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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of a mental health service user Mr M in Cornwall

February 2019

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First published: **20 February 2019**

Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1 Executive Summary

1.1 NHS England, South commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr M. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

1.5 Mrs M was found dead on 2 March 2016, the post mortem indicated that she died from suffocation the previous day and that Mr M subsequently hanged himself. Both deaths happened in the family home.

1.6 We would like to express our condolences to Mr and Mrs M's family. It is our sincere wish that this report does not add to their pain and distress, and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr M.

Mental health history

1.7 Mr M was first admitted to St Lawrence's Hospital (a mental health hospital) in 1976. This was a short admission following symptoms of "severe agitated depression and suicidal ideation". The hospital has since closed and was managed by the organisation that is now known as Cornwall Partnership NHS Foundation Trust (referred to as "the Trust" hereafter).

1.8 Mr M's GP records show that he attempted suicide using car exhaust fumes in January 1988, however we have been provided with no general hospital care and treatment records relating to this incident as this incident falls outside of the detailed scope of our review.

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[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

1.9 Trust records show secondary care involvement with Mr M's care and treatment from November 1988. Mr M had taken an overdose of paracetamol and then connected a hosepipe to the exhaust of a vehicle at work. Mr M was taken to a general hospital for immediate physical treatment, but it was documented that Mrs M felt that Mr M would not benefit from treatment at St Lawrence's Hospital again. Outpatient care was subsequently provided until December 1989 when the decision was made to discharge Mr M because he "remained well".

1.10 Mr M presented to his GP with low mood in May 2011 and with memory loss symptoms in January 2012 but is unclear from the records we have received whether he received any treatment for this at the time. The Trust has confirmed that they did not receive a referral at this time.

1.11 Mr M next presented to his GP with memory loss symptoms in November 2014 but a cognitive test completed by the GP placed Mr M well within the normal range and therefore no referral was made at that time.

1.12 In January 2015 Mr M consulted his GP complaining of feeling low. The GP diagnosed depression with anxiety and prescribed a low dose of mirtazapine.[3]

1.13 Mr M subsequently made a self-referral to Outlook South West[4] (a counselling service).

1.14 Mr M had a telephone assessment with Outlook South West in early February 2015 and this was followed up by four therapy sessions that were delivered face to face in Mr M's GP surgery. Records of these sessions were noted in the GP electronic records. Mr M's last appointment with Outlook South West was on 21 May 2015.

1.15 A depression screening questionnaire was completed in early February 2015 that indicated that Mr M was experiencing moderate depression. At the same time an anxiety screening questionnaire was also completed and indicated that Mr M was experiencing severe anxiety.

1.16 Following an appointment with his GP in mid-April 2015 Mr M was referred to the Complex Care and Dementia Team at Newquay Hospital. This team provides assessment and treatment to people with dementia, and those with severe mental health problems and complex physical needs.

1.17 Mr M was first seen by a community mental health nurse in mid-May, with a follow up appointment at the end of May. The community mental health nurse discussed the dementia pathway with Mr M and it was agreed that the community mental health nurse would contact the primary care dementia practitioner. The community mental health nurse also discussed carer's support for Mrs M. Mrs M said that she would contact adult social care services to arrange an assessment. At that time, it was noted that the

[3] *Mirtazapine is an antidepressant medication https://patient.info/medicine/mirtazapine-for-depression*

[4] *http://www.outlooksw.co.uk/*

community mental health nurse would not make any further appointments to see Mr M because he was being transferred to the memory assessment service pathway.

1.18 In late July 2015 Mr M had a CT[5] (computerised tomography) scan and this was followed up by an appointment with a consultant psychiatrist in early August. At the appointment Mr M did not appear to be depressed but had a long-standing problem with worrying. The consultant psychiatrist considered that Mr M probably had mild cognitive impairment, but he felt that Mr M's memory would improve if his anxiety could be reduced. Mr M was provided with the memory service information book and arrangements were made for the primary care dementia practitioner to contact Mr M "a few months later".

1.19 The primary care dementia practitioner visited Mr M in September and at this time he reported a decline in his memory over the previous month and that he was experiencing night terrors. Both Mr and Mrs M felt that talking therapies would benefit Mr M and the primary care dementia practitioner agreed to discuss his case with the consultant psychiatrist to seek advice.

1.20 In October Mr M was provided with some information about the Trust counselling service (BeMe) and Cognitive Analytic Therapy[6] (CAT). Mr M decided that CAT therapy was his preferred treatment. Therefore, the primary care dementia practitioner made the necessary referral to her colleague, advising that it was important to contact Mr M to inform him that the referral had been received.

1.21 In November Mrs M contacted the Trust service to ask what was happening with Mr M's therapy because they had not heard anything. This prompted the CAT therapist to write to Mr M offering an appointment in early December.

1.22 After the appointment with the CAT therapist Mr M received a long and detailed letter about the appointment. It was unclear to us when the letter was sent. The Trust has indicated that they believe the letter may have been sent at some point between 17 and 30 December.

1.23 In January 2016 Mrs M contacted the service again asking for an update on a "follow up appointment". The CAT therapist was asked by administrative staff to contact Mr M or Mrs M to discuss the matter.

1.24 At the end of February Mr M attended an appointment with a nurse at his GP surgery. He described long standing symptoms of his limbs going stiff during the night and "moaning and groaning". Mr M reported that two days previously he had experienced a "turn" during the day when he had stared blankly into space and had been shaking as if he were having a seizure. The nurse noted that she would discuss the matter with a doctor.

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[5] *A CT scan uses e-rays and a computer to create detailed images of the inside of the body. CT scans are sometimes also referred to as CAT scans.*

[6] *CAT (Cognitive Analytic Therapy) is a treatment in which the therapist helps the patient to understand why things have gone wrong in the past and explores how to make sure that they don't go wrong in the future. www.netdoctor.co.uk*

1.25 Two days later both Mr and Mrs M were found dead in their home.

1.26 Two clinical entries were made after the Trust was informed of the deaths of Mr and Mrs M. One entry related to an appointment with the CAT therapist that had taken place on 2 February 2016. The other entry related to an assessment conducted by a community mental health nurse at Mr M's home on 25 February 2016.

Relationship between Mr and Mrs M

1.27 Mr and Mrs M started courting when they were teenagers, but they had known each other since childhood. At the time of their deaths they had been married for about 53 years.

Deaths of Mr and Mrs M

1.28 On 2 March 2016 Mr and Mrs M were found dead in their home by their son and daughter in law.

1.29 The police investigation identified that Mrs M died at approximately 9:45am on 1 March 2016. The reason that such a specific time can be given is that Mrs M was wearing a heart monitor that showed heart activity ceased at around that time.

1.30 Some time after Mrs M's death Mr M hanged himself. There were unsuccessful attempts by Mrs M's family to contact her the following day, and this is what caused the family to attend Mr and Mrs M's home.

1.31 Both deaths happened in the family home.

1.32 The Coroner's verdicts were that:

- Mrs M died as a result of pressure to her neck and that she was unlawfully killed.
- Mr M took his own life and died as a result of hanging.

Internal investigation

1.33 The Trust undertook an internal investigation that was led by two internal investigators.

1.34 The report identified one care and service delivery problem that was not material to the incident:

- The absence of Routine Enquiry for domestic abuse in practice, with clinical staff not routinely starting a dialogue, asking specific questions about domestic abuse.

1.35 No service or care delivery issues were identified that were material to Mrs M's or Mr M's deaths and no root cause could be identified.

1.36 Four recommendations were made:

R1. Development of a protocol to ensure effective systems and resources are in place for response to and delivery of therapy from within the Complex Care & Dementia services to include notification of involvement to primary care and relevant others.

R2. Contemporaneous RiO entries – during supervision the team manager will implement performance management measures for the CPN/therapist to follow to ensure that administration duties are undertaken in a timely manner.

R3. Domestic Homicide Review (DHR) 3 (2013) and DHR 5 (2015) (not yet published) recommended [the Trust] commence a structured roll out to clinical teams of Routine Enquiry into Domestic Abuse – operational service line managers to prioritise and lead the review of the roll out progress and introduction of Routine Enquiry into Domestic Abuse across clinical teams.

R4. Review RiO risk assessment section on domestic abuse, add a drop-down box for: questions asked, not disclosed, disclosed – record details of disclosures, questions not asked and why.

1.37 The report was approved by the Executive Clinical Review Group on 19 August 2016. The timeframe specified by NHS England for completion of a serious incident investigation is 60 days, but there are circumstances in which the Clinical Commissioning Group (CCG) can grant an extension. The Trust requested an extension to the deadline because the ongoing police investigation meant that the Trust investigation team were unable to interview members of staff until the police had interviewed them.

1.38 The report was signed off by the Director of Nursing on 26 August 2016.

Independent investigation

1.39 This independent investigation has drawn on the internal process and has studied clinical information, witness statements, interview transcripts and policies. The team has also interviewed staff who had been responsible for Mr M's care and treatment and spoken with Mr M's family.

1.40 We have provided an assessment of the internal investigation and associated action plan, including oversight by Kernow Clinical Commissioning Group of the improvements required.

1.41 We have also reviewed the communication between the Trust and Mr M's family and have provided comment on the timeliness and appropriateness of those communications.

Conclusions

1.42 We do not consider that either Mrs M's or Mr M's deaths could have been predicted. Mr M did not have a history of violence and Mrs M denied that Mr M had ever been violent or threatening towards her, stating if he ever did

"she would leave him and he knew this". We have also considered whether Mrs M was ever violent or threatening towards Mr M, but again we have found no evidence of this.

1.43 Consequently, we do not consider that Mrs M's death could have been prevented. The tragic circumstances of the morning of 1 March 2016 were out of character and took place with no prior warning signs.

1.44 Although we have found no evidence that any actions or absence of actions by the Trust contributed to the deaths of Mr and Mrs M, we have identified some areas where practice could be improved. These are set out in the next section and in Section 7.

Recommendations

1.45 This independent investigation has made nine recommendations for the Trust, Outlook South West and commissioners to address in order to further improve learning from this event.

Recommendation 1

The Trust must ensure that it fully executes its Duty of Candour responsibilities and that where there are parallel investigations by other agencies, advice is only sought from senior staff about the most appropriate methods of communicating with affected parties.

Recommendation 2

If it has not already been actioned, the Trust must ensure that appropriate audits are undertaken regarding the effectiveness of the new protocol for the Complex Care and Dementia Team, taking any remedial action required if the effectiveness is found to be lacking.

Recommendation 3

The Trust must provide assurance that the expectations of the clinical record keeping policy are met.

Recommendation 4

Kernow Clinical Commissioning Group must ensure that the policy covering the management of serious incidents includes a requirement for oversight of provider investigation action plans, and appropriate and documented dialogue between the commissioner and relevant provider/s.

Recommendation 5

Outlook South West must consider what actions it can take to mitigate the risk of patients choosing not to share relevant clinical information with their therapist, now that therapists no longer have access to the GP clinical record system.

Recommendation 6

The Trust must ensure that SBARD (Situation, Background, Assessment of individual, Recommendation, Decision) is introduced to community mental health teams, ensuring that relevant learning from implementation in inpatient services is transferred.

Recommendation 7

The Trust must ensure that staff are able to identify and recognise the different types of supervision set out in the Supervision Policy ratified in March 2016, in order that staff can use supervision sessions appropriately.

Recommendation 8

The Trust must ensure that staff explore patients' literacy abilities and then communicate information in a way that is accessible and personalised.

Recommendation 9

The Trust and NHS Kernow Clinial Commissioning Group must assure themselves that the therapy strategy sufficiently addresses the provision and use of qualified therapy staff across the Trust, ensuring that gaps in access to appropriate therapy are properly addressed.

Good practice

1.46 Outlook South West routinely seek information about a client's reading and writing abilities in order to inform the way in which they can best engage that client in therapy. This is good practice and ensures that all clients regardless of their literacy abilities can access therapy.

Post publication of this report

1.47 This report will be published accompanied by action plans developed by organisations for whom we have made recommendations. Progress and implementation of those action plans will be monitored by Kernow Clinical Commissioning Group and NHS England.

1.48 Approximately six months after this report is published we will undertake a follow up review to independently assess the progress being made by organisations.

1.49 We will produce a follow up report that will be shared with Mr and Mrs M's family and relevant organisations.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework[7] (March 2015) and Department of Health guidance[8] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent future incidents. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.

2.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.

2.4 The investigation was carried out by Naomi Ibbs, Senior Associate for Niche, with expert advice provided by Dr Susan Mary Benbow, Consultant Psychiatrist. Family support was provided by Dave Smithson.

2.5 The investigation team will be referred to in the first-person plural in the report.

2.6 The report was peer reviewed by Carol Rooney, Deputy Director, Niche.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[9]

2.8 NHS England contacted Mr M's family at the start of the investigation to ask to meet with them. A joint meeting with Niche was arranged and we have provided details of the information received at that meeting in the "Contact with the family" section below.

2.9 Caldicott consent was sought and granted for access to Mr M's records from the Trust and the GP surgery. Clinical information from Outlook South West was granted in the public interest.

2.10 We sought permission from the Coroner in Cornwall to access the documents used in the inquests of Mr and Mrs M. It took considerable time for us to

[7] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf*

[8] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

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

receive these and this caused a delay in the completion of the investigation of about six months.

2.11 We also sought to interview Mr M's GP, Dr C. Dr C initially directed us to the author of a report commissioned by NHS England focussing on the remit of a domestic homicide review and stated that he had already provided evidence to that individual. We therefore liaised with NHS England to obtain a copy of that report and decided to wait until we had received the documents from the Coroner's office before approaching Dr C again. Dr C was reluctant to talk with us because he felt that he had already provided information to a review, however he did agree to have a brief discussion with us regarding a number of key points.

2.12 We used information from these organisations and Mr M's family to complete this investigation.

2.13 As part of our investigation we interviewed:

From the Trust
• Lead Investigators for the serious incident (internal) investigation; • Director of Nursing; • Locality Manager.
From Outlook South West
• Director of Clinical Governance; • Senior Psychological Wellbeing Practitioner.
From Narrowcliff GP Surgery
• General Practitioner (GP).

2.14 We also led a review workshop to which we invited the following staff from the Trust:

- Community psychiatric nurses;
- Consultant psychiatrist;
- Interim locality operations manager;
- Primary care dementia practitioner.

2.15 A full list of all documents we reviewed is at Appendix B.

2.16 The draft report was shared with NHS England, the Trust, Outlook South West, the GP surgery and Kernow Clinical Commissioning Group. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with the family

2.17 We met with Mr and Mrs M's daughters and daughter-in-law at the start of the investigation. They told us that in the 12 to 18 months prior to their parents' deaths Mr M had not been himself, he had changed a great deal and his temper had got worse. He would not allow people to interrupt him, he would forget sentences, was very moody and frustrated. One of their daughters also told us that Mr M became braver and more vocal and would answer back to their mother. However, another daughter told us that she saw her father as being quieter, unable to settle and always fidgety.

2.18 The family agreed that Mr M liked routine and he felt out of control when there was no routine. The family thought that Mr M had dementia but said they had been told that his brain scan showed that the changes were due to age. However, the family found this difficult to believe.

2.19 The family believe the trigger for Mr M's rapid decline in mental health, was the death of his nephew (often referred to by Mr M's family as Mr M's brother due to their close ages). Mr M's nephew died from a heart attack in 2014 and Mr M had tried to resuscitate him. Mr M's family told us that Mr M's brother-in-law had taken his own life in 1989.

2.20 We learned that Mrs M had threatened to leave Mr M because he was "very hard work" and she could not continue. Mrs M had also threatened to send Mr M to Bristol to live with one of his daughters. We do not know whether Mrs M shared these views with Mr M because they have been reported to us as third hand information.

2.21 Mrs M had described Mr M's night fits to the family. They described them to us as Mr M thrashing about in bed and then going rigid. They told us that he had seen the doctor multiple times about the issue, but nobody knew what was causing it. Following the last appointment with a locum GP the possibility of Mr M being referred to a neurologist had been discussed and Mrs M had planned to video Mr M's next episode.

2.22 We understand that Mrs M had briefly moved into the spare room in order to get some sleep, but this had "stressed out" Mr M so much Mrs M moved back into the bedroom they shared.

2.23 One of their daughters told us that Mr and Mrs M "bickered" a lot and that she found this distressing. The frequency and intensity of the bickering had increased, but neither parent was violent to the other in the presence of their family.

2.24 Mr M was described as going from "kind and loving to distant and unpleasant". One of their daughters said she "loved him but didn't like him" at that time.

2.25 We were told that the family had to do a lot of chasing when Mr M was referred to Mr T. They described the letter from the CAT therapist Mr T, as "very flowery" and that their father could not understand it, the letter had been written in a style as if writing to "another professional" and it was not written in layman's terms. The family described that Mr M had been guided towards a book but given his literacy problems a DVD would have been better.

2.26 The family told us that when they learned about their parents' deaths they thought their mother had suffered a heart attack and their father had then killed himself. This was because there had been numerous conversations about Mr M being worried about Mrs M dying first.

2.27 The family told us that they do not believe the incident could have been predicted.

2.28 We held two meetings with Mr and Mrs M's family in July 2018, before the report underwent final checks with NHS England legal advisors. The family was satisfied with the report and did not ask for any significant changes to be made. They were able to help us to ensure that Mr M's background information was correct and clarified specific details of Mr M's extended family. Some family members are keen to meet with the Trust at the pre-publication meeting, others did not wish to participate in that meeting.

Structure of the report

2.29 Section 3 provides detail of Mr M's background.

2.30 Section 4 sets out the details of the care and treatment provided to Mr M. We have also included an anonymised summary of those staff involved in Mr M's care for ease of reference for the reader, this can be found at Appendix C.

2.31 Section 5 examines the communication the Trust had with Mr M's family after the death of their parents.

2.32 Section 6 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.33 Section 7 examines the issues arising from the care and treatment provided to Mr M and includes comment, analysis and recommendations.

3 Background of Mr M

3.1 Mr M was born in 1944 and had an older sister and a non-identical twin brother. Mr and Mrs M got married in September 1963 and had three children, a son and two daughters.

3.2 Mr M's twin brother told the police during the investigation into Mr and Mrs M's deaths that Mr M was very close to his nephew. Mr M, his twin brother and his nephew had all been raised as brothers. When Mr M's nephew died of a heart attack in 2014 Mr M found it difficult to come to terms with his loss and became very depressed.

3.3 Mr M worked as a charge hand for the highways department and struggled with the paperwork aspect of his job. He described to staff in 1976 that he spent many hours at home in the evenings trying to do the paperwork and attending adult literacy classes but struggled to concentrate in these lessons.

3.4 Mr M retired from work in 2004 when he was about 60 years old but remained an active member of the community.

4 Care and treatment of Mr M

1970s and 1980s

4.1 Mr M was first admitted to St Lawrence's Hospital in 1976. This was a short admission following symptoms of "severe agitated depression and suicidal ideation". The hospital was closed in the 1990's and was managed by the organisation that is now known as Cornwall Partnership NHS Foundation Trust (referred to as "the Trust" hereafter).

4.2 Mr M's GP records show that he attempted suicide using car exhaust fumes in January 1988, however there are no Trust care and treatment records dated at around this time. We believe that this incident is the same incident as described in the following paragraph.

4.3 Trust records show specialist mental health care involvement with Mr M's care and treatment from November 1988. It was reported that Mr M had carried a bottle of 100 paracetamol for about a week and at the end of a shift at work returned to an empty depot. Mr M "swallowed the tablets" and connected a hosepipe to the exhaust. Mr M locked all but one of the doors (so that the window wouldn't have to be broken when he was found dead) and started the engine. Mr M recalled being sick and wished he could "hurry up and die". Mr M remembered seeing fire and police officers and was later glad that he had been found alive.

4.4 At assessment following this incident Mr M reported that he didn't get the chance to go out with his wife and that he felt restricted by the presence of his granddaughter. Mr M admitted to mental health staff that he needed help and said he was happy to be admitted to St Lawrence's Hospital again. However, when staff spoke to Mrs M, it was noted that she did not want Mr M to go to St Lawrence's Hospital because "last time it was no help at all".

4.5 Outpatient care was subsequently provided until December 1989 when the decision was made to discharge Mr M because he "remained well".

1990 to 2013

4.6 Mr M's GP records show that he presented with low mood in May 2011 but it is unclear from the records we have received whether he received any treatment for this at the time.

4.7 In January 2012 the GP records show that Mr M presented with memory loss symptoms but again it is unclear from the records we have received whether he received any treatment for this at the time.

June to December 2014

4.8 The first recent entry relating to memory loss or depression in the records that we have received is in November 2014. Mr M saw Dr J, a GP at his surgery, complaining of memory loss. Dr J noted that Mr M's memory had deteriorated, and that Mr M was forgetting things "quite significantly now".

4.9 A week later Mr M was reviewed by practice nurse, Mrs E. Mr M told Mrs E that he was concerned about his memory loss and gave an example of not recalling receiving a recent vaccination injection or attending an appointment with a GP.

4.10 A Six Item Cognitive Impairment Test was completed (we believe around that time) that showed Mr M had a score of 4/28. The score placed Mr M within the normal range.

4.11 Dr S, another GP at his surgery, reviewed Mr M in early December. Dr S noted that Mr M was "not currently appropriate for referral for his memory".

2015

4.12 On 15 January 2015 Mr M was seen by a third GP at his surgery, Dr H. Dr H recorded that Mr M was low in spirits, tearful and preoccupied by "thoughts of his brother's recent death, and his wife's illnesses". Mr M reported that he was worried he was not able to do more to help his wife and that he was frequently waking her during the night with worries about trivial matters. Dr H noted that Mr M looked "thin and agitated" and recorded "depression with anxiety". Dr H prescribed a low dose of mirtazapine with the aim of gradually increasing the dose if Mr M showed a good response. Dr H indicated she wanted to review Mr M two weeks later and consider making a referral to BeMe (a counselling service provided by the Trust). We have seen no corresponding referral letter or form.

4.13 Mr M self-referred to Outlook South West on 19 January. The notes from the referral conversation indicate that Mr M had got himself "wound up" about his wife's medical problems and he was stressed about her condition. Mr M said that he had been feeling this way for about three months and that he had been prescribed mirtazapine 15mg daily. Mr M reported that he had suffered severe depression in the past and that he had previously attempted suicide but that he had no thoughts of suicide or self-harm at that time.

4.14 At review on 29 January later Mr M reported that his mood and anxiety had improved after two weeks of mirtazapine, but that his wife was still concerned about his sleep. Mrs M reported that Mr M was "shaking/jerking his legs (brief seconds) around 15 times" per night but that it never occurred when he was awake. Mr M reported that he was booked in for counselling the following week. Dr H increased the dose of mirtazapine to 30mg and indicated she would review Mr M in four weeks.

4.15 On 5 February Mr M had a telephone assessment with Outlook South West. The assessor noted that Mr M was showing symptoms consistent with Generalised Anxiety Disorder (GAD) and that he was worried about his wife's physical health problems. Mr M said that he worried about how he would cope if she died before he did and reported not being able to read, write or use the computer and felt that he didn't want to burden his family. Mr M reported that when he had time to sit and think, things felt much worse and his anxiety and agitation increased. The assessor noted the plan to be for Mr M

to receive therapy to deal with the anxiety and to consider linking with Age Concern to support Mr M's life skills.

4.16 On the same date there is an entry in Mr M's GP records that shows a PHQ-9[10] score of 10/27 and a GAD-7[11] score of 15/21. The PHQ-9 score indicated moderate depression and the GAD-7 score was at the cut off point for severe anxiety. The recommendation is that when GAD-7 is used as a screening tool, further evaluation is recommended when the score is 10 or greater.

4.17 Mr M had a first treatment appointment with Mr B, a senior psychological wellbeing practitioner, on 26 February. Although Mr B worked for Outlook South West, he often met his clients in their local GP surgery and also inputted information directly into the GP records. At this appointment Mr B recorded that Mr M's anxiety had increased since his wife had become ill and that he had a lot of worries about the future, including the possibility of being on his own. Mr B noted "no risk" and that he would be working with Mr M on calming techniques and behaviours to distract him from ruminating.

4.18 Mr M saw Mr B again on 19 March when it was noted that Mr M was "Doing well. Keeping busy and focussed" and using calming breathing that was helping. Mr M reported that he was talking to more people, which was good because it helped get his fears out of his system.

4.19 Mr M next saw a GP, Dr C, on 15 April when it was noted that Mr M was feeling a bit better and the tablets were helping. Mr M also reported memory loss and weight loss, with "terrible night terrors". It was noted that Mrs M also reported that Mr M's memory was terrible, but it is unclear whether this was Mr M reporting something that his wife said, or that Mrs M was present for the consultation. Dr C conducted a Six Item Cognitive Impairment Test (6CIT)[12] on which Mr M scored 4/28. Scores of 0-7 are considered normal. The clinical entry notes that a referral letter was sent on 16 April, we did not find a copy of this in the GP records we received, however there was a copy in the records received from the Trust.

4.20 Mr M saw Mr B again on 16 April when it was noted that Mr M reported he was more able to open up to his family about his worries and that he found this helpful. He also reported that he found the calming breathing useful, and that it helped him slow down and to take time out. Mr B discussed some progressive muscle relaxation to do before going to bed as he felt it might help with the night terrors.

4.21 The referral to the Complex Care and Dementia Team at Newquay Hospital, received on 24 April, states that Mr M's brother had died suddenly, and Mrs M had been diagnosed with a heart complaint. These events had induced

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[10] Patient Health Questionnaire (PHQ-9) is a questionnaire used in primary care to monitor the severity of depression, and response to treatment.

[11] Generalised Anxiety Disorder Assessment (GAD-7) is used as a screening tool and severity measure for generalised anxiety disorder.

[12] Six Item Cognitive Impairment Test (6CIT) is used as a dementia screening tool in primary care.

severe anxiety in Mr M and although he had been prescribed mirtazapine it did not appear to have improved his symptoms. Dr C also stated that Mr M's wife was very concerned about his memory and that given his severe anxiety Dr C asked for an expert opinion on the best way forward for Mr M.

4.22 Mr M's referral was discussed in the team meeting on the same day when it was agreed that the complex care and dementia team needed to assess Mr M and that Ms G or Ms L would see him.

4.23 Ms G, a community mental health nurse saw Mr M and his wife at their home on 11 May. Mr M reported that he became worried about his wife's health problems about two years previously and in particular worried about how he would manage paying bills if she died. Shortly afterwards Mr M's brother died suddenly, and this increased his anxiety. Mr M said that he had felt more relaxed and had a "clearer" head after taking mirtazapine but that he had always been a perfectionist and a worrier. Mrs M described Mr M as being a "selfish" person with an approach of "it's his way is the only way. He has to be on top of everything". Ms G noted Mr M's night terrors and restlessness at night and that Mr M was seeing a counsellor looking at coping strategies for anxiety. Mr and Mrs M reported concerns that Mr M had memory loss and that sometimes he could not remember what he had done the day before, or what happened when their children were younger and growing up. Ms G noted that Mr M had a good appetite but that he had lost over a stone (14 lbs or 6.4 kgs) over the previous 12-18 months, although the family GP was not concerned about this. Ms G also noted Mr M's previous admissions to hospital in 1976, 1988 and that he had declined admission in 2011 for low mood. It should be noted that we have not seen any information about the episode in 2011 and the Trust has clarified that they did not receive a referral for Mr M at that time. Ms G recorded that Mr M had said that he had "played truant from school" and therefore had "difficulty reading and writing". Ms G completed a GDS[13], which gave a score of 2/15 (scores greater than 5 are indicative of probable depression).

4.24 Ms G contacted Mr M's GP surgery on 13 May to request that they organise dementia blood screening.

4.25 Mr M next saw Mr B on 21 May when Mr M reported that he was feeling much better and calmer. Mr M said he was sleeping well and more often talking through his worries with his family. Mr M spoke of "lots of good things day to day including walking, gardening, and his involvement with the hospital". It was agreed that it would be Mr M's final appointment with Mr B, but that Mr M was "welcome back any time".

4.26 Ms G saw Mr M again on 27 May when she visited him at home and also spoke with Mrs M. Mr M reported that he had been completing his diary and managing his anxiety levels in accordance with the advice. Ms G noted that he had been experiencing anxiety but that he had found using anxiety

[13] *Geriatric Depression Scale (GDS) is used as a screening test for depression symptoms in elderly people; it is ideal for evaluating the clinical severity of depression and therefore for monitoring treatment.*

management techniques helpful and his highest anxiety score was reported as 5, on a scale of 1-10. Mr M completed the ACE-R[14] test and scored 77 out of 100:

- attention 13 out of 18;
- memory 15 out of 26;
- fluency 9 out of 14;
- language 24 out of 26;
- visuospatial 16 out of 16.

4.27 The total score for the ACE-R is 100. Two cut off points are used for this test, 88 for screening and 82 for research. The ACE-R is not a conclusive test for dementia. It is a tool to help clinicians make a diagnosis, and clinical judgement should take precedence. However, the lower the score the greater the likelihood that the person tested has dementia. However, it was also considered that Mr M's score was compatible with his literacy and mood problems.

4.28 Ms G discussed the dementia care pathway with Mr M who said that he "would like to follow this". When Ms G discussed carers support with Mrs M, she indicated that she would like some counselling for "past issues" so Ms G advised Mrs M to speak to her GP or make a self-referral to BeMe. Mrs M also said that she would ring adult social care service to arrange a carer's assessment. It is unclear whether Mrs M ever contacted social care. None of Mrs M's family was aware that she had made contact and indeed Mrs M's family noted that Mrs M had often commented that she had no support. Ms G noted that she had not made any further appointments to see Mr M at that time because Mr M was being transferred to the memory pathway.

4.29 On 10 June a request was sent to the clinical imaging department for a CT scan[15] for Mr M.

4.30 On 11 June Mr M saw his GP who noted that Mr M had a depressive disorder, was waiting for a head scan, "is also going to see a psychiatrist" and "getting on well" with the mirtazapine.

4.31 On 9 July a Care Programme Approach review was held. It was recorded that it was a case notes review, and that Mr M had expressed a wish to follow the Memory Assessment Service pathway "having now complete[d] anxiety management work" with Ms G. It was noted that a CT scan had been requested and a diagnosis appointment had been arranged for mid-July with Dr R. A discussion took place with the Memory Assessment Service nurse, Ms S2, who indicated that she was happy for Mr M's care to be transferred to

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[14] *ACE-R (Addenbrooke's Cognitive Examination-Revised) test is a brief cognitive test that assesses five cognitive domains: attention/orientation; memory; verbal fluency; language; and visuospatial abilities. Total score is 100.*

[15] *A CT (computerised tomography) scan uses x-rays and a computer to create detailed images of the inside of the body. www.nhs.uk*

her caseload. It was therefore decided that Mr M would be discharged from the caseload of the complex care and dementia team.

4.32 Mr M's CT scan of his head took place on 20 July and he and Mrs M saw Dr R, consultant psychiatrist for the complex care and dementia team, on 6 August. A letter providing a detailed summary of Mr M's appointment with Dr R was sent to Mr M's GP on 7 August. Dr R noted that he did not find Mr M to be depressed at the appointment and that Mr M still had a longstanding problem with worrying. Mr M reported, "I'm alright when I have things to do. If I haven't got things to do, I sit in a chair moping… This week I've been pretty good". Mr M continued to worry about his wife's illness, about letting her down and reported that he was afraid of being on his own. Mrs M was clear with Dr R that Mr M did not let her down. Dr R noted that the prescription for mirtazapine appears to have helped Mr M. Regarding Mr M's memory, Dr R noted that although Mr M occasionally had difficulty remembering names, neither he nor his wife reported any major concerns about his memory. It was reported that Mr M was still driving, without incident, and that neither he nor his wife had any concerns about his driving. Referring to the ACE-R test, Dr R stated that he believed that Mr M's score had been reduced because of his anxiety and because he had "missed out on schooling and so has always had difficulty with tests". Dr R noted that he had informed Mr M that his diagnosis was "probably mild cognitive impairment (GP Read Code Eu057)" and that he (Dr R) believed that Mr M's memory would improve if his anxiety reduced. Dr R advised that Mr M had received the memory service information book and that his name would be given to Ms S, primary care dementia practitioner who would make contact a few months later. Dr R recommended that the prescription for mirtazapine be continued with "consideration of an increase to 45mg once at night". Dr R noted that Mrs M had reported that Mr M became restless at night, sometimes moaning and struggling when he was in a deep sleep. Dr R suggested the GP consider prescribing a low dose of clonazepam if Mr M's night-time restlessness didn't settle.

4.33 On 13 August Mr M's GP, Dr C, prescribed 28 mirtazapine 45mg tablets, one to be taken at night.

4.34 On 21 August Mr M saw another GP complaining of a general feeling of pressure in his head and ear. Mr M said he and his wife had discussed the possibility of it being caused by anxiety. The GP found no signs of infection and suggested that the problem be monitored and to return if the problem persisted or deteriorated.

4.35 On 13 September Dr C received a report from A&E, however a copy of this report was not present in the bundle of records we received from Narrowcliff Surgery, so we cannot clarify the reason for Mr M presenting to A&E.

4.36 The next contact from the Trust was on 14 September when Ms S telephoned Mr M to arrange an appointment to see him. This appointment was organised for two days later.

4.37 On 15 September Mr M attended his GP surgery where a nurse cleaned and dressed a wound to Mr M's hand and advised him to return for review three days later. We do not know how this wound was caused because we have not seen the report from A&E, however we believe that this was the reason that Mr M presented to A&E two days previously.

4.38 When Ms S met with Mr M on 16 September he reported a decline in his memory since seeing Dr R the previous month and that he was suffering with night terrors. Ms S noted his background and that Mrs M reported that she had recently been diagnosed with coeliac disease. Mrs M wondered if this had contributed to Mr M's stress. Both Mr and Mrs M felt that talking therapies would be beneficial to Mr M "considering events over the past year". Ms S noted that she would discuss Mr M's case with Dr R and the rest of the multi-disciplinary team to seek advice regarding the decline in Mr M's memory.

4.39 On 18 September Mr M attended his GP surgery for the nurse to review the wound on his hand. The nurse noted that Mr M had taped down the dressing because it had lifted since being applied three days earlier. The nurse noted that the wound appeared "very wet" with a "substantial amount of slough"[16] and irrigated it before applying a clean dressing. She also advised Mr M to try to keep the dressing as dry as possible and offered follow up appointments to clean and redress the wound every three or four days until 6 October.

4.40 Ms S next saw Mr M at home with his wife on 12 October. Ms S provided Mr M with an information leaflet for BeMe and some information regarding CAT therapy.[17] Ms S explained the referral process to BeMe and advised should he decide on CAT therapy to contact her so that she could make the necessary referral. Ms S encouraged Mr and Mrs M to take some time to read the information provided so that they could make an informed decision.

4.41 Four days later (16 October) Mr M contacted Ms S to say that he would like to engage in CAT therapy. Ms S then referred Mr M to Mr T for CAT therapy. Ms S provided a detailed summary for Mr T and referenced the conversation that took place at the multi-disciplinary team meeting. Ms S advised Mr T to contact Mr M to inform him that Mr T had received the referral "as he can become anxious if no contact is made". There is no indication that Mr T made Mr M aware that the referral from Ms S had been received.

4.42 On 20 October Mr M saw Dr C because he was keen to try a lower dose of mirtazapine. Dr C prescribed 28 mirtazapine 30mg tablets, one to be taken at night. The record does not indicate why Mr M had requested a lower dose.

4.43 On 18 November Ms S received an email from a team administrator asking Ms S to call Mrs M. When Ms S telephoned Mrs M she asked for an update

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[16] *Slough is typically a white / yellow colour. It can be found in patches or it can cover large areas of the wound. It is made up of dead cells which have accumulated in the exudate [fluid]. It [slough] may be related to the end of the inflammatory stage in the healing process, and for healing to take place it is advised that slough is removed. www.wound-doc.co.uk*

[17] *CAT (Cognitive Analytic Therapy) is a treatment in which the therapist helps the patient to understand why things have gone wrong in the past and explores how to make sure that they don't go wrong in the future. www.netdoctor.co.uk*

on the referral for therapy because Mr M had not received any communication. Mrs M also enquired how long Mr M would have to wait for therapy to start. Ms S advised that there was a waiting list, but she did not know how long Mr M would have to wait but said that she would ask Mr T to contact Mr M on the mobile number provided, as requested by Mrs M. Ms S then emailed Mr T asking him to contact Mr M.

4.44 On 23 November the records indicate that a letter was sent to Mr M offering an appointment with Mr T on 8 December. We have not seen a copy of this letter.

4.45 Mr M attended the appointment on 8 December with Mr T. Mr T noted that Mr M presented as "well kempt, pleasant and interacted well through the assessment for suitability for Cognitive Analytic Therapy". Mr T also noted that a letter had been generated that would be sent to Mr M and that he (Mr T) planned to add Mr M to the waiting list for therapy. The letter to Mr M provides a detailed overview of the appointment and notes that "it was unfortunate [the] meeting was drawn to a close so urgently by the fire alarm". Mr T stated he had hoped to introduce Mr M to a brief meditation or relaxation exercise that might help him "learn to be more tolerant with your thoughts and instead of pushing them away you could learn a new skill of simply observing your thoughts and not getting too caught up in them". Mr T encouraged Mr M to purchase a book in either paper or audio form and hoped Mr M had "no trouble finding this book". The letter ends by indicating that Mr T would be in touch with Mr M in the new year "to follow up the initial assessment". Although the letter is dated 17 December, it was not uploaded to Mr M's clinical record until 30 December. It is unclear when it was actually sent to Mr M. The Trust has told us that the letter was uploaded to Mr M's clinical record on 30 December and therefore the Trust believes that the letter was sent some time between 17 and 30 December.

4.46 On 10 December Mr M had a review appointment with Dr C. Mr M reported that he was feeling better on the lower dose of mirtazapine and that he was keen to continue with that dose. Mr M also reported that he had "started counselling" the previous week.

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4.47 On 13 January a team administrator received a telephone call from Mrs M enquiring when Mr M's follow up appointment with Mr T would take place. The administrator emailed Mr T asking him to call Mrs M to discuss the matter.

4.48 On 28 January Mr T noted a new mobile number for Mrs M but it is unclear when he actually responded Mrs M's enquiry about a follow up appointment for Mr M.

4.49 On 4 February Mr T and Ms S discussed Mr M's case with the team manager, Ms J. Ms S advised Ms J that although Mr M had a diagnosis of mild cognitive impairment, she believed that his memory problems were related to his stress and anxiety levels and had therefore referred him to Mr T for CAT

therapy. Mr T stated that he felt it would not be appropriate for him to act as Mr M's care co-ordinator "as this would not be appropriate given that he is currently offering him therapy". The issue was therefore scheduled for discussion at the multi-disciplinary team meeting the following day to ensure that a care coordinator was allocated, and it was agreed that Ms S could discharge Mr M from her caseload because he was "currently seeing [Mr T] for CAT therapy". Ms S subsequently advised Mr M of this and ensured he was aware that he could contact the service again should he have further concerns about his memory.

4.50 On 8 February Mr M's records show that Ms J3 was allocated as Mr M's care coordinator. A letter was sent to Mr M offering a home appointment on 22 February.

4.51 Two days later the team administrator called Mr M to cancel the appointment on 22 February and advise him that Ms L, a community mental health nurse, would contact him the following day to discuss an alternative appointment date.

4.52 Ms L contacted Mr M the following day (11 February) to advise that she wanted to discuss his case with Mr T because she wanted to ensure that her interventions did not interfere with the therapy being provided by Mr T. Ms L spoke to Mrs M on 12 February to arrange an appointment on 25 February.

4.53 On 29 February Mr M attended an appointment with a nurse at his GP surgery. Mr M reported "long standing turns" during the night, described as "moaning and groaning", with his limbs going stiff and a loss of memory afterwards. Mr M had experienced a "turn" during the day, for the first time, two days previously, the event was described as being noted by other people as Mr M "staring blankly into space, out of it, odd body movements – no shaking like a seizure…no recollection of events". Mrs M reported that she had mentioned the night-time events to lots of people, but the only explanation had been stress. Mrs M expressed concern about whether Mr M should be driving. The nurse noted she would discuss the matter with a doctor and suggested that Mr M abstain from driving and keep a note of any further turns. The nurse discussed the matter with a doctor who stated that it sounded like a "seizure or pseudo seizure" and that a referral to neurology would be arranged.

4.54 The following entries were made after the Trust became aware of Mr and Mrs M's deaths.

4.55 On 3 March Mr T made a late entry into Mr M's clinical record. The entry referenced an appointment with Mr M and Mrs M that had taken place more than four weeks earlier on 2 February. The entry noted that Mr M was seen with Mrs M present for more than half the appointment and that Mrs M reported that her concerns related to memory symptoms and sleep disturbances. Mr M described as a "frightening experience" the fact that he was unable to recall days out when their children were younger. Mr T suggested that it might be normal for people to lose such memories and that "men often struggle to recall dates and events that their wives seem to recall

with ease". Mr T discussed CAT and the letter that he had sent to Mr M. Mr M said he was keen to begin therapy but expressed concern about his ability to understand enough of the details of the letter and that he might not be able "to keep up in therapy". Mr T advised that the therapy would move at Mr M's pace "in order to be helpful and not overwhelming". Mr T noted that he had agreed with Mr M that CAT would be a suitable treatment plan and that Mr T was planning to start a CAT clinic soon. Mr T would be in touch with Mr M in the near future to offer an appointment to start therapy that would probably involve 16 weekly sessions. Mr T noted that he had encouraged Mr M to contact him on the phone in the meantime, if he had any questions about the plan.

4.56 Ms L also made a late entry into Mr M's clinical record. The entry referenced the appointment on 25 February. Ms L met with both Mr and Mrs M and advised that she was seeing him because he needed to have a nurse involved in his care as well as his CAT therapist. Mr M reported that he had seen Mr T twice and that he was waiting for a weekly schedule from Mr T, but that he was reading the book Mr T had given him and was listening to the relaxation tape twice a day. Mr M said that he felt a lot more relaxed and was keeping himself busy. He also said that he was eating and sleeping well, however Mrs M reported that when Mr M dropped off to sleep, after a matter of seconds he sometimes "struggles with his legs and arms, he stares and makes sounds like he is in pain". Both Mr and Mrs M said that the problem started after Mrs M had been diagnosed with heart problems. Mrs M told Ms L that she had made their GP aware and was planning to record the next episode on her phone in order to show the doctor. Mr M advised that he did not struggle with daily living skills and was able to do everything independently. He also said that both he and Mrs M would have breakfast in bed and that they would each take turns in making breakfast. Mr M described sometimes getting frustrated and this would come out as him "blowing up", raising his voice and shouting. Mrs M described an incident the previous week when Mr M felt that people in the village hall were stacking chairs incorrectly, but that this was not new behaviour and it had not increased in frequency or intensity. Both Mr M and Mrs M denied that Mr M was ever verbally or physically threatening to Mrs M. Mrs M said that if Mr M did ever hit her "she would leave him and he knew this".

5 Communication with Mr M's family

5.1 We have received copies of communication between the Trust and Mr and Mrs M's family. It appears that the first contact was an email on 24 May 2016 from one of the internal investigation team. The email offered condolences to Ms C (one of Mr and Mrs M's daughters), advised that a serious incident investigation was being undertaken by the Trust and invited a meeting with her and other family members the following week. Ms C advised that she needed to liaise with her brother and sister regarding the meeting date as they wished to attend too. On 26 May Ms C suggested a meeting on 6 June and asked if the meeting could be held in Newquay, the Trust confirmed the venue on 31 May.

5.2 On 8 June Ms K, the adult safeguarding lead professional for the Trust, sent an email to follow up four actions discussed at the meeting held on 6 June:

> 1. The delay in CFT [the Trust] contacting family members to arrange to meet.
>
> The Trust advised that on 10 March they were waiting for confirmation from police that contact could be made with relatives.
>
> On 30 March the Trust Adult Safeguarding team advised the internal investigation team that the police had confirmed that the Trust could interview staff and contact relatives. At this time it was noted that the Trust had contacted the police to ask that the police forward contact details of the Trust to the relatives, but that this had not elicited a response from the family.
>
> The following day the Trust had contacted the coroner to ask her to seek consent from the family for their contact details to be shared with the Trust.
>
> On 18 April the Head of Governance for the Trust was contacted by Mr G (Mr and Mrs M's son) who advised that he would contact his sisters to see if they wished to be involved in the investigation.
>
> On 4 May the Head of Governance was asked if she had received any response from Mr G's sisters (it is unclear from the information we have who asked the question).
>
> Two days later the Trust was contacted by Ms R, a support worker from the Homicide Service in Victim Support. Ms R advised that Mr G and his family were grateful that the investigation was being undertaken and that they wished for liaison with them to go through Ms R. The Head of Governance asked whether the family wanted the Duty of Candour letter, but Ms R advised not to send this at that time and that she would speak to the family.
>
> On 20 May Ms R contacted the Head of Governance to advise that the family would welcome a meeting with the internal investigator to discuss their questions and concerns and find out more information about the investigation. The notes for this date also state the Trust "advised that given family will be meeting up with [Mr S] to discuss it was not necessary to send out the duty of candour letter".

2. Time scales for completion of the CFT [the Trust] internal management report (called an IMR) The timescales for the IMR had not been established at that time and Ms K advised she would update the family shortly.
3. Update on time scales for the Domestic Homicide Review (DHR) panel Ms K advised that she had requested this information and that she would provide an update when she received a response.
4. Establish if your parents' death will also fall under a Mental Health homicide review. The criteria for this is a death caused by person in receipt of mental health services or death that occurs within 6 months of discharge. Again, Ms K advised that she had requested this information and that she would provide an update when she received a response.

5.3 Ms C (one of Mr G's sisters) responded on 14 June thanking Ms K for the information and advising that Mrs M's sister in law was happy for the Trust to contact her for more information about Mr and Mrs M's lives prior to their deaths. Ms C followed up this email on 17 June seeking confirmation that Ms K had received the information. Ms K responded the following day to confirm that she had received the email and to advise that the internal investigators would contact Mrs M's sister in law.

5.4 On 25 July Ms K contacted Ms C to provide an update on the outstanding questions raised at the meeting on 8 June.

2. Time scales for completion of the CFT [the Trust] internal management report (called an IMR) Ms K hoped the report would be completed in August 2016 and that she would be in contact again when she had more information to update.
3. Update on time scales for the Domestic Homicide Review (DHR) panel Ms K advised that she had given Ms C's details to a representative from the Safer Cornwall Partnership and apologised that the representative had not yet been in contact. Ms K reported that she had discussed the case that morning and that Safer Cornwall Partnership had not made a final decision about whether a domestic homicide review would be undertaken. Ms K informed Ms C that the Safer Cornwall Partnership had responsibility for making the decision and that it had been Ms K's understanding that the decision had already been taken to continue with a review. Ms K advised that she had asked the representative from the Safer Cornwall Partnership to contact Ms C as soon as possible.

4. Establish if your parents' death will also fall under a Mental Health homicide review. The criteria for this is a death caused by person in receipt of mental health services or death that occurs within 6 months of discharge.

Ms K advised that she had made enquiries with NHS England on this matter and that NHS England had advised that a mental health homicide review was no longer automatically held. NHS England would wait for the Trust internal report to assess whether it was sufficiently comprehensive and adequate, or whether an external panel would look at the circumstances of the deaths. Ms K also advised that if NHS England decided to commission an external review, it would "be held jointly with a DHR panel".

5.5 On 1 September Ms R, from Victim Support, emailed Ms K to ask for an update on the investigation. Ms K was next in contact with Ms C on 7 September to advise that the Victim Support worker had been in contact to request that she be copied in to all the communication from the Trust to Ms C and her family. Ms K sought Ms C's confirmation that this was indeed their wish. Ms K also informed Ms C that the internal report had been completed and the Trust was in a position to share this with Ms C and her family. Ms K provided some dates for a meeting with the Trust and agreed to send a copy of the report in advance of the meeting.

5.6 The family meeting was held on 14 October with Ms K, Ms A (the service manager). Ms K contacted the family after the meeting with a summary of the changes that the Trust had made to the report at the request of the family and provided a glossary of terms.

5.7 On 9 December Ms K informed the family that the amended report had been sent to the Trust commissioners and NHS England. The Trust had also sent the executive summary to the Coroner. Ms K advised that the Safer Cornwall Partnership were not planning to conduct a Domestic Homicide Review unless the family had additional information. Ms K also informed the family that NHS England intended to hold an independent investigation.

5.8 The last email that we have seen is from Ms K to the family to advise that she had sent a revised copy of the report to them with changes highlighted in yellow.

Duty of Candour

5.9 Duty of Candour is a Care Quality Commission regulatory requirement (Regulation 20). Regulation 20 was introduced in April 2015 and is also a contractual requirement in the NHS Standard Contract. In interpreting the regulation on the duty of candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- **"Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."

To meet the requirements of Regulation 20, a registered provider has to:

- "Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.

- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.

- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.

- Advise the relevant person what further enquiries the provider believes are appropriate.

- Offer an apology.

- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.

- Keep a written record of all communication with the relevant person."

5.10 The Trust has a Being Open and Duty of Candour Policy and Process that sets out what is expected from staff at different levels of the organisation. The document identifies that a "Named Person", usually a senior clinician, is nominated to keep in contact with the person involved in the incident or the person who is legally able to act on their behalf. The Named Person is separate from a Serious Incident Investigator (such as Mr S and Ms N in this case).

5.11 We have seen from the correspondence provided by Mr and Mrs M's family that the Trust Head of Governance asked the family's Victim Support Worker whether the family wanted to receive a Duty of Candour letter. The Victim Support Worker advised not to send it at that time and said she would speak to the family.

5.12 It is our view that it was not appropriate for the Trust to delegate the decision on how and when to discharge a core component of their statutory responsibility to a support worker from another agency. There is no indication that the decision was ever followed up nor that an appropriate letter of apology was ever forwarded to the family. See our Recommendation 1.

6 Internal investigation and action plan

6.1 The Trust was informed of the deaths of Mr M and Mrs M on 2 March 2016. It was reported that their son and his wife attended the family home and found both parents dead. Most of the staff within the complex care and dementia team were informed of the incident on the same day, just two members of staff were informed the following day, this was because they were not at work the previous day.

6.2 The Trust undertook an internal investigation that was led by two internal investigators, Mr S and Ms N. Both investigators are very experienced in undertaking complex reviews of serious incidents, one has a background in the NHS and the other is a retired Fire and Rescue Service senior manager.

6.3 The internal investigation also served as the organisation's internal review (IMR) contributing to a potential Domestic Homicide Review.

6.4 The Trust process for commissioning a serious incident investigation is that a virtual group of operational, governance, adult and children safeguarding leads review the initial report in order to determine whether an incident meets the criteria for a serious incident, and if so at what level it should be investigated.

6.5 In circumstances where there is the possibility of a parallel review being undertaken (such as a domestic homicide review, child or adult serious case review) both an internal investigator and an adult safeguarding investigator will be assigned to the investigation. In this case the adult safeguarding investigator was assigned shortly after the internal investigator was notified of the case.

6.6 There is a standard set of terms of reference that are circulated to the investigation commissioning manager who will approve or amend them before forwarding to the internal investigator. We understand that at the time the investigation was undertaken families were not involved in developing the terms of reference, however the terms of reference for this investigation did include addressing questions raised by the family. The terms of reference for this investigation were to:

- Critically examine the circumstances surrounding the incident including care and management issues where appropriate;
- Relate to any national and local policies;
- Identify any issues that impacted on the incident;
- Consider patient's primary care involvement;
- Escalate concerns appropriately;
- Prepare a report of the investigation and make recommendations and agree these with the appropriate service line lead;
- Identify the factors and root cause (if possible);

- Check that key questions raised (including by patient, relative or carer) are answered, where possible;
- Check that arrangement for staff, patients and relatives have been supported, as appropriate, for example Being Open, Duty of Candour and supporting staff policies.

6.7 No service or care delivery issues were identified that were material to Mrs M's or Mr M's deaths and no root cause could be identified. However, one care and service delivery problem was identified that was not considered material to the incident:

"The absence of Routine Enquiry for domestic abuse in practice was identified as a service delivery issues with clinical staff not routinely starting a dialogue, asking specific questions about domestic abuse."

6.8 Areas of learning identified are set out in Table 1 below, however it was noted that they were not identified as contributory factors in the deaths of Mr M or Mrs M.

Table 1 - Contributory factors classification

Patient factors	History of anxiety and depression Serious suicide attempt in 1988 Recent referral for treatment of generalised anxiety disorder Diagnosis of mild cognitive impairment
Communication factors	Timeliness of patient communication Updating of patient's records in electronic patient record system
Organisational factors	Recommendations from a previous serious incident and domestic homicide review had not been fully implemented

6.9 Four recommendations were made:

R1. Development of a protocol to ensure effective systems and resources are in place for response to and delivery of therapy from within the CC&D services to include notification of involvement to primary care and relevant others.

R2. Contemporaneous RiO entries – during supervision the team manager will implement performance management measures for the CPN/therapist to follow to ensure that administration duties are undertaken in a timely manner.

R3. DHR 3 (2013) and DHR 5 (2015) (not yet published) recommended CFT commence a structured roll out to clinical teams of Routine Enquiry into Domestic Abuse – operational service line managers to

prioritise and lead the review of the roll out progress and introduction of Routine Enquiry into Domestic Abuse across clinical teams.

R4. Review RiO risk assessment section on domestic abuse, add a drop-down box for: questions asked, not disclosed, disclosed – record details of disclosures, questions not asked and why.

6.10 We support the recommendations made by the internal investigation team.

6.11 One area of good practice was identified in the internal report. This related to the provision of talking therapy in the form of cognitive analytical therapy by the newly qualified member of staff, referred to in our report as Mr T. The internal team identified this as being "above and beyond what the CMHT would usually be in a position to offer a patient". Whilst we agree that it is unusual for such therapy to be offered from within a CMHT, the therapy was never provided, and Mr M was still waiting for this treatment in March 2016, having been referred in September 2015. We discuss this more in our analysis of Mr M's care and treatment in Section 7.

Questions from the family

6.12 In the process of completing the internal investigation, the team considered 16 additional questions from Mr M's family. These questions are set out in Table 2 below.

Table 2 - Questions raised by the family to the internal investigation team

No	Question
1	The family thought their relative was a simplistic man and felt that the letter from the CPN/therapist on 17 December 2015 was too detailed, contained too much information and was inappropriate for their relative, as they didn't think he would have understood it. They felt the CPN/Therapist should have phrased it in simpler terms.
2	The family did not believe that their relative understood the therapy plan.
3	The family asked about the level of priority their relative was given to receive CAT particularly as they had been waiting a long time.
4	What was the time delay on weekly appointments?
5	The family believed that the wait for CAT was a long time and wanted to know how sick their relative was considered to be. Was he assessed as being low risk and did this affect his prioritisation for CAT?
6	What history was taken from the couple?
7	Was minor cognitive decline and depression looked at together or depression alone?
8	The family asked if their relative's mental health history and previous suicide attempts were taken into account by MDF. Were the risks looked into and the links to his suicide?

No	Question
9	They asked if their relative's brother in law's (Mrs M's younger brother) suicide had an impact on developing his care.
10	How sick did the CPN/Therapist assess their Dad to be/what risk was assessed?
11	Was there any noticeable deterioration their Fathers mental health between December – February?
12	The family asked if the consultant psychiatrist considered other diagnoses e.g. bipolar or borderline personality behaviour.
13	Their relative had a brain scan and was told he had brain shrinkage and mild cognitive impairment (MCI) and the family asked if this was looked into in terms of his anxiety. Were clinicians focusing on their relative's anxiety or MCI and was there a connection?
14	What was his diagnosis – any consideration of personality disorder?
15	The family enquired why it had taken so long for the meeting to be held, what was the delay?
16	Why has it taken so long for the family to be brought into this – Trust via victim support?

6.13 All questions were set out in the report and detailed responses are provided.

6.14 We have reviewed the Trust responses to the questions raised by Mr and Mrs M's family. We consider that nearly all the questions were appropriately addressed by the Trust. However, we do not agree with the inference in the Trust response that the content of the letter of 17 December was appropriate (question one). We discuss this more in our analysis of Mr M's care and treatment in Section 7.

6.15 The report was approved by the Executive Clinical Review Group on 19 August 2016. The timeframe specified by NHS England for completion of a serious incident investigation is 60 days, but there are circumstances in which the clinical commissioning group can grant an extension.

6.16 In this case the Trust experienced delays in interviewing staff because of a police investigation. It is commonplace for NHS organisations to have to delay undertaking formal interviews with staff until police interviews have been completed.

6.17 There was a delay in liaising with the family. The Trust had no contact details for any of Mr M's family, other than his wife. The Trust reasonably liaised with the police and asked that they forward contact details for the Trust to Mr M's family. When no response was received from the family, at the end of March 2016 the Trust contacted the Coroner to seek permission from the family for their contact details to be shared with the Trust.

6.18 Although the Trust was contacted by Mr M's son two to three weeks later to advise that he was liaising with his two sisters, it was a further two to three weeks before the Trust was contacted by Victim Support on behalf of the family. This process alone meant five weeks when the Trust was unable to make direct contact with Mr M's family.

6.19 Once the Trust was in direct contact with Mr M's family (through the safeguarding lead and investigators) they were proactive in speaking with Mrs M's brother and sister in law to obtain more information about Mr and Mrs M's life during the months leading up to their deaths.

6.20 The report was signed off by the Director of Nursing on 26 August 2016.

Analysis of Trust actions

6.21 We reviewed the Trust action plan and asked the Trust to provide us with evidence of completion of relevant actions.

6.22 We also asked the internal investigation team whether they felt that the Trust action plan sufficiently dealt with the concerns that led to their recommendations. The internal investigation team told us that they felt a key action was missing in the Trust response to Recommendation 3. We deal with this issue in paragraph 6.30 below.

6.23 **Recommendation 1.** The Trust has developed and implemented a new protocol. The protocol highlights that the Complex Care and Dementia service has only one clinical psychology post, however there are a number of other practitioners within the service who are qualified to deliver psychological therapy. The protocol sets out eligibility requirements to be met when specific psychological interventions are requested:

- Patient is on existing Complex Care and Dementia Caseload due to presenting Clinical needs and is under the CPA process.
- Patient has been identified by the Care Co-ordinator as a possible candidate for psychological therapy. The Care Co-ordinator will have assessed a high level of Complex Secondary Mental Health needs, evidenced by appropriate clinical measures and clustered accordingly.

6.24 The protocol describes the referral process and is clear about what action is to be taken by whom. Should a patient be eligible for CAT and the CAT practitioner is the patient's existing care coordinator, a new care coordinator must be assigned.

6.25 Also specified is the minimum frequency of CAT supervision sessions and the expectation that those supervision sessions are to be recorded in the electronic patient record as non face-to-face contact.

6.26 If the Trust has not audited the effectiveness of the new protocol, then we would suggest an audit is undertaken. See our Recommendation 2.

6.27 **Recommendation 2.** The Trust action is noted as ensuring that record keeping is undertaken in a timely manner through regular supervision. The specific action related to the supervision and management of an individual member of staff. Therefore, we have not sought documentary evidence of actions taken but have spoken to the relevant manager. We have been advised that the individual concerned was given a timeline for improvements to be made to their record keeping and that this was monitored through regular supervision. The required improvement was achieved and maintained.

6.28 The Director of Nursing told us that record keeping was one of two areas that was "frequently identified" in serious incident reports, in both mental health and physical health care.

6.29 We discuss this issue further in Section 7.

6.30 **Recommendation 3.** The Trust action was for managers to remind staff in supervision and team business meetings to ensure that during clinical assessment, questions about domestic abuse are asked. The internal investigation team felt that a structured roll-out of Routine Enquiry was missing from the action plan. They noted that although Routine Enquiry was already in place, it had been delayed by the focus of staff being the acquisition of community services and it had not been prioritised by operational managers. We discussed this issue with the Director of Nursing who advised that the Trust has done a considerable amount of work on identifying domestic abuse and that large groups of staff had received relevant training. In addition, there is a prompt question on the patient electronic record to remind staff to ask relevant questions at appropriate times. The Director of Nursing advised that practitioners are given advice about when and how they ask questions and that staff are encouraged to discuss concerns (about how to manage their approach) with their manager. Staff are encouraged to exercise "professional curiosity" and that if staff have a "gut reaction" about a situation, they are encouraged to make a return visit or talk to other staff that may be working with the patient.

6.31 Routine Enquiry has been discussed in a number of learning and development forums within the Trust and has been a topic in Patient Safety Matters, an incident-based newsletter.

6.32 The Trust is now taking a more strategic approach to embedding Routine Enquiry into every day practice. Every practitioner receives training on what questions to ask, how to ask them and what signs to watch out for during contact with patients.

6.33 **Recommendation 4.** The Trust now has a section in the electronic patient record specifically for Routine Enquiry. Regular monitoring reports are generated that detail completion of the relevant section and performance is monitored Trust wide.

6.34 We consider that the Trust has implemented actions identified in response to the recommendations. However we would recommend that the Trust

continues to work with staff on record keeping and audit programmes to provide assurance of the quality of this aspect of clinical practice. See our Recommendation 3.

Trust and Clinical Commissioning Group oversight

6.35 Trust oversight of incident reports and action plans takes place at the Executive Clinical Risk Group. This group meets every two weeks to review all of the serious incidents across the Trust. The group also reviews incident reports for themes or services that have recurring incidents.

6.36 The Executive Clinical Risk Group is responsible for signing off incident reports and associated action plans. When this has been done the report and action plan is sent to the Clinical Commissioning Group. Unless there is a particular reason, there is not normally a dialogue between the Clinical Commissioning Group and the Trust.

6.37 We did not receive any information from the Clinical Commissioning Group specifically in relation to their oversight of this incident.

6.38 The process for the Clinical Commissioning Group to follow is set out in their Incident Management Policy, ratified in October 2015. The Governance and Assurance Committee of NHS Kernow (the Clinical Commissioning Group for Cornwall and the Isles of Scilly) receives an overview of the serious incidents reported by commissioned services. There is no reference in this policy to associated dialogue between commissioners and providers. It is our view that this should be specifically referenced. See our Recommendation 4.

7 Analysis and recommendations

7.1 It is our view that Mr M received good care and treatment from Outlook South West. Triage and therapy staff sought to understand Mr M's strengths and weaknesses and noted his poor literacy skills, adjusting their approach accordingly.

7.2 It is our view that Mr M received generally good care and treatment from the Trust. He was seen promptly after referral by his GP, and care coordination staff undertook thorough and detailed assessments. We are concerned that Mr M was left for many weeks with no contact from a therapist, despite him being made aware that it was important to let Mr M know what was happening.

7.3 Mr M's GP did not make the Trust aware that Mr M was receiving input from Outlook South West at the time

Liaison between agencies

7.4 Mr M made a self-referral to Outlook South West and therefore there was no referral letter from Mr M's GP. However, all of Mr M's appointments with Outlook South West practitioners were recorded on the GP patient record system and therefore his GP would have been aware of their input. This approach to record keeping meant that the surgery team had access to up to date information about patients.

7.5 Mr M was still under the care of Outlook South West at the time of his referral to the Trust (he had in fact attended two appointments that had been documented in the GP records). The referral was made by his GP but there was no reference to the therapy he was receiving from Outlook South West.

7.6 We learned from Outlook South West that this practice has now changed, and no direct entries are made into GP clinical records. Both we and the Outlook South West practitioner felt that this was a retrograde step and that it would result in GPs having less access to information about their patients. However, when we discussed it with Dr C he told us that GPs are more likely to review information in a formal letter from another healthcare provider, than read back on older entries on their own clinical system. Therefore, it would be less likely that information about a patient's treatment would be missed in a referral letter now.

7.7 Outlook South West has confirmed that the new record keeping arrangements has the potential to result in them not being aware of some information about a patient (for example the fact that they are being seen by a service provided by the Trust), if the patient chooses not to disclose it to them. We recognise that it is not possible to eliminate this risk entirely, however there are mitigating actions that could be put in place. We suggest that Outlook South West considers what actions it can take to mitigate the risk of patients choosing not to share relevant clinical information. See our Recommendation 5.

7.8 Neither Outlook South West nor the Trust were aware of the other agency's involvement until after Mr M's death. Therefore, it would not have been possible for any liaison between these agencies to have taken place.

7.9 There was liaison between the Trust and the GP following Mr M's initial appointment with Ms G. This was to ask the surgery to organise some blood tests to screen for dementia.

7.10 Dr R wrote to Mr M's GP on 7 August, following an outpatient appointment the previous day. The letter was very detailed and recommended that the GP continue to prescribe mirtazapine and to consider an increased dose. Dr R also suggested Mr M's GP consider prescribing clonazepam if Mr M's night-time restlessness did not settle.

7.11 We asked Dr C what his usual response would be when receiving such a letter from a consultant. He indicated that unless he had been given a direct instruction to review a particular aspect of a patient's treatment, or the issue was one that the patient would not be able to report (such as precise blood pressure) he would wait until the patient raised the issue again at a future appointment.

7.12 We consider the liaison between the Trust and the GP surgery, and Outlook South West and the GP surgery was appropriate.

Record keeping

7.13 The internal investigation identified issues of timely record keeping. We have touched on this earlier in this report, in Section 6. There were two late entries made by different members of staff:

- Mr T: late entry on 3 March relating to an appointment on 2 February. We have not been able to establish a specific reason for why the entry was not made at the time.

- Ms L: late entry on 3 March relating to an appointment on 25 February. Ms L has told us that she was struggling with a medical problem that day and actually had to leave work after the appointment. She was subsequently off work until the week of Mr and Mrs M's deaths.

7.14 During the review workshop we heard from some staff that it was sometimes difficult to ensure that records were updated in a timely fashion, because of the electronic record keeping system.

7.15 We raised this issue in our interview with the Director of Nursing and the Locality Manager. We understand that every member of staff has access to the electronic patient record system as long as they have a 3G or 4G signal, because all community staff have mobile devices. There is no Trust policy about the approach staff should take to the administrative work required following clinical appointments, however all staff are expected to use an approach that suits them and ensures appropriate and timely record keeping.

7.16 Record keeping is monitored during supervision and automatically generated reports are available to managers to aid this process.

7.17 The Trust has developed an approach in inpatient services to improve clinical record keeping. This toolkit (SBARD – Situation, Background, Assessment of individual, Recommendation, Decision) has worked well because it provides a rational for clinical interventions that staff make. The Director of Nursing told us in early 2018 that this approach had not been extended to community mental health teams, but discussions had taken place about the approach forming the basis of a quality improvement project. We suggest that the Trust ensures that this approach is formally rolled out to community teams to improve the consistency of good quality record keeping across the organisation. See our Recommendation 6.

Clinical and managerial supervision

7.18 We have reviewed the Supervision Policy, dated 5 August 2015. This is the policy that was in place at the time of the incident. The policy describes the different types of supervision: formal; informal and managerial.

7.19 Managerial supervision is a requirement for all staff and involves issues related to:

- Job purpose and function;
- Workplace;
- Developmental review;
- Performance management;
- Capability and competence;
- Supporting employees;
- Setting and reviewing objectives.

7.20 Clinical supervision is focussed on the practice of an individual's clinical work. It provides time to discuss events or experiences that are pertinent to the individual.

7.21 The Trust's supervision policy also refers to a number of other types of supervision.

7.22 Staff described the process of supervision as being "quite administrative" rather than focusing on their clinical work. We discussed this with the Director of Nursing and her view was that some members of staff were failing to recognise the two different types of supervision described above.

7.23 This is an important difference that all clinical staff should be able to recognise. Therefore, we suggest that the Trust undertakes further work with

staff to ensure that they are able to identify and recognise the different types of supervision and use the sessions appropriately. See our Recommendation 7.

Risk assessments

7.24 Risk assessments were undertaken by staff in Outlook South West and the Trust.

7.25 Mr M offered information to both agencies about his mental health crises in the 1970s and 1980s. We consider that the decision by Outlook South West staff not to record Mr M's risk as high was entirely appropriate, given the length of time that had passed since he had been admitted to a mental health ward.

7.26 Trust staff views of Mr M's risk to himself and others were well documented and discussed by his care co-ordinators. We have found no evidence that indicates that his risk rating was inappropriately low.

Service user and carer involvement

7.27 Mr M and his wife were generally seen together by Trust staff. We can see that staff sought Mrs M's views on Mr M's symptoms and that these were recorded appropriately.

7.28 Trust staff discussed carers support with Mrs M and suggested she speak to her GP or make a self-referral to BeMe in order to access counselling. Although Ms G recorded that Mrs M had said she would contact adult social care to arrange a carer's assessment, it is unclear whether Mrs M ever followed this up. We were informed that Ms G did offer to contact adult social care on Mrs M's behalf, but that Mrs M opted to self-refer, however this is not reflected in the clinical record.

7.29 On 16 October 2016 Mr M advised the Trust that he wanted to start cognitive analytic therapy. The primary care dementia nurse, Ms S, contacted the CAT therapist, Mr T, to inform him of this and to advise that he needed to contact Mr M to inform him that the referral had been received. This advice was given because Mr M was known to become anxious if he did not know what was happening. We found no evidence of any contact between the Mr T and Mr M. Indeed, on 18 November Mrs M contacted Ms S to ask about the progress of the referral and what the waiting times were.

7.30 Only after this contact, on 23 November, was a letter sent to Mr M offering an appointment on 8 December. During his interview with the internal investigation team Mr T stated he had been influenced by the "28 day response time" however there was no protocol for responding to referrals for therapy from within the team. As we have discussed earlier, the Trust has now implemented a process for managing internal referrals for psychological therapy.

Person centred care

7.31 We have not reviewed the Trust Care Programme Approach policy because Mr M's care and treatment was not being delivered through this approach. The Complex Care and Dementia Operating Procedure contains the following statement regarding Care Programme Approach:

"The principles of good quality timely care review and the involvement of family and other agencies are adopted by all the service elements. Care co-ordination utilising the practice of the Care Programme Approach is applied to all people using the Complex Care Community Service."

7.32 Mr M was first told that he probably had a diagnosis of mild cognitive impairment at his appointment with Dr R in August 2015. It is not clear to us what information Mr M received about what this probable diagnosis actually meant for him.

7.33 Mild cognitive impairment is a term used when someone has relatively minor problems with cognition that do not meet the criteria for a diagnosis of dementia. In particular that the cognitive difficulties do not interfere with the person's daily life. In some people mild cognitive impairment is a prelude to dementia but this is not the case for everyone. Approximately 10% of people with mild cognitive impairment develop dementia each year.

7.34 We do not know what the memory service information book includes about mild cognitive impairment, but it is important to explain what it means to patients and families who may not be acquainted with the term.

7.35 As we have previously mentioned, Mr M struggled with reading and writing. This information was specifically discussed as part of his initial triage meeting, noted by the triage worker at Outlook South West and future work with Mr M adjusted to account for this difficulty.

7.36 When Mr M attended his initial therapy appointment at the Trust with Mr T, he expressed concern about his difficulties reading and writing and how this would impact on his ability to engage in therapy. Mr T assured him that the therapy would be delivered in a way that was accessible to Mr M.

7.37 However, the letter that Mr M received from Mr T following the first appointment in December 2015 was very lengthy and detailed. It is our opinion that the messages within the letter were not delivered in an accessible format and we have heard from Mr M's family that Mr M did not understand the content.

7.38 Mr T was aware that Mr M "couldn't read very well" and reported this information to the internal investigation team.

7.39 The Complex Care and Dementia Operating Procedure makes the following statement about equality and diversity:

"The service accepts and treats everyone as an individual. Everyone is appropriately included and treated with respect and dignity. The service attempts to provide equal access to all people referred to the service. This is achieved through linking in with the Trust Equality and Diversity Group."

7.40 It is our view that the communication with Mr M following the initial appointment with Mr T did not reflect Mr M's individual needs. We consider that the Trust should review the way that it uses information about service users and carers to ensure that it communicates information in a way that is accessible to recipients. See our Recommendation 8.

Adult safeguarding and domestic abuse

7.41 Trust staff considered domestic abuse issues at the initial assessment in May 2015. No information was offered by either Mr M or Mrs M that should have led to concerns being raised by staff.

7.42 At an appointment in February 2016 Ms L, who was meeting Mr and Mrs M for the first time, recorded information that indicated that she had asked probing questions about domestic abuse. Her entries indicated that she had neither seen nor heard anything to cause concern.

7.43 During the review workshop held with Trust staff we specifically asked staff to consider if there was any information that, with the benefit of hindsight, might have indicated any domestic abuse by either Mr M or Mrs M. All staff stated that there was no indication at all of domestic abuse.

7.44 It is our view that although Trust staff did not undertake active questioning about domestic abuse of Mr or Mrs M without the other spouse present, staff assessments were appropriate.

Cognitive Analytic Therapy (CAT)

7.45 Cognitive Analytic Therapy brings together approaches from cognitive therapies and psychoanalytic approaches into an integrated therapeutic approach. It looks at the way people think, feel and act and is tailored to the needs of the individual. CAT can help people with problems such as depression and anxiety, both of which were diagnosed in Mr M.

7.46 The decision to refer Mr M for CAT was made on the basis that it was one of two therapy routes available for Mr M. The other was the BeMe service, essentially the same service as Mr M had already accessed through his referral to Outlook South West. Although it is important to note that Trust staff were not aware of that referral and therefore would not have known that they were offering Mr M the same service.

7.47 CAT was offered by the team because Mr T had recently qualified as a CAT therapist. We understand that the therapist had been offering CAT to clients on the team caseload for about a year prior to his involvement in Mr M's care and treatment. The Trust has since indicated that Mr M did not meet the criteria for referral to the Trust psychological therapy service. We found no

evidence that such a referral was considered and discussed by the team prior to making the offer of referral to BeMe or CAT therapy.

7.48 We understand that Mr T offered CAT to clients because he was interested in it and the team were happy to support him because they could see the benefit to clients. It was not part of an organisational strategic decision and in fact therapy is now no longer offered by care coordinators because of the impact it has on the ability of those staff to manage higher numbers of clients on their caseload.

7.49 The Trust is working on a therapy strategy that it is hoped will address the use of qualified therapy staff across the organisation. We strongly recommend that the Trust and commissioners assure themselves that this strategy sufficiently addresses the gaps in accessing appropriate therapy, regardless of age. See our Recommendation 9.

Predictability and preventability

7.50 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[18] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[19]

7.51 Prevention[20] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

7.52 We do not consider that either Mrs M's or Mr M's deaths could have been predicted. Mr M did not have a history of violence and Mrs M denied that Mr M had ever been violent or threatening towards her, stating if he ever did "she would leave him and he knew this". We have also considered whether Mrs M was ever violent or threatening towards Mr M, but again we have found no evidence of this.

7.53 Consequently, we do not consider that Mrs M's death could have been prevented. The tragic circumstances of the morning of 2 March were out of character and took place with no prior warning signs.

7.54 Although we have found no evidence that any actions or absence of actions by the Trust contributed to the deaths of Mr and Mrs M, we have identified some areas where practice could be improved.

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[18] *http://dictionary.reference.com/browse/predictability*

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

[20] *http://www.thefreedictionary.com/prevent*

Recommendations

7.55 This independent investigation has made nine recommendations for the Trust, Outlook South West and commissioners to address in order to further improve learning from this event.

Recommendation 1

The Trust must ensure that it fully executes its Duty of Candour responsibilities and that where there are parallel investigations by other agencies advice is only sought from senior staff about the most appropriate methods of communicating with affected parties.

Recommendation 2

If it has not already been actioned, the Trust must ensure that appropriate audits are undertaken regarding the effectiveness of the new protocol for the Complex Care and Dementia Team, taking any remedial action required if the effectiveness is found to be lacking.

Recommendation 3

The Trust must provide assurance that the expectations of the clinical record keeping policy are met.

Recommendation 4

Kernow Clinical Commissioning Group must ensure that the policy covering the management of serious incidents includes a requirement for oversight of provider investigation action plans, and appropriate and documented dialogue between the commissioner and relevant provider/s.

Recommendation 5

Outlook South West must consider what actions it can take to mitigate the risk of patients choosing not to share relevant clinical information with their therapist, now that therapists no longer have access to the GP clinical record system.

Recommendation 6

The Trust must ensure that SBARD (Situation, Background, Assessment of individual, Recommendation, Decision) is introduced to community mental health teams, ensuring that relevant learning from implementation in inpatient services is transferred.

Recommendation 7

The Trust must ensure that staff are able to identify and recognise the different types of supervision set out in the Supervision Policy ratified in March 2016, in order that staff can use supervision sessions appropriately.

Recommendation 8

The Trust must ensure that staff explore patients' literacy abilities and then communicate information in a way that is accessible and personalised.

Recommendation 9

The Trust and Kernow Clinical Commissioning Group must assure themselves that the therapy strategy sufficiently addresses the provision and use of qualified therapy staff across the Trust, ensuring that gaps in access to appropriate therapy are properly addressed.

Good practice

7.56 Outlook South West routinely seek information about a client's reading and writing abilities in order to inform the way in which they can best engage that client in therapy. This is good practice and ensures that all clients regardless of their literacy abilities can access therapy.

Post publication of this report

7.57 This report will be published accompanied by action plans developed by organisations for whom we have made recommendations. Progress and implementation of those action plans will be monitored by Kernow Clinical Commissioning Group and NHS England.

7.58 Approximately six months after this report is published we will undertake a follow up review to independently assess the progress being made by organisations.

7.59 We will produce a follow up report that will be shared with Mr and Mrs M's family and relevant organisations.

Appendix A – Terms of reference

Purpose of the investigation

1. To identify whether there were any gaps, deficiencies or omissions in the care and treatment that Mr M received, which, had they been in place, could have predicted or prevented the incident. The investigation process should identify opportunities for learning and areas where improvements to services are required which could prevent similar incidents from occurring.

2. The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and the Provider.

Terms of Reference

3. Review the assessment and treatment that was provided by all NHS provider organisations (and including, if appropriate non NHS organisations) identified in the level 2 investigation, following Mr M's contact with services in January 2015.

4. Review the contact, liaison and care planning between the GP, Outlook South West and Cornwall Partnership NHS Foundation Trust services.

5. Assess if Mr M's risks to himself and others were accurately and consistently assessed, understood and managed appropriately in the context of his social and family history.

6. Appraise the appropriateness of the allocation to CAT therapy and what support Mr M and his wife received while waiting for therapy to commence.

7. Assess the application of the Trusts CPA policy including the effectiveness of communication, information sharing and decision making between agencies and services.

8. Determine whether there were any missed opportunities to refer either Mr M or his wife to local safeguarding vulnerable adults services.

9. Assess whether Mr M's wife and family were involved in the assessment and delivery of care [and] had their own needs assessed robustly.

10. Review the documentation and record keeping of key information by the Cornwall Partnership NHS Foundation Trust against its own policies, best practice and national standards.

11. Comment on the standard of clinical and case management supervision available to frontline staff within the Cornwall Partnership NHS [Foundation Trust] teams detailed within the Level 2 report.

12. Review the Trust's internal investigation report and assess the adequacy of 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.

13. To review and comment on the Trust and CCGs enactment of their Duty of Candour.

14. To assess and review any contact made with the victim and perpetrator families involved in this incident, measured against best practice and national standards

15. To comment and test the Trust and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with particular reference to this incident.

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

17. We expect the investigators to include a lay person on their investigation panel to play a meaningful role and to bring an independent voice and challenge to the investigation and its processes.

Level of investigation

18. **Type C**: An investigation by single investigator examining a single case (with peer reviewer).

19. **Timescale:** The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter.

Initial steps and stages

NHS England will:

20. Ensure that the families are informed about the investigative process and understand how they can be involved including influencing the terms of reference.

21. Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this investigation.

22. Seek full disclosure of the perpetrator's clinical records to the investigation team.

Outputs

23. We will require monthly updates and where required, these to be shared with families.

24. A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.

25. A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.

26. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

27. Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference.

28. At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation and engage the clinical commissioning group with these meetings where appropriate.

29. A concise and easy to follow presentation for families.

30. A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

31. The investigator will deliver learning events/workshops for the Trust, staff and commissioners as appropriate.

32. We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public.

Appendix B – Documents reviewed

Cornwall Partnership NHS Foundation Trust documents

- Being Open and Duty of Candour Policy and Process
- Carers' Policy ratified November 2011
- Carers' Policy ratified November 2017
- Complex Care and Dementia Community Services Standard Operating Procedure ratified July 2014
- Complex Care and Dementia Newsletter Issue 27 October 2016
- Complex Care and Dementia Operational Assurance Group minutes March 2016
- Complex Care and Dementia Psychological Therapy Interface/Referral Process undated
- Internal investigation emails regarding contact with Mr M's family
- Internal investigation report and associated action plan
- Internal investigation staff interview minutes
- Open RiO Quality Manual June 2016
- Record Keeping Policy ratified March 2014
- Routine Enquiry key actions
- Routine Enquiry key questions
- Serious Incidents Policy ratified March 2016
- Serious Incidents Policy ratified December 2015
- Supervision Policy ratified August 2015
- Supervision Policy ratified March 2016
- Various screen shots from RiO showing new mandatory forms

Outlook South West documents

- Patient clinical questionnaire
- Therapist Risk Assessment form
- Therapist Risk Rating guidance
- Therapist Assessment guidance

NHS Kernow documents

- Complex Care and Dementia Acute Inpatient Liaison Service Specification
- Complex Care and Dementia Community Liaison Service Specification
- Improving Access to Psychological Therapies (IAPT) Service Specification
- Incident Management Policy ratified October 2015
- Serious Incident Policy ratified September 2017

Other documents

- Narrowcliff GP Surgery clinical records
- NHS England Domestic Homicide Review scoping paper
- Cornwall Coroner's records

Appendix C – Professionals involved

Pseudonym	Role	Organisation
Dr C	GP	Narrowcliff Surgery
Dr H	GP	Narrowcliff Surgery
Dr J	GP	Narrowcliff Surgery
Dr R	Consultant psychiatrist	Cornwall Partnership NHS Foundation Trust
Mr B	Senior psychological wellbeing practitioner	Outlook South West
Mr S	Internal investigator	Cornwall Partnership NHS Foundation Trust
Mr T	CAT therapist and community mental health nurse	Cornwall Partnership NHS Foundation Trust
Mrs E	Practice nurse	Narrowcliff Surgery
Ms G	Care co-ordinator	Cornwall Partnership NHS Foundation Trust
Ms J	Team manager	Cornwall Partnership NHS Foundation Trust
Ms J2	Care co-ordinator	Cornwall Partnership NHS Foundation Trust
Ms K	Adult safeguarding lead professional	Cornwall Partnership NHS Foundation Trust
Ms L	Care co-ordinator	Cornwall Partnership NHS Foundation Trust
Ms N	Internal investigator	Cornwall Partnership NHS Foundation Trust
Ms S	Primary care dementia practitioner	Cornwall Partnership NHS Foundation Trust
Ms S2	Memory assessment service nurse	Cornwall Partnership NHS Foundation Trust