable element in the whole process. Yet a panel which lacked a member with similar qualifications was called upon to weigh up his judgments against those of the treating physicians and of the qualified psychiatrist who chaired the

CFT's IMR. In our view the panel appointed to conduct a DHR in any case where mental illness has been a factor in a domestic homicide should include an experienced, professionally qualified forensic psychiatrist.

In relation to this last point, we recognise of course the difficulty of diagnosing definitively the mental condition of someone like Adult B. Although many of us had known her for over 30 years, we ourselves had no inkling that she was capable of the behaviour that she exhibited on this occasion. And as we understand things there remains even now, despite her detention and intensive observation and treatment for over two and a half years, considerable doubt as to her true condition – for example as to whether she suffers from a personality disorder or simply some form of psychosis.

In these circumstances we can well see that it would have been very hard to tell whether she was suffering from illusory fears of abandonment and bankruptcy or from delusional jealousy, or indeed from some combination of these conditions. We do note, however, that the forensic psychiatrist, Dr McKenna, said in his report that "I think it is very likely that at the times when she was severely depressed, Adult B's beliefs did at times include notions of infidelity that were delusional in nature". As indicated above, we do not seek a retrospective verdict on this matter; we merely wish to be reassured that in future all these possibilities – with their potential implications for treatment – will be properly considered.

Turning from this particular DHR to any lessons that it may hold for the DHR process generally, we offer the following observations:

(i) the concept of the DHR is fundamentally sound: performance across the organisations involved in cases of domestic homicide should be reviewed with the objective of learning lessons and improving future practice;

(ii) family members should be supplied with and given opportunity to comment on draft IMRs.

(iii) the involvement of the victim's family is crucial and should be pursued proactively by those conducting the review and before that by those preparing the IMRs that contribute to it;

(iv) family members should be given the opportunity, at the least, to meet panel members collectively and possibly to nominate one of their number to sit in on its deliberations as an observer;

(v) the chair of the DHR should be fully independent of the bodies whose performance is under review and to ensure this should be contracted and funded by a separate, central body (perhaps the Home Office) and ideally be drawn from a panel of trained professionals assembled for the purpose;

(vi) panel members should possess the expertise, skills and experience necessary to assess critically and comprehensively the evidence provided by the individual organisational IMRs and from any other valid sources, including commissioned reports and family testimony;

(vii) where necessary further studies should be commissioned to supplement the information available from IMRs so as to enable the DHR to reach better founded conclusions about the lessons to be learnt from the case (as happened in this instance with the very helpful report from a forensic scientist); and

(viii) relevant information from the DHR should be drawn to the attention of, and made available to, those responsible for the custody and treatment of the perpetrator of the crime committed.

One final point, arising from the last above, relates to the relationship between the health and justice systems in a case such as this, where someone who has been found guilty of a serious crime has been judged to have been mentally unwell at the time that he or she committed it. The appropriate treatment of such an offender raises issues quite different from those addressed by a DHR and relating to the extent to which he or she was responsible for his or her actions and poses a continuing danger to other members of society.

These are undeniably murky waters into which the bereaved relatives of a victim venture at their peril, given that they are inevitably less than wholly objective. It does seem to us, however, that at present there is too sharp a demarcation between the realms of justice and of health. Despite the efforts to forge a link (through for example the Section 37/41 Order made in this case), there seems to be an assumption that once someone has been assigned to hospital rather than prison, his or her care becomes essentially a medical task – one of cure rather than custody. Judgements about the patient's leave on release would appear to be made largely on the basis of the benefits that might accrue to the individual's treatment, with limited regard either to culpability for the original offence or even to the danger that he or she might pose to others when out in the community.

Surely this is too simplistic. Does the fact that someone is psychotic automatically absolve that person of all responsibility for his or her actions, however grave their consequences? And can even apparently successful treatment of their mental condition assure the public that they no longer constitute a danger, when they have previously shown themselves to lack the sort of inhibitions that prevent most humans from killing each other? The latter question is all the more pertinent when the individual's recovery may well be dependent on a regime of medication with which it is impossible to ensure that they will comply in a non-institutional setting.

We raise these questions because like the matters of practice addressed by the DHR, they underline the need for close collaboration between different arms of government to ensure that every case is handled in the way most appropriate to its unique circumstances and that the prospects of the most satisfactory achievable outcome are not jeopardised by inadequate communication between the various authorities involved.

Section One

Introduction and background

1.1 Introduction

This Domestic Homicide Review (DHR) examines the circumstances surrounding the unexpected death of Adult A on 15 November 2013. The DHR was commissioned by Cornwall Council on behalf of Safer Cornwall.

The panel would like to place on record its sympathies to the family of Adult A for the loss of a loved father and brother.

1.2 Purpose of the Domestic Homicide Review

DHRs came into force on 13 April 2011. They were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act (2004). The act states that a DHR should be a review '*of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by —*

- *A person to whom he was related or with whom he was or had been in an intimate personal relationship, or*

- *A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'*

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Identify what needs to change in order to reduce the risk of such tragedies happening in the future to prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

1.3 Process of the review

A DHR was recommended and commissioned by Cornwall Council on behalf of Safer Cornwall in line with the expectations of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2013. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Adults Act 2004.

The DHR has also sought to satisfy the standards and requirements of a Mental Health Homicide Review under Health Service Guidance (94) 27 which requires such a review when a homicide has been committed by a person who is or has been in receipt of mental health services and has been subject to the regular or enhanced Care Programme Approach of specialist mental health services in the six months prior to the event.

By drawing together these reviews within the DHR framework it has been possible to avoid unnecessary duplication of process, make more effective use of time and enable improved organisational engagement and learning.

The panel met for the first time in December 2014 following the appointment of an independent Chair and author, Dr. Jane Monckton Smith. Dr. Monkton Smith is a specialist in domestic homicide and works for the University of Gloucestershire. She did not work for any of the agencies which had contact with Adult A or Adult B and she was independent of any agency that had involvement with the case.

In April 2015, Steve Appleton, Managing Director of Contact Consulting (Oxford) Ltd was appointed by NHS England South to provide additional mental health expertise and to assist the Chair in writing the Overview Report.

In October 2015, Dr. Monckton Smith withdrew as the Independent Chair and Steve Appleton took over the Chairing of the DHR and authoring of the Overview Report. Dr Monckton Smith provided the review panel with a summary of her input to the review and outline themes to have emerged from her work to the point when she stood down upon which the panel has drawn in finalising this Overview Report.

This report did take a significant amount of time to complete. There was a delay in the original submission and this was due to both the changes in chairing and the degree of engagement with family members. The commissioning of an independent forensic psychiatry review also involved some delay. The original report was withdrawn after submission, following request by the family of the victim. Further amendments to report were made and these took some time to agree. This meant that the second submission was delayed.

Panel Membership

The DHR panel comprised a range of people representing local agencies, all of whom brought relevant expertise and knowledge, not only in terms of domestic abuse but also in relation to mental health and broader public services. The individuals involved represented the following agencies:

- Cornwall Council
- NHS England
- NHS Kernow Clinical Commissioning Group
- Devon and Cornwall Police

Voluntary Sector and National Probation Service have membership but have been unable to attend meetings.

Independent mental health expertise was provided by Steve Appleton and was commissioned via NHS England. This input continued when he took over the Chairing of the panel and responsibility for writing the overview report.

Cornwall Partnership NHS Foundation Trust (CFT) was not formally represented on the panel however; the CFT IMR author attended panel meetings and provided information on the IMR and internal processes at the request of the panel.

Chair and Overview Report Author – Steve Appleton

Steve trained as a social worker and specialised in mental health, working as an Approved Social Worker. He has held operational and strategic development posts in local authorities and the NHS. Before working independently he was a senior manager for an English Strategic Health Authority with particular responsibility for mental health, learning disability, substance misuse and offender health.

Steve has had no previous involvement with the subjects of the review or the case, nor does he have any connection to the agencies that had contact with Adult A or Adult B. He has considerable experience in health and social care, and has worked with a wide range of NHS organisations, local authorities and third sector agencies. He is a managing director of his own limited company, a specialist health and social care consultancy.

Steve has led reviews into a number of high profile serious untoward incidents particularly in relation to mental health homicide, safeguarding of vulnerable adults, and investigations into professional misconduct by staff and has chaired a Serious Case Review into an infant homicide. He has chaired and written DHRs for a number of local authority Community Safety Partnerships.

1.4 Subjects of the review

Adult A
White British Male
Date of Birth May 1953
Date of Death November 2013
Deceased was husband of Adult B

Adult B
White British Female
Date of Birth May 1955
Adult B was wife of Adult A

1.5 Time Period

The DHR has focused on the two year period prior to the homicide, however where information about contact between agencies and Adult A or Adult B prior to that has been available this has been reviewed to provide any relevant context or information that might assist the DHR process.

1.6 Terms of reference

The DHR's specific terms of reference, as agreed by the panel were:

- To establish the facts about events leading up to and following the death of Adult A on 15 November 2013.

- To examine the roles of the organisations involved in his case, the extent to which he had involvement with those agencies, and the appropriateness of single agency and partnership responses to his case.

- To establish whether there are lessons to be learnt from this case about the way in which organisations and partnerships carried out their responsibilities to safeguard his wellbeing.

- To identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result.

- To identify whether, as a result, there is a need for changes in organisational and/or partnership policy, procedures or practice in Cornwall in order to improve our work to better safeguard victims of domestic abuse and their families.

The scope of the panel review:

- To establish which agencies had contact with the family (chronology requests were sent to the following agencies: GPs (NHS England), Cornwall Partnership NHS Foundation Trust, Devon & Cornwall Police, Domestic Abuse Sexual Violence Providers and Probation, Victim Support and National Probation Trust.

- To produce a chronology of events and actions in relation to the case of the perpetrator, from the period 1992 (Adult B's first episode of mental ill-health) until Adult A's death on 15 November 2013 seeking information from:

- Organisations which had contact with him or the perpetrator: Mental Health services; GP services; Relate; Social Inclusion Team; Devon and Cornwall Police.

- To review current roles, responsibilities, policies and practices in relation to victims of domestic abuse – to build up a picture of what should have happened.

- To review this against what actually happened to draw out the strengths and weaknesses.

- To review national best practice in respect of protecting victims and their families from domestic abuse.

- To draw out conclusions about how organisations and partnerships can improve their working in the future to support victims of domestic abuse.

The review will also specifically consider:

- An assessment of whether family, friends, key workers or colleagues (including employers) were aware of any abusive or concerning behaviour from the perpetrator to the victim (or other persons).

- A review of any barriers experienced by the family, friends, colleagues in reporting any abuse or concerns, including whether they (or the victim) knew how to report domestic abuse had they wanted to.

- A review of any previous concerning behaviour or history of abusive behaviour from the perpetrator and whether this was known to any agencies.

- Whether family, friends, colleagues, employers, wanted to participate in the review. If so, ascertain if they were aware of any abusive behaviour by the perpetrator prior to his death.

- Whether any organisational policy training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

- Whether the work undertaken by the services in this case are consistent with their own professional standards, compliant with their own protocols, guidelines, policies and procedures.

In addition this review will also include an inquiry into the care and treatment of Mental Health by Cornwall Partnership NHS Foundation Trust: Purpose of the inquiry:

- To identify whether there were any gaps or deficiencies in the care and treatment that Adult B received, which could have been predicted or prevented the incident on 15 November 2013 from happening. The investigation process should also identify areas of best practice,

opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring.

- The outcome of this investigation will be managed through corporate governance structures in NHS England, the Safer Cornwall Partnership, NHS Kernow and the provider's formal Board sub-committee.

Terms of Reference for the mental health inquiry:

- Review the engagement, assessment, treatment and care that Adult B received from Cornwall Partnership NHS Foundation Trust from her referral in 2012 up to the time she was placed on home leave in November 2013.

- Review if the Trust fully assessed and appreciated Adult B's comprehensive mental health (key episodes going back to 1994), her diagnosis and if they provided appropriate support, care and treatment options which met national standards.

- Consider the safeguarding issues in relation to Adult B's self-harm, attempted suicide and the potential for harming others.

- Review if there was a carer's assessment undertaken.

- Review the care planning and risk assessment, policy and procedures and compliance with national standards and best practice.

- Review the communication between Adult B's husband and family and the Trust including the sharing of information regarding risks to Adult B and others to inform risk assessment and management.

- Review the Trust's internal investigation report and scrutinise its findings, recommendations and implementation of the action plan and identify:

- If the investigation satisfied its own terms of reference.

- If all key issues and lessons have been identified and shared.

- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt.

- Review progress made against the action plan.

- Review processes in place to embed any lessons learnt.

- Having assessed the above, to consider if this incident was predictable or preventable and deliberate on relevant issues that may warrant further investigation and comment.

- To fully ensure that the families' questions to the internal investigation are fully addressed.

- To fully assess and review the Trust's engagement with the victim and perpetrator's families, before and after the incident, including information sharing and involvement in the internal investigation, measured against best practice and national standards.

1.7 Individual Management Reviews (IMRs)

IMRs were requested from a range of agencies that had been in contact with or providing services to both Adult A and Adult B.

The objective of the IMRs which form the basis for the DHR was to provide as accurate as possible an account of what originally transpired in respect of the incident itself and the details of contact and service provision by agencies with both Adult A and Adult B.

The IMRs were to review and evaluate this thoroughly, and if necessary to identify any improvements for future practice. The IMRs have also assessed the changes that have taken place in service provision during the timescale of the review and considered if changes are required to better meet the needs of individuals at risk of or experiencing domestic abuse.

This Overview Report is based on IMRs commissioned from those agencies that had involvement with Adult A and Adult B as well as summary reports, scoping information and interviews with Adult A's sisters. The panel also commissioned an independent forensic psychiatry review relating to Adult B's mental health treatment and care. This was done following discussion with family members and with the support of NHS England (South).

The IMRs have been signed off by a responsible officer in each organisation and were discussed with IMR authors during panel meetings.

The report's conclusions represent the collective view of the DHR Panel, which has the responsibility, through its representatives and their agencies, for fully implementing the recommendations that arise from the review. There has been full and frank discussion of all the significant issues arising from the review.

The DHR Panel has received and considered the following Individual Management Review Reports (IMR):

- NHS England – Primary Care
- Devon and Cornwall Police
- Cornwall Partnership NHS Foundation Trust

An independent forensic psychiatry review conducted by Niche Patient Safety was also reviewed.

The panel also commissioned an independent forensic psychiatry report. This was done after discussions with Adult A's family members and was procured using the NHS England national framework agreement for the investigation of mental health homicide. The review was awarded to Niche Patient Safety and was conducted by an independent forensic psychiatrist, Dr. John McKenna. An executive summary of his report is appended to this Overview Report.

The panel would like to thank Dr. McKenna and Nick Moor of Niche Patient Safety for their diligence in progressing that review thoroughly and in a timely and sensitive way.

1.8 Diversity

The panel has been mindful of the need to consider and reflect upon the impact, or not, of the cultural background of Adult A and Adult B and if this played any part in how services responded to their needs.

"*The Equality Act 2010 brings together the nine protected characteristics of age, disability, gender reassignment (with a wider definition) marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation*."[1]

There are further considerations relating to income and pay gaps, the gender power gap in public sector leadership positions and politics, and the causes and consequences of violence against women and girls, under the Gender Equality Duty.[2]

The nine protected characteristics in the Equality Act were considered by the panel. Of those nice, gender has direct relevance to the review. The review has been cognisant of the prevailing but incorrect assumption that domestic abuse is only committed by men rather than women. In the course of the review we have sought to recognise that this assumption may have played a part in the thinking, attitudes and responses of professionals.

In particular the panel has been clear throughout and wishes to stress here, that the instances of suspected or actual domestic abuse referred to in this report were those perpetrated by Adult B upon Adult A including the eventual homicide.

[1] Paragraph taken from Home Office Domestic Homicide Review Training; Information Sheet 14. P47
[2] Gender Equality Duty 2007. www.equalityhumanrights.com/.../1_overview_of_the_gender_duty

1.9 Confidentiality

The DHR was conducted in private. All documents and information used to inform the review are confidential. The findings of the review should remain confidential until the Overview Report and action plan are accepted by Safer Cornwall. The Overview Report has been anonymised in relation to Adult A and Adult B and family members.

1.10 Involvement with the family

The panel has sought throughout the review to ensure that the wishes of the surviving family members have informed its work and that their views are reflected in this Overview Report.

The engagement with family members of Adult A has taken place through email, telephone contact and face-to-face meetings.

The views of Adult A's family members were gathered through a face-to-face meeting with the Chair and they have been kept informed of progress with the DHR. This followed an earlier discussion between them and Dr. Monckton Smith.

Adult A's family members met two of the IMR authors so they could be presented with the facts of the IMR but also afforded the opportunity for them to discuss the IMR with the author. The family had requested copies of the IMRs and were directed to the individual agencies to make that request. They were provided with a redacted copy of the Primary Care IMR, the Police declined the request but held a meeting with the family to discuss the IMR's contents and hard copies of the CFT internal review and action plan were provided, but not a copy of the IMR.

The family of Adult A had the opportunity to review the draft of the Overview Report. They provided detailed written responses with a range of comments and suggested amendments, and a further set of comments was received as part of the final drafting process. The majority of these suggested amendments have been incorporated into the final version of the Overview Report.

1.11 Involvement with the perpetrator

Dr. Jane Monckton Smith and Michelle Davies met with Adult B on 26 May 2015 to explain the purpose of the DHR and ascertain her views on events leading up to the death of Adult A. In addition to the IMRs the panel has had access to Adult B's GP records, her mental health records held by Cornwall Partnership NHS Foundation Trust and court reports prepared by Consultant Psychiatrist involved in her current treatment and care.

1.12 Evidence and lack of full criminal trial

A DHR necessarily draws upon the evidence provided within the IMRs and any additional scoping information drawn from relevant agencies. It is important to note the fact that there may be inconsistencies in the accounts provided by Adult B and the findings of the police investigation and the family of Adult A have asked that this be stated here.

Because Adult B pleaded guilty to manslaughter, a fuller criminal trial did not take place. The DHR is not a judicial process nor is it a substitute for a criminal trial, rather it seeks to identify any failures and deficits in relation to the interventions of statutory organisations that had contact with Adult A and Adult B. The lack of a criminal trial thus makes is harder for the DHR to establish beyond reasonable doubt the exact events of the night in question.

Section Two

Domestic Homicide Review Panel Report

2.1 Summary facts of the incident

This overview report is an anthology of information and facts from agencies that had contact with, had provided or were providing support for Adult A and Adult B. That information is supplemented by what has also been passed on and confirmed by family members. The report examines agency responses to and support given to Adult A and Adult B prior to the incident on 15 November 2013. The report necessarily provides particular focus on the facts relating to the interactions and interventions of services with Adult B. This should not be viewed in any way as a diminution of the victim, Adult A, whom the report has striven to represent appropriately and clearly throughout.

This overview of the events of the incident is drawn from the Devon and Cornwall Police IMR which provides a helpful and clear summary of the facts as known.

At the time of the homicide Adult B was a 58 year old woman. She lived at the family home in Cornwall with her husband Adult A, a 60 year old male. She had been an inpatient on Bodmin ward and returned home one week before the incident. Both Adult A and Adult B had worked as General Practitioner's (GP's) in Cornwall, however Adult B had retired in September 2011 due to ill health. Adult A was still practicing as a GP in Cornwall at the time of his death. The couple are survived by their two sons.

Adult A and Adult B had been married for approximately 30 years. Adult A grew up in Cornwall and was one of seven children. Following his studies and training to become a doctor he returned to Cornwall to live and work. It is understood that it was upon his return to Cornwall that he met Adult B and they married in 1980.

On Friday 15 November 2013 at around 07:40hrs Adult B called an ambulance to the home address. Ambulance control informed Police of the call stating that Adult B had informed them that she had stabbed Adult A. On arrival Police found Adult A in the bedroom with a puncture wound to his chest and not breathing. Ambulance staff were in attendance but Adult A was pronounced deceased at the scene. Adult B also had sharp instrument wounds to her chest which she reported were self-inflicted.

Adult B told attending officers she had stabbed her husband. Adult B was arrested on suspicion of murder of Adult A and was taken to the Royal Cornwall Hospital for the treatment of her injuries. On 19 November 2013 Adult B was discharged from hospital and was taken into custody at Camborne Police Station.

On 20 November Adult B was interviewed by Police regarding the offence. Adult B told officers that on the morning of Thursday 14 November she had seen someone from the Mental Health Team and that following this she had gone to Hell's Mouth,

a well known beauty spot in the area with cliffs that are one of the highest points in that area of Cornwall.
Adult B told Police that she had gone there with the intention of taking her own life, but changed her mind and returned home later that evening.

Adult B stated that Adult A had guessed where she had been and was cross with her. She and Adult A had gone to bed at approximately 2300hrs on 14 November. Adult B stated she had not been able to sleep and had been worrying about finances and her marriage which she described to Police as 'distant'. After some hours of being unable to sleep she had got up and went to the kitchen where she said she had taken a knife from the drawer with the intention of killing herself.

Adult A had been disturbed by the noise and had gone into the kitchen, at which time he spoke with Adult B and persuaded her to return to bed, however Adult B secreted the knife and kept it with her. She described having confused thoughts which involved the belief that Adult A was going to leave her. She stated that she had also been preoccupied with thoughts of harming herself. Adult A suffered a single stab wound to the heart, inflicted upon him by Adult B. The pathologist indicates that death would have occurred relatively quickly.

Adult B told the Police she then decided to take her own life and stabbed herself in the chest, having called the ambulance for Adult A. During the interview Adult B described her marriage to Adult A as 'going downhill', however she did not elaborate on the context of this or the detail of the incident itself. Adult B stated that she could see with hindsight the consequence of her action but that at the time she did not anticipate the fatal outcome.

Adult B was charged with the murder of Adult A and pleaded guilty to manslaughter. On 6 June 2014 Adult B was convicted of the manslaughter of Adult A on the grounds of diminished responsibility. The judge noted Adult B's high risk of relapse and she was sentenced to a Section 37 & 41 Hospital Order under the provisions of the Mental Health Act.

A Section 37 is a hospital order, which is an alternative to a prison sentence. This means the court sends the individual to hospital instead of prison. The judge in this case exercised the option of adding a Section 41 restriction order to this, making the Section a 37/41. The judge in a Crown Court can do this if they think a person is a risk to the public.

The restriction order means that there are restrictions on the individual and their Responsible Clinician. This includes the stipulation that the Responsible Clinician needs to get permission from the Secretary of State for Justice before they can be released from detention, this includes any move; or temporary (escorted or unescorted) leave; or permanent discharge

2.2 Analysis of individual management reviews

This section of the report analyses the IMRs and other relevant information received by the panel. In doing so it examines how and why the events occurred and analyses the response of services involved with Adult A and Adult B, including information shared between agencies, why decisions were made and actions taken or not taken. Any issues or concerns identified are a reflection of the evidence made available.

In doing so the panel have been mindful of the guidance relating to the application of hindsight in DHRs and have attempted to reduce it where possible. As reviewers after the fact, we are in possession of information and knowledge not possessed by those people whose actions we are reviewing that they did not have at the time. Thus it follows that to criticise or make judgments about how they should have acted by using his hindsight we could apply would be to use an unreasonable bias or test. The panel has also borne in mind the helpful statements contained in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[3]

The panel has also paid attention to the Pemberton Homicide Review conducted in 2008. That review stated: "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time.*"[4] This DHR panel has sought to ensure that, in accordance with the Pemberton review, the insights of those involved in the case at the time of the homicide have been given due weight in the considerations of the panel.

It is important that the findings of the review are set in the context of any internal and external factors that were impacting on delivery of services and professional practice during the period covered by the review.

[3] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013.
[4] A domestic homicide review into the deaths of Julia and William Pemberton. Walker,M. McGlade, M Gamble, J. November 2008

2.2.1 Devon and Cornwall Police

Devon and Cornwall Police (DCP) covers an area of 3,961 square miles and incorporates five upper tier/unitary local authorities and eight district/city councils. One of its key priorities agreed in the Peninsula Strategic Assessment is that of domestic, family and sexual abuse.[5]

The DCP IMR was produced by a Detective Sergeant with expertise and experience of work in relation to domestic abuse and homicide.

Analysis of involvement and lessons learned

The IMR states that neither Adult A nor Adult B had any previous convictions and that DCP had no contact with either of them until 9 August 2012. The IMR also makes clear that all DCP contact with both Adult A and Adult B centred on concerns about Adult B and her mental health.

Between August 2012 and November 2013 DCP had six contacts with Adult A and Adult B including their response to the homicide. All contacts involved both Adult A and Adult B. The first contact related to a request from Adult A for police assistance on 9 August 2012. Adult B had been brought back from Hell's Mouth where she had been walking with her sister-in-law. The IMR states that during that walk, Adult B attempted to take her own life by jumping off the cliff edge. She was stopped from doing so by her sister-in-law and was then driven home. During the drive home Adult B attempted to exit the moving vehicle. Once back at her home address, Adult B refused to enter the house.

Adult A informed Police that Adult B was diagnosed with depression and he was concerned that she was suicidal. Adult A had contacted a Psychiatrist who had knowledge of Adult B's condition and had advised Adult A to contact the Police and request her detention under Section 136 of the Mental Health Act (MHA) 1983.

Police attended outside the family home where they spoke with both Adult A and Adult B and subsequently detained her under Section 136 Mental Health Act 1983. This section of the Mental Health Act states that "*If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety within the meaning of Section 135 above.*"[6]

[5] www.devon-cornwall.police.uk Accessed April 2016
[6] Mental Health Act 1983 amended 2007 HMSO

Adult B was taken by officers to Longreach House, an inpatient hospital service which is the designated place of safety for that geographic area. Adult B was admitted to Bay Ward at Longreach.

The second contact took place on 9 November 2012. Adult A contacted Police expressing concerns for the welfare of Adult B. He informed Police that he had returned home to find that Adult B was not there and presumed her to be missing. Adult A was particularly concerned as Adult B had only recently been discharged from Longreach hospital.

Given the recent events, and the information Adult A provided, the Police identified that Adult B may be at risk of suicide and consequently the incident was graded as an immediate response. Officers located Adult B at Hell's Mouth 35 minutes after the incident was first reported to them. Adult B was again detained under Section 136 of the Mental Health Act and again officers took her to Longreach where she was initially detained, but was subsequently discharged after assessment. A vulnerable adult non-crime enquiry was created recording the actions taken by officers and their reasons for invoking Section 136 of the Mental Health Act.

The third contact too place on 12 November 2012. A Community Psychiatric Nurse (CPN) working with Adult B contacted the Police after becoming concerned for her welfare. The CPN had attended Adult B's home address for a planned appointment but became concerned when she could get no response at the address and was able to see cartons of empty medication inside the property. The incident was graded as requiring an immediate response.

The Police attended the home address and due to the circumstances, and their concerns for the welfare of Adult B they forced entry to the property under Section 17 of the Police and Criminal Evidence Act 1984 which confers on officers powers to enter and search a property to save life or limb or prevent serious damage being caused. Adult B was not present.

The Police made contact with Adult A, who was at work at the time of the incident; he informed officers that Adult B may have gone to Hell's Mouth, as she had done before. The Police were able to make telephone contact with Adult B who confirmed that she was walking on the cliffs at Hell's Mouth.

Police went to Hell's Mouth where they found and detained Adult B under Section 136 of the Mental Health Act, again taking her to Longreach. Officers made attempts to update the enquiry record with the outcome from Adult B's admission to Longreach, however it is recorded on the enquiry that staff at Longreach would not discuss the case due to patient confidentiality.

The fourth contact took place on 7 October 2013, just under a year after the previous event. Adult A contacted the Police reporting concerns for his wife having returned home from work to find her missing. He told Police that she suffered from depression, and had previously threatened suicide. He also informed Police that she had previously been located at Hell's Mouth.

A member of the public had contacted Police approximately two hours earlier having seen a female in a distressed state on the cliffs at Hell's Mouth, near a memorial to a man who had committed suicide from the cliffs.

The Police had searched the area for an hour without finding the woman described. Acting on Adult A's information the Police attended Hell's Mouth where they located Adult B sitting in her car in the car park. On this occasion a Response Officer took her back to her home address in a police vehicle. The other attending officer drove Adult B's vehicle back to her home address. With the agreement of Adult A, Adult B was not on this occasion detained under Section 136 of the Mental Health Act.

The fifth contact was on 17 October 2013, just under a month prior to the homicide. A member of the public contacted Police after seeing Adult B sitting on the cliff edge at Hell's Mouth. The reporting person stated that Adult B was sitting next to a memorial, as in the incident on 7 October 2013, and that she appeared to be in a distressed state. The incident was graded as an immediate and officers were sent to Hell's Mouth where Adult B was located in a distressed state. She had informed officers that it was the best place to go and end it all. Police officers detained Adult B under Section 136 of the Mental Health Act and took her to Longreach House where she was admitted and assessed. A non-crime mental health enquiry was created by officers and was updated on the 28 October 2013 to record that Adult B had been transferred to Fletcher Ward (an acute admission unit at Bodmin Hospital.

The sixth and final contact was on 15 November 2013 when the Police responded to the fatal incident.

The IMR states that there was no recorded history of domestic abuse in relation to Adult A and Adult B. DCP does have a domestic abuse policy which governs working practices in relation to policing responses to domestic incidents. During 2010 DCP mandated the Domestic Abuse Stalking and Harrassment and Honour Based Violence 2009 (DASH) risk assessment framework. Both the policy and the DASH framework were in place at the time of incident.

DCP's contacts with Adult A and Adult B were all undertaken in response to concerns for Adult B's mental health, her whereabouts being unknown or both. They were therefore undertaken within the policy and operational context of those two issues.

In respect of the missing person element of those contacts by DCP, the management of those incidents is supported by a police computer network system known as COMPACT which was introduced in 2007. COMPACT contains a risk assessment that consists of 11 questions including one that asks if the person is a victim or perpetrator of domestic abuse. The COMPACT risk assessment was completed for both the second and fourth contacts described previously. The IMR states that the majority of questions in the risk assessment were marked as 'unknown' including the question about domestic abuse. This suggests that the question may not have been asked.

When an incident relating to a missing person is resolved, the missing person enquiry officers are expected to complete a Found Report. This includes a checklist of potentially relevant factors in the case including relationship problems and domestic abuse. The Found Report should be completed with the subject (the missing person). The Found Report for the second contact was recorded as 'declined by subject' and the fourth contained limited information.

The third contact was not initiated as a missing persons enquiry and was progressed as a concern for welfare. The IMR notes that once officers were unable to locate Adult B then a missing person investigation should have been commenced. This did not directly impact on the Police response, which was appropriately graded for response, and the enquiry was undertaken swiftly.

Adult B was identified by DCP as being at risk due to her mental health problems and her suicidal thoughts. DCP appropriately responded to missing person enquiries and welfare concerns. At no stage did either Adult A or Adult B indicate that domestic abuse was a factor in their relationship and no such indication was observed by officers. It is known that victims and perpetrators of domestic abuse often seek not to reveal it. This makes it difficult for professionals to establish its presence unless they observe it or make direct enquiry about it. This direct enquiry, as highlighted elsewhere did not take place in this case.

The IMR demonstrates that the mental health of Adult B was at the forefront of DCP's contact with her. It is clear that DCP officers made appropriate use of their powers under Section 136 of the Mental Health Act. Adult B was properly detained and appropriately transferred to a place of safety in line with the Mental Health Act and the associated Code of Practice.

On all occasions attending officers created a mental health non-crime enquiry, documenting their rationale for detention under Section 136; this is in line with guidance contained within the Section 136 Protocol. The IMR states that the rationale is clearly recorded and in line with practice guidance.
Officers are also required to update the enquiry with the outcome from the place of safety and this has been completed on all four occasions. The non-crime enquiry

relating to contact three is of note in that it is recorded that staff at Longreach would not provide an update relating to Adult B due to patient confidentiality.

Contact four was different in that Section 136 was not used to detain Adult B. The IMR states that the author spoke with both attending officers. They reported that they established that Adult B was the missing female they were looking for. Although Adult B appeared to be upset there were no indications that she had any suicidal intentions or thoughts of harming herself at that time, and officers did not feel that the requirements of Section 136 were met, in that she did not appear to him to be in need of immediate care and control. They also stated that they had no specific concerns for Adult B's immediate safety and had established that Adult A was able to look after her.

The IMR states that two hours before Adult A reported the fourth incident, a member of the public reported seeing a female lying on the cliff edge towards Hell's Mouth. The reporting person had described her as lying on the floor, holding onto bushes with her legs hanging over the cliff. The reporting person grabbed the female's legs and pulled her away from the cliff edge.

This incident was recorded on a separate log and was cross referenced with the later log. The same officers who responded to the contact from Adult A were tasked from both logs, however both stated that they had not been passed the information about how the female had been found on the cliff edge.

One of the officers recalled locating Adult B sitting in her car and that she was cold. He had informed her that Adult A was concerned about her whereabouts. Adult B told the officer that she had wanted some time to herself and it was quite apparent to the one of the officers that Adult B did not want to discuss her personal matters in detail and that he did not feel comfortable pressing her for information.

He recalled returning Adult B to her home address where they were greeted by Adult A. He stated that Adult A appeared very concerned for Adult B and had wanted her returned home saying words to the effect *'Don't worry I'm a doctor, I'll take care of her'*. Both officers stated that had they known the detail of the earlier report this may well have changed the course of their actions.

DCP held no records relating to Adult B prior to the first contact. There was no indication from the information gathered during those contacts that Adult B was a risk to others, indeed the focus was upon the potential risk to herself. The IMR does state that during the DHR process DCP have become aware, as have other agencies, that Adult B had experienced depression since 1994 but there was no indication to them that Adult B presented a risk to others as a result of her mental health problems or that Adult A in particular was at risk of harm.

As described previously the DCP response to Adult B was governed by protocols and policies relating to missing persons and mental health. It is clear from the IMR that although those include appropriate and robust risk management systems, these were not always fully utilised and this is a learning point that arises from the DCP IMR.

The IMR highlights the fact that mental illness and domestic abuse are often exhibited together and can be closely intertwined. The IMR rightly highlights the need to ensure that staff within DCP should be aware of the links between the two when dealing with relevant enquiries.

The IMR points to the professional status of Adult A and Adult B as a possible factor in the way in which officers responded to them and how they engaged with initial risk assessment processes and how comfortable or not they felt in asking what they may have felt to be potentially difficult or intrusive questions.

In respect of information sharing there is a Devon and Cornwall process for sharing risk data relating to mental health. It includes a form, MH1 that is used to request access to data held by another agency. The form and associated process allows for agencies to seek data from each other about people considered to be at risk to themselves or others. An MH1 form was not completed in respect of Adult B although information was shared by DCP officers with staff at Longreach Hospital.

There is no evidence to indicate that DCP officers responded or made judgments about their response to Adult B's mental health that were anything other than appropriate and based upon the information they had at the time. Although there were omissions in the use of COMPACT it is clear these had no direct influence or bearing on the quality or outcome of their interactions with either Adult A or Adult B.

DCP does have structured processes for the risk identification and assessment of domestic abuse incidents and clear risk management pathways affording victims the opportunity to engage with a range of national and local domestic abuse services, however these procedures were not invoked as part of their contact with Adult A and Adult B.

The IMR highlights more recent actions to focus upon the ambition for zero suicide in the area and that a task and finish group has been established to take this work forward. Allied to this is work to scope the capacity to refer cases of attempted suicide into the Multi-Agency Referral Unit (MARU) process.

The contacts with Adult A and Adult B did not meet the threshold for multi-agency strategy or safeguarding investigation and as such it was appropriate not to escalate them further.

The DCP IMR concludes that the homicide could not have been foreseen. It does rightly acknowledge that opportunities to identify risk indicators including domestic abuse and relationship difficulties were not fully utilised under the Missing Persons investigation procedures, however it is unlikely that this impacted in any way upon the eventual outcome.

The DCP IMR makes two recommendations which can be found in Section Five.

2.2.2 NHS England - Primary Care

NHS England commissioned an independent author to produce the IMR relating to primary care involvement. The author, who is an experienced clinician who now works independently, had previous experience of conducting reviews of serious incidents in the NHS and producing similar reports for multi-agency reviews. In conducting this IMR, the author had access to all GP notes and associated information held by GPs. The author was unable to secure an interview with Adult A's GP who felt that such an interview was not necessary. The author did interview Adult B's GP as part of the review.

Analysis of involvement and lessons learned

The GP practice had up to date Safeguarding polices in place at the time of the incident and it was registered with the Care Quality Commission (CQC). At the time the IMR was written the practice had not been inspected by the CQC.

The IMR raises the issue of Adult B's professional background and whether this had any impact on either the relationship between her and her GP, and whether this affected her response to the advice given. Adult B's GP felt that her professional background and qualifications meant she had clear views about the management of her condition and as a result, the advice offered by the GP was not always adhered to.

Adult B's GP reported that she had a good relationship with the GP's at the practice and that the number of GP's she met with was kept to a minimum in an attempt to provide consistency and effective communication. Adult B was seen urgently when required and there is no evidence of delays brought about by access to primary care input.

In relation to risk, the IMR finds that the notes document issues of heightened risk and that this information was shared with partners in the practice to ensure that engagement with Adult B was consistent and that all practice colleagues had up to date information. Both Adult A and Adult B's GP practices had professionals working in them who were appropriately trained and experienced, including in the assessment of risk and risk management. The IMR does not provide clarity about the extent to which they were sufficiently skilled in the specific assessment and management of risk in relation to mental health and complex needs. Although the notes indicate that risk assessments were conducted there is a lack of documentary evidence to indicate that they were undertaken using any recognised methodology or recording framework.

It is clear that the focus of assessment was upon Adult B's risk to herself rather than to Adult A or others. The IMR states that at no point did the GP believe there was any indication that Adult B posed a risk to either Adult A or any other individual. There was no history of behaviour that provided any insight into Adult B's subsequent actions. In the context of the information available this was a reasonable approach, but it did not encompass a broader view of the circumstances of Adult B and risk to others was not sufficiently explored with her.

The IMR finds that the GP records indicate that a full range of options for treatment and support were offered to Adult B, both from primary care and secondary care services. These include medication, but the IMR notes that Adult B would make her own judgment about the use of prescribed medication.

The IMR finds that there is no evidence that indicates that the needs (or views) of Adult A and Adult B's children (albeit that they were not young children) were routinely sought by the GP's at the practice. No carer assessment was suggested or offered to Adult A and this should have occurred.

Both GP practices had comprehensive notes. The notes do indicate that where information was shared it was done so in a timely way with other agencies.

In the view of Adult B's GP, communication with secondary care services, in particular with community mental health services was not as effective as would have been hoped or expected. The notes suggest that both Adult A and Adult B's GP practices did receive information from other clinicians that informed their input but that this was inconsistent. Specifically, Adult B's GP reported instances when the practice was not aware of whether Adult B was in hospital or of the nature of her contact with and support from community mental health services and that they were not made aware of discharges from hospital or home leave periods. Effective joint working between primary and secondary care was affected by this inconsistency of communication and the GP would have preferred to have been in possession of more accurate information that could have informed their own interaction and engagement with Adult B.

This support offered by Adult B's GP practice was complicated by her engagement of private practitioners and by her reluctance to engage in the treatment offered. This became more problematic over time and the complexity of Adult B's mental health required a range of inputs from several clinicians and workers. Referrals to other agencies and services were appropriate but there is no evidence of regular multi-disciplinary team meetings to discuss and review the treatment and support being offered across primary and secondary care.

It is not evident that Adult B's case was discussed or referred to senior managers or partners in the practice. However, Adult B's GP did state that partners in the

practice were informed about particular approaches to management, including attempts to 'streamline' Adult B's contact to a GP so that requests from her for medication could be reviewed and approved by that GP to provide consistency of decision making based on good knowledge of her case.

Both Adult A and Adult B sought regular help from Adult B's GP practice over a number of years. The notes indicate that Adult B received timely and knowledgeable, responses when presenting and that Adult A had his concerns regarding his wife listened to and acted upon.

There is no evidence to suggest that the GP practice was unaware of how or to whom to refer when specialist intervention was required and the IMR notes that various interventions were proposed and/or recommended with varying degrees of success. The notes indicate that referrals were followed up by the GP's, but there is no evidence or audit or quality assurance of either the impact of treatment or their individual long-term outcomes.

The IMR indicates that Adult B's GP strove to support her and to ensure that partners at the practice were kept informed of her presentations, which were taken seriously and responded to with a clear focus aimed at addressing the presenting symptoms. The success or otherwise of this was impacted by Adult B's fluctuating willingness to engage with the advice, support and treatment offered.

GP's did appropriately engage in Mental Health Act assessments with Adult B and clearly liaised with psychiatrists and Approved Mental Health Act Professionals (AMHPs) in conducting those assessments, which considered detention under the Mental Health Act.

Adult B was reluctant to reveal much information about her private life and certainly did not offer such information voluntarily, indeed it is noted that she resented such questioning from professionals involved in her care and support. She has been described in the IMR as an independent person who preferred to manage her own health issues and would choose when and how to engage with her GP and other clinicians and whether to accept or act upon their advice about treatment. The focus of the GP interaction was around the presenting symptomatology and as such did not provide a more holistic view of Adult B's wider circumstances or the needs of Adult A or her family. Although Adult A's concerns for his wife were responded to, there was a lack of consideration of the impact of her illness and behaviour upon both Adult A and the wider family, including upon their children.

Although it may have helped if more effective joint working and communication between primary and secondary care had taken place, it is not clear that this

would have had any direct bearing on the eventual outcome. Equally it cannot be said with any certainty that it would not have.

This may have been compounded by Adult B's unwillingness to disclose information, her attempts to manage her illness herself and her fluctuating engagement with health care services. The extent to which her own medical training and professional background influenced the approach of the GP's is unclear but the IMR rightly suggests that the use of reflective practice and more collaborative approach within the GP practice might have assisted in working with someone whose medical knowledge led her to challenge other health professionals about their advice and support.

There is no evidence that the GP practices sought to explore issues of domestic abuse or to establish whether Adult B posed any risk to Adult A or others in this regard. The IMR demonstrates that both GP practices showed respect for both Adult A and Adult B and that they sought to respond to their needs in a timely and empathic manner. In particular Adult B's GP practice attempted to support her effectively, despite the challenges she presented.

The IMR highlights the complexities of working with someone whose willingness to engage fluctuates, and whose professional background had an impact on how they manage their health problems. The GP from the practice was clear that the fact the Adult B was a GP herself and therefore understood her own condition to some extent did not influence the treatment they advised which was based on the clinical presentation and history given by the patient, as is usual. The IMR found that the named GP with whom Adult B had most contact displayed a clear awareness of the potential for Adult B to influence her care and ensured that this was also scrutinised through the practice collaborative and approach to consistent care for Adult B. This might best be described as a "check and balance" process for all practice staff collectively to ensure that they were not being unduly influenced by Adult B.

It also shows that effective risk assessment needs to focus on risk to others as well as risk to self and that work is needed to develop the skills of GP's (and most likely other health care professionals) in taking an holistic view of an individual, rather than one that is more focused on the symptoms they present. The needs of others in the family, in this case particularly Adult A, and the impact of Adult B's condition could have been explored and responded to more effectively and joint working across primary and secondary care may have assisted this.

The IMR makes a set of recommendations that can be found in Section Five of this Overview Report.

2.2.3 Cornwall Partnership NHS Foundation Trust (CFT)

As of 1 April 2016 Cornwall Partnership NHS Foundation Trust (CFT) provides 16 adult community health services across the county. The CFT IMR was produced by the adult safeguarding lead professional for CFT. She possesses expertise in mental health and domestic abuse and in undertaking internal IMRs for reviews of serious incidents, DHRs and mental health homicide reviews, both internally and for external organisations. A specialist independent Consultant Psychiatrist was also part of the CFT IMR process. This was requested by the IMR author to aid objectivity and transparency as well as bringing additional clinical expertise to the process.

At the time of the incident Adult B was a patient of and in receipt of services from the West Home Treatment Team (HTT), Carrick Community Mental Health Team (CMHT), and she was an informal patient on Fletcher ward. Adult B was on home leave supported by the West HTT and her family and was seen daily by staff from HTT while she was on leave which commenced 8 November 2013, seven days before the incident.

Detailed background of CFT engagement with Adult B

The IMR provides particularly detailed information about Adult B's mental health and her contact with mental health services. This Overview Report sets out the background of that engagement in some detail, given the particular relevance of Adult B's mental health to the review, to reflect the level of information within the IMR and to provide the necessary overview within this report.

Adult B's documented mental health problems appear to date back to 1994 when during a GP consultation symptoms of depression were observed. This resulted in a prescription for an anti-depressant medication. A subsequent referral to a Consultant Psychiatrist (Consultant 1) took place; hypomanic behaviour was the primary issue. This may have been drug induced or it may have been bi-polar disorder. Due to particular sensitivity to medication, it was discontinued. Adult B had shown some particular sensitivity to medication and she was noted to be excessively consuming alcohol at this time.

In January 1995 Adult B was described as having reduced her alcohol intake and appeared improved, she 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.

The IMR also noted that there is a record towards the end of January 1995 that

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.[7]

In January/ February 1995 Adult B saw Consultant Psychiatrist 2. There had been a reoccurrence of depressive symptoms attributed to domestic stress and there was a reported exacerbation of pre-existing marital problems.

In November 1996, Consultant Psychiatrist 2 wrote to Adult B's GP with an update. The IMR notes that it was reported that there was no evidence of manic depressive illness. In December 1996, at a GP consultation Adult B stated she had stopped seeing Consultant Psychiatrist 2 as she was feeling better. Consultant Psychiatrist 2 was of the opinion that there was no evidence of depressive illness, and believed that Adult B may have had serotonin syndrome[8] rather than a manic episode. There was also some thought that there may be issues related to personality traits or stressful lifestyle. The IMR states that this may have been a more acceptable diagnosis for Adult B who had expressed concern about what a manic depressive diagnosis might mean for her career as a GP.

In July 2000 Adult B was referred to Consultant Psychiatrist 3, who made one assessment and referred her to RELATE. Adult B had a period of time off work, returning in August 2000.

It has been reported that there are missing medical records, however it is reported there was no further contact with Adult B until she was referred again in January 2009.

In January 2009 Adult B consulted her GP about psychiatric problems and was referred to Consultant Psychiatrist 4 at CFT's Trenqweath Unit; but the IMR reports that the outcome of this is unclear.

By December 2010 Adult B had a number of chronic long-term conditions, including coronary heart disease, diabetes, asthma, hypertension and high cholesterol. At this time Adult B had a colonoscopy which was normal. She was unhappy with the outcome and was worried she had colon cancer and requested a second opinion. Family members reported that the results were normal.

In February 2011 Adult B was seen in the Emergency Department (ED) there were

[7] Next of kin is in fact not the determining factor under the Mental Health Act. The nearest relative is the person with whom an Approved Mental Health Act Professional must inform of detention, or when assessing under Section 3, seek consent for detention from) The nearest relative may or may not be the next of kin. The Code of Practice provides guidance about who constitutes a nearest relative.

[8] Serotonin syndrome occurs when the levels of a chemical called serotonin in your brain become too high. It is uncommon but is usually linked to taking a Selective Serotonin Reuptake Inhibitor in combination with another medication that raises serotonin levels. Symptoms include confusion, agitation, sweating and diarrhoea. Information from www.nhs.uk

concerns about a stroke; had some difficulty with her speech, a right facial droop, mild facial nerve palsy. In March 2011 Adult B was followed up in the stroke clinic as her symptoms lasted over seven days. She had other concerns about her health, unstable angina and concerns about the stress of work necessitating time off work; this led to her decision to retire from GP practice in September 2011.

The IMR notes that the loss of her career and role may have been a precipitating event in Adult B subsequently developing a psychotic depression and she reported that she did not cope well following retirement and found it hard to fill her time.

In April 2012 Adult B experience a recurrence of depressive symptoms and was commenced on Citalopram (an antidepressant). On 16 May 2012 she was seen at A&E (with Adult A present) by the CFT Psychiatric Liaison Service after taking an overdose of 21 tablets of Citalopram 20mgs. After this assessment Adult B returned home with the support of Adult A. On 26 July 2012 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 psychotic". 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. The IMR notes that Adult B believes she was unhappy about only one psychiatrist.

Medication was prescribed and given that night. The IMR states that Adult A told Consultant Psychiatrist 5 he did not want Adult B referred to the NHS because his wife would be angry with him. Consultant Psychiatrist 5 understood this as Adult A being concerned about damaging his relationship with his wife. Consultant Psychiatrist 5 reportedly told both Adult B and Adult A that if she was not going into hospital it had to be a condition of care that Adult B was never left alone.

On 30 July 2012 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 her psychotic ideas and crucially that she had been acting on these delusional ideas. In her letter Consultant Psychiatrist 5 commented on Adult B having delusions of poverty believing she was bankrupt and that 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 them. 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. The IMR notes that at this time Adult B was described as being deliberately guarded as she was concerned she might be sectioned and admitted to hospital. She had stopped her medication, was not driving due to poor concentration; and was agitated.

The letter concluded that Adult B was severely depressed with psychotic delusions, in a perpetual state of anguish, with classic symptoms of depression present. Consultant Psychiatrist 5 advised that if Adult B was unwilling to cooperate and take medication consideration needed to be given to hospital admission.

On 9 August 2012 in the evening Adult A rang Consultant Psychiatrist 5 saying that Adult B would not 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 that as Adult B was outside in the car to make a phone call to the police, and they would consider using Section 136 of Mental Health Act (MHA). Later that evening Adult B was detained on a Section 136.

The clinical notes record that while Adult B and her sister in law were out walking, her sister in law tried to drag Adult B back from cliff edge and Adult B tried to jump out of the car, as described in the DCP IMR.

At 23:14 there was a MHA assessment and Adult B was admitted to Bay Ward at Longreach Hospital under Section 2 of MHA 1983. Admitting medical staff noted that Adult A was supportive but possibly due to her illness there was friction in the relationship. Consultant Psychiatrist 5 spoke to Adult A later that night and the following morning, establishing that Adult B was safe in hospital. On the Monday Consultant Psychiatrist 5 faxed all reports through to the CMHT consultant psychiatrist for the Carrick CMHT.

From 9 August 2012 to 11 September 2012 Adult B remained on the ward under Section 2 MHA. She was treated with anti-depressant medication and anti-psychotic 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 that there “maybe some tenuous evidence of psychosis.” Adult B was reported as being guarded in what she would disclose and the notes comment on her as being “unwilling to discuss/disclose how she is feeling”. A care coordinator was allocated from the CMHT on 28 August 2012.

On 2 September 2012 a disclosure was made to ward staff about Adult A during

one to one time requested by Adult B. She spoke about recently finding out that Adult A 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.

On the 4 September the care coordinator attended the ward round to meet Adult B and Adult A. Documentation records a diagnosis of depression with psychotic symptoms. On this date Adult B was discharged from Section 2 of the MHA.

From September 2012, Adult B was on leave from the ward and supported by the HTT. Leave was agreed on 11September 2012. She was visited on 13 September and was described as not doing well at home by herself. The HTT planned with the ward for her to spend time on the ward during the day and to be at home at night when Adult A was present.

On 17 September Adult B was brought back to the ward by Adult A. She got up during night and had gone to Hell's Mouth with the intention to jump off the cliff. Adult B was clear she did not want to come back to the ward, but acknowledged she did have suicidal ideation at time of going to Hells Mouth.

In early October 2012 Adult B was assessed as having depression with psychotic symptoms but that she was improving and leave continued with HTT follow up. On 10 October 2012 HTT made a home visit. She described on going thoughts and fears about Adult A leaving her. HTT staff questioned whether Adult B was masking symptoms and/or making efforts to present as well as possible.

On 6 November 2012 at ward round, Adult B's discharge from hospital was agreed. Her diagnosis at discharge was given as severe depression with psychotic symptoms. The Care Programme Approach level was agreed as being the enhanced level. Adult B had an allocated care coordinator and was given her contact number. She was advised not to drive and to inform the DVLA regarding her admission. A risk of noncompliance with prescribed medication was noted with an increased risk of relapse of her illness if medication was not taken, this was assessed as moderate risk.

After discharge from the ward Adult B was seen by the HTT at home on 8 November 2012. During this visit Adult A telephoned while the HTT worker was present. The IMR notes that it was recorded that Adult B liked to speak to her husband a couple of times a day for reassurance; Adult B told the HTT worker that Adult A was 'getting fed up with it every day'.

Handover to the CMHT was in place, the care coordinator planned to visit on 12 November 2012 and the social inclusion worker on Wednesday 13 November 2012. Adult B was given the out of hours service telephone number to call if she felt she needed extra support.

On 9 November 2012 Adult B was detained by police on Section 136 of the MHA. She had been found sitting at Hell's Mouth. She had thoughts about jumping off cliff, mostly prompted by her worries that Adult A was going to speak to a solicitor seeking divorce. Assessing staff noted there was no evidence of psychotic thoughts; Adult B wanted to go home and was accepting of HTT support. The assessing staff spoke with Adult A, who was reportedly surprised at the events as he felt Adult B was improving and the previous day had been good, and they were planning their holiday.

The assessment concluded that Adult B was not detainable under the MHA and that she should go home with support from Adult A who agreed to collect Adult B and take her home. The plan was for HTT to support Adult B with home visits the next day.

On 10 November 2012 the HTT made a home visit following the previous day's events. Adult A joined them at the end of the visit. The IMR notes that Adult B was reported as appearing anxious and perplexed. She told the HTT worker that the previous day 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's mood was difficult to assess, she described experiencing overwhelming emotions she was unable to control, prompting her to drive to Hells Mouth. Adult B felt Adult A was likely to grow tired of her, that he was fitter, more attractive and had aged better than her. Risk was assessed and Adult B denied on-going thoughts of self-harm or suicide.

The HTT staff concluded that the risk issues were that Adult B continued to present with high level of unpredictable impulsive suicidal acts. When HTT visited the next day, 11 November 2012, Adult B reportedly remained troubled. She voiced concerns that Adult A was planning to leave her. She was encouraged to consider the reassurance Adult A had offered the previous day. Adult B stated that Adult A was 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 had previously considered her suspicious, paranoid or over anxious and she wished to make it clear her fears were not a figment of her imagination and that Adult A's behaviour, the emotional distance between them and their relationship had altered and was of concern to her.

On 12 November 2012 Adult A phoned the care coordinator to report Adult B was on cliffs at Godrevy, and the police were informed. Adult B was found standing next to the cliffs and the Police detained her using Section 136 MHA. Later that day a full Mental Health Act Assessment (MHAA) was undertaken Adult B stated she had had a small row with Adult A over car keys and was worried about; finance, concerns about tax, worried Adult A was having an affair and planned to leave her. 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 to HTT support at home.

Adult A also stated that Adult B was monitoring his movements 24hrs a day and he was finding this restrictive. Adult A could not say whether Adult B was compliant with medication.

The assessment concluded that Adult B was not delusional, but had anxiety, overvalued ideas[9] (*they were capable of challenge as opposed to being held with absolute conviction*) with regard to her husband, and detention in hospital under MHA was not required because the risks were reduced at that time as Adult A was happy to have her back home and provide support.

On 4 December 2012 the care coordinator saw Adult B with the consultant psychiatrist. She described feeling a lot better and denied any thoughts of self-harm. The IMR notes that Adult B was described as lacking in insight into the past and why others would be worried about her. She had on-going worries regarding her pension, the settlement of financial arrangements at her previous practice and whether Adult A might leave her. The notes states that the impression formed was that these issues were part of her depressive illness and seemed likely to be anxiety related ruminations and that no psychotic symptoms or obsessive compulsive disorder symptoms were noted.

The social inclusion worker visited Adult B four times between 11 December 2012 and 15 February 2013 and worked to engage her in a range of activities with limited success.

When the care coordinator next visited on 14 February 2013 Adult B was noted as remaining pre-occupied with her marital relationship and was especially focused on what were planned separate holidays. Adult B was concerned Adult A would meet someone else and she could not imagine life without him. Adult B had agreed to attend a training course to become a volunteer with the Citizen's Advice Bureau.

[9] The overvalued idea, first described by Wernicke, refers to a solitary, abnormal belief that is neither delusional nor obsessional in nature, but which is preoccupying to the extent of dominating the sufferer's life. McKenna, P. J. BJPsych 1984

Having been enabled to drive again she 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. Adult B was aware her mood generally improved in the spring and was keen to spend time on the boat she and Adult A owned, doing so with him.

On 15 February 2013 the CMHT Consultant Psychiatrist saw Adult B. Her diagnosis was recorded as anxiety and depression (resolved) but anxious rumination continued. She was noted to have progressed well but was also noted as continuing to have anxieties around her marriage and financial affairs, however these were less marked than previously. Adult B was planning a week's skiing holiday with a friend and her husband was going with another friend separately.

Adult B was next seen by her care coordinator on 7 March 2013. She reported that her holiday had gone well, but talked about having second thoughts about work with Citizen's Advice Bureau. She was attending the Women's institute and the Women Register and was also thinking about attending church again. She reported that there had been no increase in anxiety since the reduction of her medication. The care coordinator planned to see Adult B again on 10 April 2013. At this point the care plan was for monthly contact with the care coordinator and in-between to have contact with the social inclusion worker for activity planning/ support.

The care coordinator cancelled the next planned appointment on 10 April 2013 at 14:00hrs and made an entry on RiO (the electronic recording system) which showed referral transfer. This was an error; there was no referral transfer.

The next contact with the care coordinator was a home visit on 15 May 2013. At this visit Adult B appeared more relaxed, and had spent a few days away with Adult A in France. The care coordinator next planned to see Adult B on 13 June 2013 and reminded her she could contact the care coordinator before then if needed.

On 9 October 2013 Adult A telephoned the service to request an urgent appointment as Adult B had gone missing and was found by police at Hell's Mouth. Adult A was requesting an urgent review with the CMHT consultant psychiatrist. Adult B was seen by the Consultant Psychiatrist and the care coordinator alone and then with Adult A. The event leading up to this was their son's wedding on 5 October 2013. The lead up to the wedding appeared to have been stressful and on the day of the wedding Adult B was very anxious, and ruminating about their financial situation. She 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 questioned whether this coincided with Adult B gradually reducing her medication which it was planned for her to increase again, making clear that any plans or action to reduce were against medical advice.

On 17 October 2013 the care coordinator visited Adult B at home. At this visit the IMR states that she appeared distracted, her concentration was difficult and she remained worried about money and the fear that Adult A would leave her. She denied self-harm or thoughts of suicide but 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 that Adult B had the ability to do this. The importance of taking medication was reiterated to her and she was strongly encouraged to contact a therapist of her choice for psychological intervention, and another appointment was made for 24 October 2013. Adult B's risk assessment was updated by the care coordinator. The IMR states that 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 detained Adult B using Section 136 of the MHA 1983. She was again found at Hell's Mouth sitting on the edge of the cliff. Adult B stated she went to Hell's mouth with a plan but changed her mind.

A Mental Health Act Assessment was then undertaken and Adult A was contacted. His view was that Adult B was as poorly as she has been in the past, he was concerned about the risk of suicide and believed she would make active attempts to slip away from family again and that this was a worry. Adult B was offered and accepted voluntary admission to hospital. There was no bed available at Longreach hospital therefore she was admitted to Fletcher ward at Bodmin Hospital, with a plan to transfer when a bed became available. The family reported that Adult A had felt he had to uncharacteristically press for Adult B's admission by saying the absence of a bed at Longreach 'was not his problem'.

On 21 October 2013 Adult B requested medical staff to allow her to go home and was seen by a junior doctor. She stated she felt better and she did not want to stay in hospital, although she was still feeling low and anxious, she wanted to go home to sort out financial issues. Medical staff explained to her she had only been on the ward a few days and there was no great improvement and that three days was not enough to properly assess her. Adult B decided to stay in hospital to be seen by the consultant psychiatrist. During her time on the ward her medication was increased. While on the ward Adult B expressed concerns to staff, she had concerns about finances, about Adult A leaving her, and concerns about her vulnerability if he leaves her and concerns about being sectioned. She reported that Adult A was willing for her to go home. It was noted that she struggled with the concept of how she would know when she was 'better' and feared it was inevitable that Adult A would leave her and if that happened she would have no home and no income.

On 4 November 2013 Adult B was reviewed by the Consultant Psychiatrist who felt it may be appropriate for her to go on leave with HTT support. There was a plan for HTT to assess, and give their view. There were mixed views, with ward staff feeling that Adult B was not well enough for leave, although when assessed by HTT on the same day the view from HTT was that she should have some unescorted ground leave and be reviewed again by the Consultant Psychiatrist prior to going on leave with HTT support.

On 6 November 2013 Adult B was reviewed by the Consultant Psychiatrist. It was noted anxiety, ruminations and delusions remained but that Adult B was less distressed by them. Adult B was assessed as able to go home on leave at the weekend when Adult A was around and with HTT daily support, with a plan to see her at the next ward round on 12 November 2013.

The Consultant Psychiatrist commenced a trial of haloperidol 1mg (a drug often prescribed for the treatment of acute psychosis) to augment other medication. The IMR author advised that following a question from Adult A's family members about the use of haloperidol she spoke with the prescribing Consultant. The Consultant advised that haloperidol now often used in small doses for anxiety as well as psychosis, and that it had less side effects of weight gain and he was hoping Adult B would benefit from this.

Adult B agreed to phone the ward if she felt unsafe. She remained on the ward until 8 November 2013 when she went on home leave with Adult A with support from HTT.

On 9 November 2013 the HTT visited Adult B at home, she was anxious and her mood appeared low. She had anxious thoughts about money, worries about housekeeping, she denied thoughts of suicide, but responded to risk questions evasively and her risk to self was considered by HTT to be high. A plan was made for HTT to monitor home leave, to encourage with activity planning and to visit daily.

On 10 November 2013 HTT qualified staff made a home visit. Adult B continued to voice anxieties about Adult A leaving her. She requested an afternoon visit the next day to allow her some time alone in the morning. On 11 November 2013 HTT staff made a telephone call to Adult B to arrange the home visit. She again expressed concerns that she was worried about Adult A leaving her.

During the home visit Adult B again expressed anxieties about whether Adult A would come home that night and whether staff thought he had stayed with a 'lady friend' while she was in hospital. Adult B was described as unable to accept any reassurance and reported that Adult A was unable to reassure her either. HTT staff assessed her as remaining at risk of impulsive actions of self-harm.

On 12 November 2013 Adult B and Adult A attended 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 and HTT staff were present at this meeting. Adult B was 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.

At this review Adult B stated she wanted to drive again, her husband was worried about her driving to Hell's Mouth to attempt suicide and he expressed a view that there were never any signs prior to her actions. She was noted as more anxious when Adult A was working; she had thoughts of him leaving her.

The junior doctor recorded the risk as difficult to determine, Adult B was vague about the topic, and would not commit to answer on suicidal thoughts. Risk was discussed with Adult A and Adult B. The junior doctor documented "We cannot 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 Adult A and daily contact from HTT, medication was to remain the same, social inclusion was already offered by HTT, and Adult A was to reconsider the risk of driving if Adult B is fit enough.

On 13 November 2013 HTT qualified staff made a home visit. Adult B again presented as anxious with thoughts that Adult A may leave her. She also had concerns about finances. On leaving Adult B showed HTT staff Adult A's wardrobe and stated there were several empty hangers, that shirts and other items of clothes had disappeared. HTT staff discussed whether going out when they visit would be of benefit. She 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 the ward review and to monitor Adult B's mental state and risk. HTT contacted the social inclusion team who agreed to bring forward their input. The HTT shift leader planned the next day's activity and allocated a Support Time & Recovery worker (STR)[10] to visit Adult B with the purpose of taking her out on a social activity.

[10] STR workers primary function is to **S**upport service users and carers by giving them **T**ime and so help their **R**ecovery. Details of the role was set out in the original STR guidance published in 2003. STR workers A Competency Framework DH 2008

Events relating to CFT immediately prior to the incident

Adult B was last seen prior to the death of Adult A on 14 November 2013 by an HTT STR worker. The time of the visit was 11:00 – 12:20hrs. The purpose of this contact was to provide a social activity with support as a distraction to some of Adult B's anxious thoughts, which were observed on 13 November 2013 when HTT qualified staff visited.

During the contact with Adult B on 14 November 2013 she was observed to relax and engage in conversation with the STR worker. It was noted that her agitation increased when they got back to her house. She expressed concerns that Adult A's intention was to leave her, and she was unsure whether Adult A would return that evening. Adult B could not be reassured. When leaving to go to the next visit, the STR worker was concerned when Adult B got into her car before she pulled out of the drive. The STR worker asked Adult B if she felt safe, but she did not answer this question.

The STR worker engaged Adult B in conversation for approximately 20 minutes and left her with a plan to occupy her time until Adult A came home from work. The plan was to make a drink, phone Adult A, phone one sister in law, and go for a walk with another sister in law as previously planned.

The STR worker phoned into the HTT base to make the team aware of the increase in Adult B's anxiety. Upon return to the office base in the afternoon/evening after visits, the STR worker discussed the concern about Adult B's increase in anxiety with staff in the team and the shift leader was later informed. There was a plan made for qualified staff to go out the next day to review Adult B to consider if she needed to be back in hospital.

Adult B was visited by her sister in law on the afternoon of 14 November 2013 and they went for a walk. She was described as being in good spirits when her sister in law left their house in the afternoon. Upon returning from the walk Adult B describes feeling a lot worse, she knew Adult A would not be back from work until 19:00 that evening, so she decided to drive to Hell's Mouth, with the intention of taking her own life.

Adult B arrived there after dark, and according to the IMR recalled being determined that she should end her life by jumping off the cliff. The IMR records that Adult B found she was unable to take her life, in part influenced by her religious beliefs and thoughts about her children. She returned to her home but the timing is not clear. The IMR indicates that Adult B stated that her husband knew where she had been, that he did not say much in reply to her various concerns, and they went to bed.

In her statement to the Police Adult B said that she was unable to sleep and at about 03:00hrs she got up. She continued to have thoughts about killing herself and went to the kitchen to get a knife. Adult A called her back to bed and Adult B took the knife to bed with her, hiding it from her husband as she wanted to cut herself.

At approximately 07:00hrs Adult B described that the alarm went off, that she had a mundane conversation with Adult A. Adult B then stabbed Adult A once in the heart at approximately 07:30hrs. Adult B called an ambulance and stated she had stabbed her husband. The IMR states that Adult B told the assessing psychiatrist that when she called the ambulance she knew Adult A would die and when she realised what she had done she stabbed herself several times. It is reported that Adult B told staff that she was not prepared to let Adult A leave her and that she continued to believe that he was being unfaithful.

Adult B was treated for her wounds at the Royal Cornwall Hospital and was provided with support by staff from CFT Mental Health Service. Staff provided 24 hour, two to one line of sight observations, until Adult B was medically fit to leave, upon which she was arrested on suspicion of murder.

Analysis and lessons learned

The introduction of HTT services is intended to keep the length of inpatient stays to a minimum, but Adult B's first inpatient admission in 2012 was relatively lengthy and this would indicate that her progress towards recovery was slow.

Between August 2012 and December 2013 the Care Programme Apporach (CPA) care coordinator did not complete the care coordinators information on RiO electronic recoding systems. A care plan, risk assessment and CPA was not completed by the care coordinator. No named care coordinator is formally recorded in the correct RiO section, this did not take place until transfer to the CFT Centre for Mental Health & Justice (Forensic) team was undertaken following the incident. In addition the section on risk of harm to self was not updated and was not completed.

There was a lack of care co-ordination and regular contact with Adult B between May 2013 and October 2013. Some of this is attributable to sickness absence, which was believed to be related to work place stress. This work place stress does not appear to have been shared in detail with managers prior to periods of sick leave. At the same time it is clear that, as the IMR states, there was insufficient and inadequate line management and supervision of the care coordinator, nor was there an adequately robust response to the poor standards of record keeping highlighted in the IMR.

The lack of a written care plan, risk assessment and CPA review is a serious deficit not only in recording but also in the delivery of care services to Adult B.

The RiO risk summary was not updated with information about Adult B monitoring Adult A's movements 24hrs a day and that Adult A found that restrictive. The IMR found that the RiO progress notes do not contain this information either. This was not recognised as a high risk factor in domestic abuse and there was no recognition of the possibility of jealousy and potential associated risk. The RiO audit conducted by the IMR author shows the clinical team was unaware of the risk factor as the clinical team did not read the RiO section where the full MHA assessment was recorded, staff read only the progress notes summary of the assessment. The thinking of the CFT staff at the time was that Adult B continued to voice a range of concerns and there was equal weight to these concerns - finances, pension and her relationship, a view that with the benefit of hindsight was inaccurate. The constant raising of concerns by Adult B about Adult A leaving her and her fears of abandonment were not recognised as a risk factor in relation to him from her.

There was a lack of comprehensive history taking from Adult B during both her admissions to hospital. Even accounting for her reluctance to disclose what she saw as private information, this lack of comprehensive history meant that there were most likely gaps in the knowledge of her circumstances and the background to her illness that meant that a full view was not available to CFT staff working and as such they were not always as well informed as would have been expected.

Reductions in medication were most usually undertaken by Adult B and not by clinicians either in secondary or primary care.

There was a failure to offer or conduct a carer's assessment for Adult A. If this had been undertaken then it would have provided a confidential and safe process for him to share his concerns and views, thus giving a more holistic view of the situation. It also appears that no opportunity was provided for other family members to contribute their views. It is recognised that such an opportunity for them to do so may well have been constrained by Adult B's wishes but no exploration of this possibility appears to have taken place.

Adult B's mental health seemed to deteriorate over a two-year period and she became increasingly anxious about her relationship with Adult A and about their joint finances. This distress seemed to escalate in the months before Adult A's death and Adult B was very focused and fixated on her concerns. She began to become visibly distressed and there was suicidal ideation, with a number of incidents occurring where she threatened, or attempted, to take her own life.

The degree to which Adult B was concerned with Adult A's behaviour and whereabouts would better have been described as having been controlling. The fact these concerns occurred in the broader context of her mental ill health appears to have impacted on how this behaviour was viewed by mental health professionals, taking account of the limited knowledge of domestic abuse among staff at that time.

Adult B would constantly text or call Adult A when he wasn't at home. This is often linked to a fear that someone may leave. Adult A was constantly having to reassure Adult B that he was not going to leave, he even said it was 24 hours a day and restrictive, this is a high risk factor in itself. If the victim does not state they are frightened or alarmed by the behaviour the significance of it may not be recognised. This repetitive texting and calling is a high risk marker, and when put together with Adult B's irrational fear of Adult A leaving, starts to build a picture of increasing risk to Adult A, a picture that was not recognised. However, in the context of her presentation, from the information available to staff as described in the IMR, her presentation would not automatically have steered those staff to consider domestic abuse.

CFT staff did not perceive Adult B's behaviour to be domestic abuse given that it took place as part of her mental health problems. As such no routine enquiry in relation to domestic abuse took place. Routine enquiry was not part of CFT mental health care at this time. There was a lack of knowledge relating to domestic abuse risk factors and behaviours. This is learning for CFT. Asking about domestic abuse is now one of the questions on the RiO risk assessment. This was implemented from recommendations from the IMR, and all from line clinical staff are required to attend the full day domestic abuse awareness course with more senior clinical staff undertaking the DASH risk assessment second day in addition.

It is evident that Adult A was relied upon heavily to provide support and monitoring of Adult B, most usually during periods of home leave. The support of the HTT was built on the assumption that he could cope and that he was not at risk. It is possible staff made an assumption the relationship was a good one as they were not considering domestic abuse or risk of harm to Adult A. Staff may have interpreted Adult A's calm and patient presentation throughout Adult B's care as one of him coping.

As has already been highlighted, the assessment of risk was not well documented. However, it is evident from the IMR that the focus of concern was upon Adult B's risk to herself and not to others. Based on the information available this was probably reasonable. She had engaged in a number of acts where she had thought about ending her life and had continued to have thoughts of suicide throughout her contact with CFT's services.

Adult B had not, as far as can be ascertained, ever talked about taking Adult A's life or harming him in any way. There is no evidence that physical domestic abuse was or ever had been a factor in their relationship.

Staff were properly concerned with the risk that she might take her own life, but did not adequately explore or assess the potential risk(s) that she might pose to Adult A or others. However there was a failure to follow expected good practice in risk assessment.

Poor record keeping has been highlighted as a significant deficit in the practice of CFT staff in this case. The RiO system of recording has been identified as fragmented and that at the time of the incident, staff were inconsistent in the way in which they utilised the system, with many of them having different levels of knowledge about how to use it. This contributed to poor recording practice.

In the period prior to the incident the HTT had no direct access to dedicated medical time within the team. The IMR author advised that the HTT model CFT use is one where there is no dedicated Consultant - a dedicated HTT consultant would be the usual model. In Cornwall the Consultants did not want to use this model. They believed that the consistency of HTT being able to access the consultants from the CMHT was the model they wanted and that patients benefitted from the consistency of the Consultant. There are on-call Consultant arrangements for out of hours. The staff when interviewed stated that in their assessment, based on what was known about Adult B and her presentation her anxiety was not new and they would not have contacted the Consultant on call in the knowledge that Adult A was at home and would contact them if he was concerned when the shift leader learned about her increase in anxiety.

The model of HTT in place in Cornwall may be viewed as resulting in less easy access to medical expertise and advice than that found in differing models used by other NHS Trusts.

The CFT staff involved in Adult B's care had a limited knowledge and experience of forensic psychiatry, pathological or delusional jealousy and of domestic abuse. These gaps in knowledge combined to result in a deficit of understanding the wider context in which Adult B's concerns and behaviours were taking place.

Adult B's professional status as a retired GP was found in the IMR to have been a factor in the way in which professionals dealt with her. She was given greater autonomy and less intense supervision than might have been usual in other circumstances. The degree to which she influenced her treatment is less clear, although there are examples of professionals feeling reassured by Adult B's professional status and background and acquiescing in writing about her choices to take the level of medication she thought appropriate, even if it was against their medical advice.

It is likely that as with many professionals Adult B was able to present a 'working face' and able to present in such a way as to mask her illness and its effects. In this regard she may at times have underplayed the degree to which her symptoms were influencing her behaviour and thoughts.

This issue of professional influence is one that correlates with the concerns raised by family members and the challenges identified in the GP IMR. Whether this affected the eventual outcome is not certain, but as the IMR concludes, the impact of Adult B's professional background and the resulting less intensive supervision most likely increased the potential risk, certainly to herself and quite possibly to others.

The response by the HTT STR worker after visiting Adult B on 14 November 2013 was appropriate. Her role was to undertake the social activity planned by qualified staff based on their assessment a social activity would be helpful. The STR worker's role was to undertake activity and report back to the team and she did this. During the IMR process the STR worker stated she did not leave the visit anticipating a significant incident would occur, otherwise she would have stayed at the house and requested HTT staff attend.

The professional judgment and clinical decision by the shift leader when considering the report from the STR worker had a clear rationale and was based on what was known about Adult B, both from the past and at the time, and took into account the support from Adult A.

Adult B's mental ill health contributed to her concerns and possibly to her actions. She had a long-standing depressive disorder and at times, probably due to her medical background, she sought to make changes to her medication regime and reduced dosages and frequency of medication. This would likely have exacerbated her mental ill health.

The CFT IMR is a thorough, transparent and detailed document that identifies a number of deficits in practice. The IMR makes a number of recommendations, which can be found in Section Five. It should be noted that CFT have already taken a number of actions to address those recommendations and the deficits highlighted in the IMR report.

2.3 Niche Patient Safety Independent Forensic Psychiatric Review

Following panel discussions and a meeting with members of Adult A's family it was agreed that it would be helpful to both the panel and family members to gain a further, independent insight into a range of issues relating to Adult B's mental health and treatment. The Chair met with members of Adult A's family to consider the specific issues they wished to explore and following this meeting the Chair developed a brief to invite proposals to conduct an independent forensic psychiatric review as part of the DHR.

The review was commissioned with the assistance of NHS England South and its independent investigation team. The brief was circulated to companies approved on the NHS national framework for conducting mental health homicides.

Following a competitive tender process, Niche Patient Safety was appointed to conduct the independent psychiatric review. The work was overseen by Niche's director Nick Moor and conducted by Dr. John McKenna. Dr. McKenna is an experienced consultant forensic psychiatrist with over 20 years' experience as a consultant. He also has particular expertise in the review of mental health homicide and writing statutory reports.

The brief for the independent forensic psychiatric review

The brief for the review was developed in consultation with members of Adult A's family and sought to address a specific set of issues:

- The validity of the mental health diagnoses and clinical decisions throughout Adult B's treatment to the point the incident occurred;
- The extent to which Adult B may have been able to manipulate or mislead her treating teams and whether this influenced her actual diagnoses and treatment; and,
- To what extent, if any, can it be judged whether Adult B was psychotic prior to the killing, or when carrying it out, or both?

The executive summary of the report can be found at Appendix One of this Overview Report.

Summary of Dr. McKenna's key findings

The validity of the mental health diagnoses and clinical decisions throughout Adult B's treatment to the point the incident occurred.

Regarding diagnostic issues, the report concludes that a number of features in Adult B's case are compatible with narcissistic personality disorder, or with longstanding significant related traits. This may have led her to have been especially vulnerable to difficulties in coping with the loss of her health (especially receiving a psychiatric diagnosis) and the loss of her professional status and rewards.

The report suggests that this issue should be specifically considered when considering future risk assessment and management. The symptoms described by Adult B from April 2012 are strongly suggestive of a depressive disorder, which from July 2012 was correctly characterised as a severe depressive disorder with psychotic features (and that this was properly treated).

The depressive relapse experienced by Adult B by October 2013 was appropriately recognised and treated. By this time, prominent concerns about her marital relationship and about her financial position were established. These were variously described as concerns, preoccupation, ruminations, strongly held beliefs, and delusions, and it seems likely that their character fluctuated. It is very likely that at times when she was severely depressed Adult B's beliefs did intermittently include notions of infidelity, and were delusional in nature. When she was less unwell, the content of her ideas was more akin to abandonment and being alone than to infidelity per se, and their form was closer to overvalued ideas (i.e. they were capable of challenge as opposed to being held with absolute conviction).

The report concludes that it is highly likely that during the final admission (from 17 October 2013) that Adult B was suffering from psychotic depression, and that she was as unwell - or approximately as unwell - when on home leave as when in hospital. The report notes that none of the subsequent medico-legal reports or other post-event assessments fail to endorse this diagnosis. In his report Dr. McKenna does indicate that a number of features in Adult B's presentation were compatible with Narcissistic Personality Disorder, or with long standing significant related traits. While endorsing the assessment of severe depression with psychosis, Dr. McKenna has drawn attention to both the matter of Narcissistic Personality Disorder and delusional jealousy, neither of which were identified or addressed by CFT.

The extent to which Adult B may have been able to manipulate or mislead her treating teams and whether this influenced her actual diagnoses and treatment.

The report helpfully approaches this issue by distinguishing four aspects of Adult B's position or status during her care:

- She was a patient;
- She had a psychiatric diagnosis (i.e. she was a psychiatric patient);
- She was a medical practitioner; and,
- She may have been confident, or perhaps overconfident, about her own diagnostic acumen.

The report describes how *patienthood* often involves a social position or expectation of relative powerlessness (even deference), inequality and anxiety. It sets out research that shows that one of the benefits valued and indeed sought by patients who 'go private' is that the doctor-patient relationship is – or is felt to be – more equal, mutual and less formal, with friendship replacing traditional deference.[11] In short, a traditional 'patient' role can be associated with unease and anxiety, and people may understandably try to correct, balance or otherwise resist this – for example, by seeking a less unequal relationship, by controlling information that they reveal, or by trying to influence treatment decisions.

Secondly, it describes how being a *psychiatric* patient may be especially problematic, because of the experience or anticipation of stigma and shame involving popular notions or attributions of 'character weakness' or vulnerability, irrationality and unpredictability. Again, people using services may try and resist such personal consequences (generated themselves or by others), and this could be reflected in different ways of 'challenging' diagnosis and treatment recommendations.

Thirdly it notes that Adult B was a '*physician patient*', and this status can be especially difficult and complicated. There can be problematic embarrassment (a recurrent theme, and especially for mental health problems and a sense of loss of control, as one's role and power 'switches over'. This role reversal may be associated with a sense of loss of identity, self-worth and status, and may be resisted. Furthermore, personality traits that can be professionally adaptive (e.g. perfectionism) may become unhelpful when roles are reversed, and abandoning a professional / personal veneer of being special and invincible can be challenging or threatening to the individual.[12]

[11] Wiles & Higgins, 1996
[12] Wessely, Prof. S. & Gerada, Dr. C. 2013

The report states that treating doctors have reported problems managing their doctor-patients' access to consultations and second opinions and in a recent paper co-authored by a former Chair of the UK Council of General Practitioners and the current President of the Royal College of Psychiatrist's it is suggested that as part of a process of socialisation:

"graduates become embedded in a profession that implicitly or explicitly sees itself as special … doctors who become patients often try to regain control of their medical self during consultations by talking shop to reassert their medical self " [13]

The report states that it could be argued that controlling information provided to professionals, and trying to influence management and treatment decisions, might not be unexpected where a doctor develops a serious mental disorder and enters services as a patient, especially perhaps if that doctor is also relatively proudly, or even narcissistically, invested in the concept of being a doctor and is someone who tends to adopt or claim a position of superiority and control more generally in their life.

It is Dr. McKenna's view that the relevance of this issue in this case is perhaps not so much whether information was controlled or hidden by Adult B (he concludes that it almost certainly was), but the extent to which such behaviours affected diagnosis, management and - in particular - risk management, a point also made in the CFT IMR. Dr. McKenna does not conclude that Adult B's style of engagement significantly affected or impaired the diagnostic process after 2012. His report suggests that her later 'guardedness' and 'vagueness' was more closely linked to an ongoing or recurrent depressive state, as opposed to the mechanisms speculated about above and that from his interviews with clinicians involved in her care, Adult B's symptoms were apparent for all to see, and that they were easily and repeatedly elicited at interview.

To what extent, if any, can it be judged whether Adult B was psychotic prior to the homicide, or when carrying it out, or both?

The report sets out Dr. McKenna's conclusion that it is more likely than not that during the final period in hospital (17 Oct - 8 Nov 2013) Adult B was suffering from psychotic depression (she was certainly severely depressed). Ideas about abandonment were still evident, and possibly more evident, after she then went on home leave. They were associated with her misinterpreting events as supporting her preoccupation. Adult B also expressed morbid ideas about her finances. She altered her behaviour in line with her concerns, and described feelings of shame and loss.

There was evidence of self-neglect, a marked contrast to the premium she reportedly typically had placed on her appearance and grooming. On the evening

[13] Wessely, Prof. S. & Gerada, Dr. C. 2013

of 14 November 2013, Adult B was concerned that her husband might leave her that evening. In Dr. McKenna's opinion, it is quite likely that Adult B was psychotic, in the context of a severe depressive disorder, in the period immediately prior to the homicide, at the time of its commission, and for several weeks afterwards.

The report highlights a number of specific deficits in relation to the care provided to Adult B. These are as follows:

The report notes that Adult A did have significant access to professionals and care planning meetings, and was kept well-informed about his wife's care and treatment. However, although acting as a carer for Adult B, he was nevertheless not offered a carer's assessment, which represents poor practice. Although professionals had several opportunities to specifically (and independently) explore with Adult A his perspective on the marital relationship and his wife's behaviours, it appears this did not happen. The clinical team did not specifically ask about thoughts of harming others, or her husband. It is not possible to conclude that doing so would have resulted in changed management of Adult B.

Because CFT mental health records for the period 1994 – 2009 could not be located by the treating teams, professionals had constrained knowledge about Adult B's past medical and psychiatric history. This was compounded by the failure of staff to compile or obtain a comprehensive history (including a collateral history), including during both of her hospital admissions. This may have been in part related to the fact that the patient and her husband / carer were both medical practitioners, but even so it was a significant failing in practice.

The unplanned - and apparently unrecognised - absence of care coordinator contact for over twenty weeks during the period May – October 2013 clearly represents a failure of care delivery. Her line manager was unaware of the absence of key records documents (e.g. care plan, risk assessment), and did not review records as part of caseload supervision.

The report also notes that professionals did not specifically consider the possibility of delusional jealousy, and did not ask Adult B or Adult A about risk to others. Instead, risk to self was the focus of attention. However, given the absence of any known history of violence or aggression, and Adult B's age and her gender, 'overshadowing' of risk to others by much more evident concerns about risk to self is not surprising. Furthermore, it should be noted that concerns about abandonment and money were much more prevalent and prominent in her presentation than ideas that her husband was actually involved in another relationship.

While Adult B was on home leave after 8 November 2013, there were five home visits by five different staff. The report concludes that this practice must, overall,

make it more difficult for staff to take a longitudinal view of a patient's progress and, in particular, to accurately judge whether symptoms and distress are changing over time. The report also states that this must also tend to impede the development of rapport and a therapeutic relationship, so that it is likely that professionals will feel that they 'know' a patient (e.g. key warning signs), and less easy for a patient to feel understood. The records indicate that medication non-compliance (which was to be retrospectively reported by Adult B) was neither inquired about by staff nor reported by Adult B. The report concludes that this fell below the standards of properly expected care.

Finally, Dr. McKenna's report concludes that none of the failings and weaknesses in the system and practice of care described in his report can be described as 'causing' the killing, or as having a direct or linear causal link to other specific adverse clinical outcomes. Nevertheless, the report concludes that each of them can act to increase the probability that patients in general will experience unsafe care.

Dr. McKenna concludes by stating that this case is not one in which professionals could have been alerted to an increased and imminent risk by improved risk assessment at an individual level. The homicide (in the context of mental illness) represents an extremely rare event - an event of a type that often is not signaled by increased and imminent risk - and which in this case involved a patient where key recognised risk factors were generally absent.

2.4 Views of the family of Adult A

In conducting this review the panel has sought the views of Adult A's family members in order to inform its understanding of the incident and the events that led up to it.

The Chair met with the members of Adult A's family as part of the review and did so in the presence of an advocate from AAFDA (Advocacy After Fatal Domestic Abuse) who was providing advocacy and support to one of the family members. This followed an earlier meeting with the previous Chair.

The Chair has maintained contact with the AAFDA advocate to provide updates on the progress of the review, in the commissioning and sharing of the Niche report, and in sharing the draft of the DHR Overview Report.

The family of Adult A have asked that this report acknowledge the guidance and advice received from AAFDA which they have found helpful in navigating their way through an unknown process at a time of deep distress.

In addition the Chair has maintained contact with a specific member of Adult A's family, who has provided a consistent point of contact. This contact has involved organising a family meeting with the Chair to listen and respond to family members views, communicating with the treating team at the hospital where Adult B is currently detained and in the commissioning of the Niche report, as well as receiving and responding to comments and feedback on the draft Overview Report.

2.4.1 Summary of key issues discussed with the family members of Adult A

This section sets out the key elements from our discussions with family members during the DHR.

Family members were consulted about the Terms of Reference and had input to their development, as did the advocate represented one of the family members.

When the Chair of the DHR changed, the family became aware of the change before being formally advised by Safer Cornwall. This was unfortunate and regrettable, but was not intentional. Safer Cornwall did contact the family and as soon as he took up the role the family were immediately contacted by the new Chair to ensure a smooth handover that reduced the potential for repetition of previously shared information.

Throughout the DHR process the family have been keen to be informed of developments and to review appropriate information. Requests were made to have access to the IMRs and the family members were directed to the relevant organisations to make those requests. A redacted version of the NHS England IMR was shared with them, and contact with the Medical Director of NHS England South (SW Region) was undertaken.

Family members also met with the author of the DCP IMR. A meeting did take place between family members and the Chief Executive of CFT and a redacted IMR has been shared.

Throughout the DHR process the family have shared their views and insights and this has proved invaluable to the work of the DHR panel. In addition, a family statement about Adult A has been included in the Overview Report.

Family members have expressed their ongoing concerns about the eventual discharge of Adult B from detention and sought reassurances from the Chair about the arrangements that might be made. The Chair provided written information about the process for reviewing and discharging patients who are detained under Section 37/41 of the MHA. In addition the Chair wrote to the then Responsible Clinician for Adult B to facilitate ongoing engagement, where appropriate and within the boundaries of patient confidentiality, with members of Adult A's family, with a view to providing them with reassurance about future discharge and in particular consideration of potential risks to them. The Responsible Clinician declined to engage further with members of Adult A's family.

Many of the questions discussed with family members during the DHR are contained in the brief and terms of reference for the Niche report. The commissioning of this review, which has assisted the DHR panel, has also provided assurance to family members. It has also addressed many of their questions about the validity of diagnosis, the influence or otherwise that Adult B exerted in her care and treatment and matters of risk assessment and management. Given that those questions have been responded to in the Niche report, this Overview Report does not set them out in detail here, but refers the reader to the Niche report itself at Appendix One.

The members of Adult A's family have consistently stressed to the Chair their wish to understand what happened and that the DHR should contribute to learning from homicide in order that the chances of similar events occurring should be reduced.

The DHR panel and the Chair take this opportunity to thank the members of Adult A's family for the part they have played in helping to understand not only their views about the incident and the questions they wanted to be addressed, but to knowing the person that Adult A was.

Section Three

Key findings

3.1 Key findings arising from the review

Having reviewed and analysed the information contained within the IMRs and having considered the chronology of events and the information provided by family members the panel has identified a range of key findings:

- Adult B had long standing mental health problems. Her presentation was predominantly one of depression, with psychotic features. Her mental ill health was first identified in the early 1990's during a GP consultation.

- There is a lack of historical records within CFT relating to Adult B's mental health care between 1994-2009. This meant that information relating to her wider history was unavailable to those mental health professionals working with her and this limited their knowledge.

- The diagnosis of psychotic depression was correct. In the period leading up to the homicide, at the time of the act itself and for a period afterwards Adult B was probably experiencing symptoms of psychotic depression.

- Adult B had a history of suicidal thoughts and made a number of visits to Hell's Mouth with the intent to end her life, being stopped on one occasion by a family member. Suicidal ideation was a particular feature of her illness when she was acutely unwell.

- Adult B had found it difficult to adjust to the loss of her professional status as a GP and this was a contributing factor in her illness.

- Adult B did seek to control the information she shared with professionals and at times underplayed or was vague about the true nature of her symptoms and their impact on her thinking and actions.

- There is nothing inherently unusual in a person seeking to control the information they share with professionals providing care and treatment in that people using services often seek to do so in order to restrict the personal consequences they believe may result from fuller disclosure.

- Adult B was a physician patient and this posed particular challenges for those working with her. There are examples where she took decisions about her care, for example in relation to medication compliance, that appear not to have been challenged directly by professionals and this may have in part been due to her professional status.

- It is less clear that Adult B's professional status and background directly influenced those professionals working with her, but to some degree it was

a factor in some of the interactions between her and health care professionals.

- Adult B's mental health and welfare was uppermost in the thinking of those Police officers who engaged with her.

- Section 136 of the Mental Health Act was appropriately used to detain Adult B and to secure further full assessment of her mental health in line with the Code of Practice.

- The focus of risk assessment by professionals in primary and secondary care services was exclusively upon Adult B's risk to self and not upon the potential risks she may have posed to others, specifically Adult A. Given that Adult B had not presented any evidence that she intended to harm anyone other than herself this focus is in itself reasonable. However, to overlook and not enquire about the potential for risk to others is a missed opportunity.

- There is no evidence that direct enquiry was made in relation to domestic abuse. The knowledge and understanding of domestic abuse and in particular the nature of coercion and control was not well enough developed within local organisations. This is as true of the Police contact as it is of the contact from health care services.

- The Police had a domestic abuse policy in place at the time of the incident, but the completion of their COMPACT risk assessment form was not fully completed at the resolution of missing person enquiries relating to Adult B. This included questions relating to domestic abuse.

- Although the GP practice had a Safeguarding policy in place at the time of the homicide, there was no dedicated domestic abuse policy.

- The mental health service professionals working with Adult B relied heavily upon Adult A to undertake monitoring of her mental health. It does not appear that this was due to his status as a practicing GP, but nevertheless this reliance on him to manage without support to him is questionable.

- There was a failure to offer Adult A a carer's assessment. There is a legal duty to assess any carer who requests a carer's assessment or who appears to need support.

- In her interactions with health professionals Adult B sought to minimise how she actually felt and the degree to which she was mentally unwell. In particular she was reluctant to reveal matters about her private life and

resented such questioning from professionals. This may have been related to the previously described concerns Adult B had about the impact of her diagnosis and possible hospitalisation.

- In their work, health professionals did not make attempts to elicit information or views from Adult A about the impact of Adult B's illness upon him or other members of the family. Although the children of the couple were adults there was no enquiry made by professionals to establish if there were children in the family under the age of 18 or any enquiry about the impact of Adult B's illness and associated behaviour on the adult children. There is some evidence to indicate that when Adult A raised concerns directly these were heard, no pro-active attempts were made to enquire about the home circumstances and the effect of Adult B's illness and associated behaviour on him or their relationship nor what support he might have wished for or needed.

- The responses provided by primary care services, specifically from Adult B's GP practice were timely and appropriate. The practice was able to appropriately refer for specialist secondary care input.

- The GP practice did attempt to provide consistency of worker in their engagement with Adult B and the number of different GP's she saw as kept to a minimum.

- HTTs are intended to deliver acute care in community settings and most have a range of staff who undertake visits. Five different mental health staff undertook visits to Adult B in the period immediately prior to the homicide. This lack of continuity likely had an impact on the ability of professionals to adequately monitor and assess changes in her mental illness and recovery.

- Compliance with medication, although noted as a risk factor was not properly managed. The HTT staff were part of the means by which this should have been monitored but this approach alone was not sufficient to provide certainty about compliance. It is not clear that HTT where tasked with checking on medication compliance, it is however clear that they did not undertake this task.

- Written risk assessment and the management of risk were not adequate and represent failings in the provision of home based support to Adult B.

- The emergence of more community based forms of mental health care gathered particular pace in the early 2000's with the implementation of the National Service Framework for Mental Health. The accompanying Policy Implementation Guide set out the models of service and team compositions that were to be adopted. In 2003 as part of the implementation process, STR workers were first introduced and they were intended to be part of Home Treatment Teams (sometimes then known as Assertive Outreach Teams and Crisis Resolution and Home Treatment Teams). In 2007 New Ways of Working was published and this guidance set out changes to the mental health workforce in England. The report built upon previous guidance and promoted a model where 'distributed responsibility' is shared amongst team members and no longer to be delegated by a single professional.

  One of the key changes brought about by New Ways of Working was the expectation that the people with the most experience and skills should work face to face with people who have the most complex needs. More experienced staff would then support other staff to take on less complex or more routine work. All qualified staff would be able to extend the boundaries of what they do and there would be more chances for new roles such as STR and primary care mental health workers and assistant practitioners to take their places within teams. New Ways of Working began being implemented in 2008 and the STR role is well established. The majority of mental health provider Trusts have adopted this model of working and it has become accepted practice.

- The deficiencies identified within the Home Treatment Team, described earlier in this section of the report serve to highlight the importance of appropriate allocation of workers to complex cases. Those mental health workers who were working directly with Adult B in the period immediately prior to the incident were non-qualified. Drawing attention to this is not to diminish the valuable part that non-qualified workers play in supporting people with mental health problems, indeed this is recognised to be helpful in many instances. However, given the issues raised and the knowledge of Adult B's risk to herself, the lack of oversight or direct intervention from a qualified mental health professional at the time it was reported immediately after the visit and later when reported to the shift leader was a missed opportunity to engage professionals with particular skills and expertise. It cannot be said that this directly contributed to the incident, but is a learning point for the organisations involved to consider.

- Communication between primary care and secondary care mental health services was not adequate. There are examples of primary care services not being aware that Adult B had been discharged from hospital, was on home leave or when she had been admitted.

- The constraints of confidentiality do not appear to have directly hindered information sharing between agencies. There is an example of an assessment not being shared by psychiatric liaison services with the GP or being recorded on the mental health records. The Consultant who saw Adult B in private practice did share details with the GP. However there remain issues about the consistency of that sharing between private practice with NHS organisations more generally which are not confined to Cornwall.

- No comprehensive history was ever taken during either of Adult B's in-patient admissions. This was poor practice and represents a missed opportunity to gather relevant information that could have informed treatment and care decisions.

- There were failings in care co-ordination of Adult B's care under the Care Programme Approach (CPA). There was a period between May and October 2013 when no care co-ordinator was in place and there was no regular contact with mental health services.

- There was no written care plan in place as is required under the CPA guidance.

- There was a lack of adequate or robust line management of the care co-ordinator assigned to Adult B's case.

- There was no up to date risk assessment written by the care co-ordinator in place. Risk issues related to delusional jealousy were not considered and thus not addressed. This was a significant deficit in the care and support provided to Adult B. In addition domestic abuse was not considered as part of any risk discussions between professionals.

- Recording did not meet the required standard. The nature of the RiO electronic patient records system and the understanding of its use by mental health staff most likely played some part in the recording deficits identified.

- Adult B was expressing concern that she believed Adult A was going to leave her and that he was being unfaithful at various points in the period prior to the homicide, she appeared to be fixated in this belief. This concern

with someone leaving may be articulated as delusional jealousy in some cases and such is an indicator of risk. The degree of risk may be high depending on the strength with which the concern about abandonment is held. No consideration of delusional jealousy was undertaken. It is not clear if the outcome would have been different had delusional jealousy been identified, it may or may not have been, however it is clear that the lack of identification demonstrates a gap in knowledge and understanding and did not allow for any alternative forms of treatment to be considered or provided.

- It appears that the fact that Adult B's beliefs about infidelity and possible estrangement in relation to Adult A were seen through the lens of her mental illness. This likely militated against professionals viewing and understanding those beliefs in the wider context relating to potential domestic abuse, in particular the coercion and control aspects of Adult B's relationship with Adult A. It is important to bear in mind that the offence of coercion and control was only introduced into the existing legislative framework in 2015 and thus there is work to be done to embed knowledge and understanding of this into agency practice and a wider piece to shift cultural and societal attitudes and understanding of the less obvious behaviours that may constitute abuse.

- The panel is aware that counselling was available for the staff involved following the incident but no such offer appears to have been made to members of the family. The importance of support for family members in the aftermath of such incidents should not be underestimated and sensitive and timely approaches should be made to establish what support, if any, could be made to family members affected by similar incidents.

Section Four

Conclusions

4.1 Conclusions

This section sets out the conclusions of the DHR Panel, having analysed and considered the information contained in the IMRs and the Niche review within the framework of the Terms of Reference for the review. The Chair of the DHR is satisfied that the review has:

- Been conducted according to National Guidance and best practice, with effective analysis and conclusions of the information related to the case.
- Established what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support vulnerable people and victims of domestic violence.
- Identified clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.
- Reached conclusions that will inform recommendations that will enable the application of these lessons to service responses including changes to policies and procedures as appropriate; and
- Will assist in preventing domestic abuse, homicide and improve service responses for all vulnerable people and domestic abuse victims through improved intra and inter-agency working. Coercion and control do not usually manifest as violent acts.

The conclusions presented in this section are based on the evidence and information contained in the IMRs and Niche report and draws them together to present an overall set of conclusions, starting with the central issues of whether the incident was predictable or preventable.

Knowledge of domestic abuse

Knowledge of domestic abuse and domestic violence, both in terms of the risks and the triggers was not of a sufficient depth and quality within the services that had contact with Adult B. The indicators of domestic abuse, particularly in relation to coercion and control, even in the context of a mental illness were not recognised and thus were not acted upon.

In addition, those agencies in contact with Adult B did not use routine enquiry in relation to domestic abuse as an approach in their interactions with her. This meant that information about potential risks and triggers was not gathered.

Risk assessment

Risk assessment was variable and focused primarily on Adult B's risk to herself. Risk to others and in particular to Adult A was not adequately considered or explored. This meant that those risks that can now be identified as a result of this review were not known and thus not acted upon. There are wider questions about lack of recorded risk assessments, the lack of risk assessment in the community while Adult B was on home leave and the adequacy of the risk assessments that were undertaken and these have been addressed within the IMRs.

Care planning and care co-ordination

Care planning and care co-ordination fell below the standard that should be expected. The lack of a written care plan, the lack of contact and the absence of the care coordinator in the months prior to the homicide represents a deficit in the care and support provided to Adult B or to her carer, Adult A, the victim of this homicide.

Record keeping and history taking

Record keeping fell below the standard that should be expected. The nature of the RiO system did play some part in this, but the lack of up to date records represents poor practice. As highlighted in the Niche Review, this lack of records and history had the potential to increase the probability of unsafe care. The fact that a full history was not taken from Adult B contributed to the presence of gaps in the knowledge of her background, previous presentation, the genesis of her illness and is likely to have impacted the wider understanding of her condition.

The deficiencies in the accessing of records emerged as part of CFT's investigations and it is of concern that without this incident and its review, these issues may have continued to persist.

Recognition of Adult A's needs

It is evident that throughout Adult B's illness, Adult A attempted to care and support her as much as possible. He did so in the context of her delusional beliefs about their relationship and he sought to reassure her at all times, often without success. He willingly took on responsibility for caring for her, in at least one instance this willingness avoided a hospital admission.

Adult A did have good access to professionals working with Adult B, sometimes attending appointments with her and he does appear to have been kept informed about her care and treatment.

However there does seem to have been an over reliance on him and his ability to cope. This related to the inevitable pressures of caring for Adult B, especially in the context of the content of her delusions, but also to him having to monitor and alert services when help was needed. This placed particular demands on him which he was not provided with an opportunity to articulate confidentially to professionals.

Adult A's needs as a carer, and the impact of Adult B's illness and the content of her delusions were not adequately explored and he was not offered a carer's assessment.

Adult B's professional background and status

Adult B's professional status as a medically qualified, retired GP had some impact on the way in which she engaged with health care professionals. In the most part this manifested itself in her unwillingness to reveal aspects of her life that she considered private and to alter her medication regime and compliance with that medication based on her own medical background and knowledge.

The style of Adult B's engagement with health professionals appears to be consistent with that which might be expected in someone who is a physician patient. It does appear that her medical background influenced the degree to which she revealed information and the management of her medication, there is no evidence from the DHR or the Niche review that this unduly influenced or impeded the diagnostic conclusions of the treating Consultant Psychiatrist or that their advice about her care was compromised by her professional status.

Adult B's mental health at the time of the homicide

Adult B had been diagnosed with psychotic depression and the conclusion of the panel, based on the information reviewed, is that this diagnosis was valid. It is also clear, based on the information reviewed that in the period leading to homicide, during the incident itself and for a period of time afterwards, Adult B was in all probability psychotic in the context of her severe depressive disorder.

Predictability and preventability

The review has not identified any evidence that indicates that physical violence had previously been a factor in Adult B's relationship with Adult A. There was evidence that in the context of her delusional beliefs about infidelity and estrangement, Adult B engaged in controlling behaviour, by requiring unreasonable levels of reassurance from Adult A about his whereabouts and activities, the kind of reassurance that would not have normally been expected.

The review has identified gaps and poor practice in the process of risk assessment but it is reasonable to conclude that there was an awareness of the risks Adult B posed to herself, particularly in relation to self-harm and thoughts of suicide, thoughts that she had come close to acting upon on more than one occasion. There was no evidence found in this review that Adult B had articulated plans for any act of violence towards Adult A or any other individual. Nothing was observed that led professionals to consider that Adult B was at risk of harming others, and in particular harming Adult A. Staff did not consider delusional jealousy and risk and this went unrecognised.

The Niche report also states that the internet searches conducted by Adult B prior to the homicide may not provide corroborative or substantive evidence that she had planned the homicide in advance. The knowledge of these searches came about during the police investigation. There are grounds however to conclude that, in large part, they may have related to her delusional beliefs at the time**.**

Coming to a view about the predictability of the homicide is necessarily a nuanced judgment. The panel has come to the conclusion that given the information available and Adult B's presentation at the time that the homicide was **not predictable**.

Turning to the matter of preventability, neither the police or health services received any information or calls around the time of Adult A's death alerting them to the fact that there was an immediate threat.

In the Niche report, Dr. McKenna highlights a number of areas that had they been addressed, he believes could have prevented the incident. These include written risk assessment and risk management being properly implemented, addressing the matter of non-compliance with medication and treating this as a high risk issue, continuity of care within the HTT and their access to Consultant opinion and advice. Dr. McKenna draws a definitive conclusion that the incident could have been prevented.

The panel has considered this carefully and agrees that it can be argued that if more had been done to ensure compliance with medication, more effective monitoring, and improved risk assessment had been undertaken, these may have played a part in the possible prevention of the killing. Having said that, it is the view of the panel that it is not certain that it would have. As highlighted in the Niche review, this case is not one in which professionals could have been alerted to an increased and imminent risk by improved risk assessment at an individual level.

The deficiencies exhibited by mental health professionals involved in Adult B's care have been highlighted in this Overview Report and the CFT IMR. However, none of those failings can be conclusively proven to have had a direct causal link to the killing. As research quoted in the Niche report highlights "*… there are a substantial group of people who display none of the accepted indicators of violence before committing homicide*"[14]

Taking all of this into consideration and the lack of predictability it is the conclusion of the panel that if the matters highlighted in this report and within the Niche report had been properly addressed **Adult A's death may have been prevented.**

In conclusion, this was a particularly tragic case. The homicide occurred in the context of Adult B's mental illness, but it was an illness that presented in such a way that recognised risk factors that might have signaled the possibility of such an incident were only seen in the context of the presenting mental ill health. This is not to underplay the deficits that have been highlighted in this review, which demonstrate that in some instances the care provided to Adult B was not of the required standard, that the possibility of domestic abuse was not considered or recognised and that the effect of Adult B's illness upon Adult A was not fully explored or considered.

[14] Role of risk assessment in reducing homicides by people with mental illness Munro E and Rumgay J BJPsych Feb 2000

Section Five

Recommendations

5.1 Recommendations

This section of the Overview Report sets out the recommendations made by the DHR panel and then the recommendations made in each of the IMR reports.

5.1.1 DHR Overview Report Recommendations

Many of the issues raised in the IMRs that have been analysed and commented upon in the Overview Report are subject to recommendations within those IMRs. In addition, there are some similar features within this DHR that have been revealed in another recent DHR in Cornwall. With this in mind there is necessarily some congruence between the recommendations in this report.

The DHR panel offers the following overarching recommendations for local action:

1. We recommend that there should be a clear and robust domestic abuse policy in place at each GP surgery in the county. These policies should be regularly reviewed by practice managers and subject to audit at regular intervals. Such a policy should be distinct and separate from policies relating to Safeguarding.

2. We recommend that a training needs analysis for GP's, mental health workers and others should be conducted to identify which staff would benefit from training in recognising markers for domestic abuse. Further work should be undertaken across local agencies to ensure the dissemination of regular training and information in relation to domestic abuse. In particular the use of a specialist package like IRIS to support GPs in their responses to domestic abuse should be used.

   Work should also be undertaken in relation to training in recognising signs of and risks of coercion and control, which has recently been legislated for.

   All training should highlight the fact that domestic abuse may be perpetrated by women on men as well as vice versa.

3. We recommend that direct enquiry into domestic abuse is used by all agencies in any assessment or risk assessment process. Direct enquiry should be considered as part of the tool kit of skills and interventions to be utilised within statutory organisations.

4. We recommend that assessment and risk assessment processes be reviewed to ensure clearer guidance about the need to consider and respond not only to the risks of harm to the individual, but also to others including spouses, partners and children.

5. We recommend that a programme of work be undertaken in relation to the provision of carer's assessments. There is a statutory requirement to offer a carer's assessment. Work is required to ensure that this duty is being met and it should be regularly audited.

6. We recommend that training be put in place to develop the skills and expertise of health care professionals in working with physician patients or those who may have health care expertise and experience

7. We recommend work be undertaken to develop further skills in risk assessment and risk management to ensure that methods and approaches are consistent with current standards in specific organisations and that in particular, professionals routinely consider the potential for risk to others, whether or not this is articulated by the individual being worked with.

8. We recommend that a process and protocol be put in place to guide practitioners and managers about how best to ensure continuity of care provisions, most notably, continuity of worker. Recognising the constraints of workforce capacity and workload, it is nevertheless important to place emphasis on the need to provide continuity wherever possible. Such a protocol should include guidance about decision making relating to the appropriate use of qualified and non-qualified staff.

9. We recommend that a process and protocol be put in place across Cornwall to ensure the timely and appropriate notification of GP's about care plans, current treatment and changes to that, including hospital discharge by secondary care NHS Trust providers.

10. We recommend a programme of work to review recording processes and an associated regular audit of recording practice. In particular this should focus on the requirements to ensure written care plans are in place, that risk assessments are properly recorded and appropriately reviewed and updated. In addition, focus should be given to ensuring that staff working in local organisations fully understand how to utilise the electronic recording systems that are currently used in statutory organisations.

In addition, the matters relating to missing or incorrectly coded medical records should be subject to review by CFT to establish the reasons for the lack of historical notes and measures put in place to ensure CFT request copies of all historic mental health care notes from the GP to be uploaded into the current clinical record.

11. We recommend that a focused themed review of previous DHRs in Cornwall be undertaken to identify common themes and issues, from which focused learning and practice development can take place with local organisations. We make this recommendation in the context of there having been previous DHRs in Cornwall where the quality of risk assessment in the wider context of an individual and the effect this may have on understanding whether they pose a risk to others is an area of practice that should be considered for wider learning and practice development.

    There is one particular case that the panel is aware of from discussions with the family of Adult A and although it is outside the scope of this DHR to review that case we believe there may be commonalities and it would be of benefit to the local system to know and understand these so that a co-ordinated approach to learning and development can be undertaken in response to DHRs undertaken as a whole rather than seeing each in isolation.

5.1.2 Recommendations made in the individual IMRs

Devon and Cornwall Police IMR recommendations

1. Consideration should be given to reviewing the mechanisms for triggering a response under the Neighbourhood Harm Reduction Register, particularly where cases straddle two consecutive periods. Refinements to this process may improve opportunities to coordinate a holistic response to individuals coming to police attention as a result of mental health issues.

2. It is recommended that D140 (Mental Health Issues Policy) be reviewed with a view to drawing together risk areas, including domestic abuse, mental health, missing persons and child abuse investigation. Guidance and procedures should be reviewed with consideration to incorporating a 'think family' approach under mental health protocols and practices.

NHS England – Primary Care IMR recommendations

1. Undertake a formal regular audit of complex cases, which includes the impact on other family members

2. NHS England action the training needs of GPs as identified within their current audit.

3. GPs develop a consistent approach to regular risk assessments that are formally shared with other relevant agencies and a copy is stored within the notes.

4. Further identification of areas within current practice where processes need to be developed or tightened to ensure cohesive support for individuals and their immediate family.

5. Joint training (in relation to domestic abuse and safeguarding) is undertaken as standard, wherever possible.

6. Consideration of the thresholds for referrals/communication between agencies and where unnecessary waiting, gaps or insufficient communication will cause significant risks to individuals.

7. That the learning from these domestic homicide reviews is routinely shared with professionals working within adult and children's services to facilitate proactive support that could minimise the potential for escalating risk or reoccurrence within the next generation.

8. That the full impact on understanding the potential risks and management of individuals with complex mental health needs are addressed through the support systems and time offered to both professionals and carers.

Cornwall Partnership NHS Foundation Trust IMR recommendations

Standards of Record Keeping

1. CFT review the current performance data for dates / timescales of review, undertake an audit of records to consider overall standards of record keeping and quality of content. Develop an action plan as required.

2. CFT use the 'Human error model' to identify the cause of poor practice in record keeping in clinical records (slip/lapse, mistake, violation) and design a solution based on the findings.

3. CFT provide an easy to read aid memoire card to clinical staff outlining good practice and expected structure of writing progress notes.

   The aim is to improve the quality of the progress notes, for staff to consistently record information in a structured format that includes: date, time of contact, purpose of contact, assessment of presentation of service user, risk assessment, rationale for decisions, link to care plan and plan of action.

4. Review of current RiO quality manual and risk management policy to ensure the information is clear and compatible. Establish clear standards for how to use the risk summary, including staff must record in each section, where there is no new information staff to record ‘no new information’.
5. When the RiO system is redesigned by CFT in 2015:

   . A comprehensive admission clerking in process be required by junior doctors, that it is recorded in one place and that it is audited.

   . Clinical staff from a range of services to be involved in order the system is designed to meet clinical need and improve the teams understanding of how the system works and should be used.

   . Develop specific guidance for RiO to identify the expected standards of use for each function in RiO.
   . CFT to audit the expected standards for RiO functions. CFT to provide exception reporting to individual staff, and teams to ensure learning and improve consistency of how staff use RiO.

. Ensure the core risk areas include a drop down box list of known associations with high risk. Include in this list - relationship difficulties, domestic abuse and pathological jealousy.

. CFT to review the RiO guidance to ensure it clearly states staff are required to record narrative in the ‘reasons box’, source of information and rationale for decision Policy Development.

Policy development

6. The supervision policy to be reviewed to ensure case load supervision includes the expectation for line managers to view random samples of records, look at content and quality.

7. CFT to introduce a policy requiring staff to document information about care and staff involvement at the time of an incident which is reported as a Serious Incident (SI).

Training

8. CFT provide training to clinical staff about pathological jealousy

9. STORM trainer to advise staff the use of "guaranteeing safety" is not mental health terminology, is not an assessment of risk, this is poor practice and should not be used in documentation. Training to remind staff their assessment requires documentation of the discussion about risk, protective factors, risk rating and the management plan.

10. Staff in HTT and CMHT are prioritised to undertake the Domestic Abuse and DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) two day training

Domestic Abuse

11. CFT to consider how carers assessments might be used to consider concerns about domestic abuse.

12. Clinical staff to ensure there is opportunity and time to interview both service user and partner separately to be able to take account of domestic abuse, allowing time for disclosure.

13. Clinical staff to ensure the service user is asked when they are on their own if they wish their partner to be present in clinical meetings, and staff to document this.

14. Review of job descriptions to ensure staff are clear their adult and child safeguarding responsibilities include responding to concerns about domestic abuse.

15. Employers responsibilities to victims of domestic abuse to be referenced in CFT disciplinary policy

Service delivery and contracting development

16. The Trust consider working arrangements between NHS and private practice.

DHR5 Action Plan

No.	Recommendation	Measure	Lead	Timescale
1.	The DHR Panel recommend that there should be clear domestic abuse policies/policy written for all GP surgeries in the county. These policies should be regularly reviewed by practice managers and subject to audit at regular intervals. Such a policy should be distinct and separate from policies relating to safeguarding.	Develop GP Domestic Abuse Policy and Guidance including local pathway Scope number of GP practices operating in Cornwall. Deliver domestic abuse training to each GP practice including GP Policy and local pathway Report progress to the Domestic Abuse & Sexual Violence Strategic Group on and quarterly basis.	NHS Kernow Safeguarding Lead and Kernow CIC	Development of GP Policy and Guidance by 31 January 2017. Scope GP numbers by 31 January 2017. Delivery of training by 31 March 2017. Confirm completion of delivery in end of year performance report to DASV Strategic Group by 31 May 2017.
2.	The DHR Panel recommend that a training needs analysis for GPs, mental health workers and others for example, NHS Kernow commissioned services such as psychological therapies should be conducted to identify which staff would benefit from training in recognising high risk markers for domestic abuse. Further	Develop workforce development programme to enable frontline staff to identify, risk assess and refer those at risk of domestic abuse in GPs, mental health and other NHS Kernow commissioned services.	NHS Kernow Safeguarding Lead and Kernow CIC	Development of workforce development training by 31 January 2017. Scope numbers by

	work should be undertaken across local agencies to ensure the dissemination of regular training and information in relation to domestic abuse. In particular the use of a specialist package like IRIS to support GPs in their responses to domestic abuse should be used.	Scope number of services and frontline staff operating in Cornwall. Deliver workforce development training including local pathway Report progress to the Domestic Abuse & Sexual Violence Strategic Group on and quarterly basis.		31 January 2017. Delivery of training by 31 June 2017. Confirm completion of delivery in end of year performance report to DASV Strategic Group by 31 October 2017.
3.1	The DHR Panel recommend that direct enquiry into domestic abuse is used by all agencies in any assessment or risk assessment process. Direct enquiry should be considered as part of the tool kit of skills and interventions to be utilised within statutory agencies.	Scope number of services and frontline staff operating in Cornwall. Deliver workforce development training including local pathway Report progress to the Domestic Abuse & Sexual Violence Strategic Group on and quarterly basis.	Safer Cornwall Strategic Board	Development of workforce development training by 31 January 2017. Scope numbers by 31 January 2017. Delivery of training by 31 June 2017. Confirm completion of delivery in end of year performance report to DASV Strategic Group by

				31 October 2017.
3.2	Create a Culture of TELL, ASK and REFER by; – Raising awareness of Domestic Abuse in the Community to encourage increased reporting to REACH – Ensuring the commissioned provider delivering LSCB Safeguarding Children Training includes a Domestic Abuse Specific module including the DASH Risk Assessment. – Including a specific Domestic Abuse DASH module on the Safeguarding Adults Board Training – Ensuring all Designated Child Protection Officers working for the Cornwall Education Authority attend DASH training as part of enhanced Child Safeguarding Training. – Commission Domestic Abuse & DASH Training for Multi Agency Practitioners including the Voluntary Community Sector, Probation, Mental Health, Drug & Alcohol Services and the Health Sector.	A culture of TELL will be achieved through the implementation of a Communication Strategy. A culture of ASK will be achieved by providing all professionals with access to Domestic Abuse and DASH Risk Assessment Training – and equipping them with the knowledge to feel competent and confident to ASK, Risk Assess and REFER. A culture of REFER will be achieved by making it easier for the Public and Professionals to refer cases to REACH for Information, advice, risk evaluation and access to specialist Domestic Abuse Services. A measure of progress will be; – The Commissioning of a Domestic Abuse Training Program by 31 January 2017; – The number of Professionals attending DA Training;	All trained professionals will be required to include a copy of the DASH Risk Assessment when referring a client to REACH. This will provide the DASV SG with evidence of DASH completion, adherence to guidance and effectiveness of training.	Table the recommendations and actions from this Domestic Homicide Review at the DASV Strategic Group within one-month of Home Office approval to Publish. Commission a Multi-Agency Domestic Abuse Training Programme by 31 January 2017. Set a time frame for individual agencies to implement actions and report back to the DASV Strategic Group.

	– Provide DASH Training to all Special Constables, First Response Officers, Supervisors (including Communication staff), Call Handlers and Sexual Offences Domestic Abuse Investigation Teams.	– The number of new DASH Forms accompanying referrals to REACH; – The number of Non-Police Professionals referring cases to MARAC – A year on year increase in the identification and overall reporting of Domestic Abuse		
4.	The DHR Panel recommend that a focused themed review of previous DHRs in Cornwall be undertaken to identify common themes and issues, from which focused learning and practice development can take place with local organisations.	Review of all local DHRs and collation of common themes.	DASV & SOC Strategy Lead	Review of current DHR recommendations to identify common themes 31 August 2016. Inclusion of common themes in DASV Strategy 2016-20 by 31 November 2016. Quarterly reporting to DASV Strategic Group.
5.	Review of service specification for Cornwall	• Provision of carer's assessments; there is a statutory requirement to offer a	NHS Kernow and Cornwall	Review completed by 31 December

	Foundation Partnership Trust	carer's assessment. Work is required to ensure that this duty is being met and it should be regularly audited. • Upskill health care professionals in working with physician patients or those who may have health care expertise and experience. • Development of risk assessment and risk management to ensure that methods and approaches are consistent with current standards in specific organisations and that in particular, professionals routinely consider the potential for risk to others, whether or not this is articulated by the individual being worked with. • Development of a process and protocol to be put in place to guide practitioners and managers about how best to ensure continuity of care provisions, most notably, continuity of worker. Recognising the constraints of workforce capacity and workload, it is nevertheless important to place emphasis on the need to provide continuity wherever possible.	Foundation Partnership Trust	2016 Service specification amended by 31 March 2017

		Such a protocol should include guidance about decision making relating to the appropriate use of qualified and non-qualified staff. • Development of a process and protocol be put in place across Cornwall to ensure the timely and appropriate notification of GP's about care plans, current treatment and changes to that, including hospital discharge by secondary care NHS Trust providers. • Development of a programme of work to review recording processes and an associated regular audit of recording practice. In particular this should focus on the requirements to ensure written care plans are in place, that risk assessments are properly recorded and appropriately reviewed and updated. In addition, focus should be given to ensuring that staff working in local organisations fully understand how to utilise the electronic recording systems that are currently used in statutory organisations.		

		• Review of missing or incorrectly coded medical records by CFT to establish the reasons for the lack of historical notes and measure put in place to ensure CFT request copies of all historic mental health care notes from the GP to be uploaded into the current clinical record.		
6.	Reviewing the mechanisms for triggering a response under the Neighbourhood Harm Reduction Register, particularly where cases straddle two consecutive periods. Refinements to this process may improve opportunities to coordinate a holistic response to individuals coming to police attention as a result of mental health issues.	Review completed. Audit of process.	Devon & Cornwall Police	Review completed within 3 months of publication. Audit completed within 1 year of review.
7.	Review of D140 (Mental Health Issues Policy) to streamline risk areas, including domestic abuse, mental health, missing persons and child abuse investigation. Guidance and procedures should be reviewed with consideration to incorporating a 'think family' approach under mental health protocols and practices.	Review completed. Audit of process.	Devon & Cornwall Police	Review completed within 3 months of publication. Audit completed within 1 year of review.
8.	NHS England to review GP service specification and delivery in respect of the following additional	Safer Cornwall will ensure that national recommendations are sent with a copy of the DHR to NHS England within one month	NHS England	Safer Cornwall has no influence on the timescale for

	requirements; • Undertake a formal regular audit of complex cases, which includes the impact on other family members • Audit training needs of GPs and develop a training package which responds to the needs including identifying domestic abuse including coercive control and where this co-exists with mental health • Develop a consistent approach to regular risk assessments that are formally shared with other relevant agencies and a copy is stored within the notes • Joint training (in relation to domestic abuse and safeguarding) is undertaken as standard, wherever possible • Review of the thresholds for referrals/communication between agencies and where unnecessary waiting, gaps or insufficient communication will cause significant risks to individuals • That the full impact on understanding the potential risks and management of individuals with complex mental health needs are addressed through the support systems and time offered to both	of Home Office endorsement of the report		national recommendations

	professionals and carers.			
9.	CFT Standards of record keeping	CFT to undertake an audit of records to consider overall standards of record keeping and quality of content. The audit must consider; • Progress notes in relation to date, time of contact, purpose of contact, assessment of presentation of service user, risk assessment, rationale for decisions, link to care plan and plan of action Develop an action plan that addresses areas for improvement found within audit in addition to; • Easy to read aid memoire card to clinical staff outlining good practice and expected structure of writing progress notes • Review of current RiO quality manual and risk management policy to ensure the information is clear and compatible. Establish clear standards for how to use the risk summary, including staff must record in each section, where there is no	NHS Kernow and Cornwall Foundation Partnership Trust	Review completed within 3 months of publication. Audit completed within 1 year of review.

		new information staff to record ‘no new information’ • A comprehensive admission clerking in process be required by junior doctors, that it is recorded in one place and that it is audited. • Clinical staff from a range of services to be involved in order the system is designed to meet clinical need and improve the teams understanding of how the system works and should be used. • Develop specific guidance for RiO to identify the expected standards of use for each function in RiO. • CFT to audit the expected standards for RiO functions. CFT to provide exception reporting to individual staff, and teams to ensure learning and improve consistency of how staff use RiO. • Ensure the core risk areas include a drop down box list of known associations with high risk. Include in this list - relationship difficulties, domestic abuse and pathological jealousy.		

		• CFT to review the RiO guidance to ensure it clearly states staff are required to record narrative in the 'reasons box', source of information and rationale for decision Policy Development. Report areas of improvement to NHS Kernow. NHS Kernow to include areas of improvement within contract management.		
10.	CFT Policy Development	The supervision policy to be reviewed to ensure case load supervision includes the expectation for line managers to view random samples of records, look at content and quality. CFT to introduce a policy requiring staff to document information about care and staff involvement at the time of an incident which is reported as a Serious Incident (SI). NHS Kernow to include areas of improvement within contract management.	NHS Kernow and Cornwall Foundation Partnership Trust	Review completed within 3 months of publication. Audit completed within 1 year of review.
11.	CFT Workforce development	CFT provide training to clinical staff about pathological jealousy	NHS Kernow and Cornwall Foundation	Review completed within 3 months of

		STORM trainer to advise staff the use of 'guaranteeing safety' is not mental health terminology, is not an assessment of risk, this is poor practice and should not be used in documentation. Training to remind staff their assessment requires documentation of the discussion about risk, protective factors, risk rating and the management plan. Staff in HTT and CMHT are prioritised to undertake the Domestic Abuse and DASH (Domestic Abuse, Stalking, Harassment and Honour Based Violence) two day training	Partnership Trust	publication. Audit completed within 1 year of review.
12.	CFT Domestic Abuse	CFT to consider how carers assessments might be used to consider concerns about domestic abuse. Clinical staff to ensure there is opportunity and time to interview both service user and partner separately to be able to take account of domestic abuse, allowing time for disclosure. Clinical staff to ensure the service user is asked when they are on their own if they	NHS Kernow and Cornwall Foundation Partnership Trust	Review completed within 3 months of publication. Audit completed within 1 year of review.

		wish their partner to be present in clinical meetings, and staff to document this. Review of job descriptions to ensure staff are clear their adult and child safeguarding responsibilities include responding to concerns about domestic abuse. Employers responsibilities to victims of domestic abuse to be referenced in CFT disciplinary policy		